Public Document Pack

Sefton Council

Overview & Scrutiny

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

DATE: Tuesday 7th January, 2025

TIME: 6.30 pm

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

Member	**Substitute**
Councillor	Councillor
Councillor Lunn-Bates (Chair)	Councillor Richards
Councillor Myers (Vice-Chair)	Councillor Roche
Councillor Conalty	Councillor McGinnity
Councillor Desmond	Councillor Carragher
Councillor Duerden	Councillor Webster
Councillor Grace	Councillor Danny Burns
Councillor Hinde	Councillor Brodie - Browne
Councillor Lloyd-Johnson	Councillor Sonya Kelly
Councillor Neary	Councillor Christopher Page
Councillor Pugh	Councillor Brodie-Browne
Ms. Diane Blair (Healthwatch)	
Mr. Brian Clark (Healthwatch)	

COMMITTEE OFFICER: Laura Bootland
Senior Democratic Services Officer
Telephone: 0151 934 2078
E-mail: laura.bootland@sefton.gov.uk

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.

We endeavour to provide a reasonable number of full agendas, including reports at the meeting. If you wish to ensure that you have a copy to refer to at the meeting, please can you print off your own copy of the agenda pack prior to the meeting.

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 - 10)

Minutes of the meeting held on 15 October 2024.

4. Shaping Care Together Programme (Pages 11 - 34)

To receive a presentation of the Programme Director, Shaping Care Together, Mersey and West Lancashire Teaching Hospital.

5. Proposed Changes to NHS Gluten Free Prescribing (Pages 35 - 112)

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

6. NHS Cheshire and Merseyside, Sefton - Update Report (Pages 113 - 116)

Report of the Sefton Place Director, NHS Cheshire and Merseyside

7. NHS Cheshire and Merseyside, Sefton - Health Provider (Pages 117 -

Performance Dashboard 124)

Report of the Sefton Place Director, NHS Cheshire and Merseyside

8. Right Care, Right Person Initiative (Pages 125 - 222)

Report of the Sefton Place Director, NHS Cheshire and Merseyside

9. CQC Assurance Update

To receive a verbal update from the Sefton Place Director, NHS Cheshire and Merseyside.

10. Adult Social Care Performance Data Review (To Follow)

Report of the Assistant Director, Adult Social Care and Health.

11. Domestic Abuse Update (To Follow)

Report of the Assistant Director, Communities.

12. Report on the Public Health Performance Framework (Pages 223 - 276)

Report of the Director of Public Health.

13. Cabinet Member Reports (Pages 277 - 296)

Report of the Chief Legal and Democratic Officer

14. Work Programme Key Decision Forward Plan (Pages 297 - 314)

Report of the Chief Legal and Democratic Officer

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

Overview & Scrutiny

OVERVIEW AND SCRUTINY COMMITTEE (ADULT SOCIAL CARE AND HEALTH)

MEETING HELD AT THE COMMITTEE ROOM - BOOTLE TOWN HALL, TRINITY ROAD, BOOTLE, L20 7AE
ON TUESDAY 15TH OCTOBER, 2024

PRESENT:	Councillor Lunn-Bates (in the Chair) Councillor Myers (Vice-Chair) Councillors Desmond, Duerden, Grace, Hinde, Lloyd-Johnson, Neary, Pugh and Sonya Kelly, Diane Blair (Healthwatch).
ALSO PRESENT	Councillor Doyle (Cabinet Member, Public Health and Wellbeing) Councillor Moncur (Cabinet Member, Adult Social Care).

18. APOLOGIES FOR ABSENCE

An apology for absence was received from Councillor McKee.

19. DECLARATIONS OF INTEREST

In accordance with Paragraph 9 of the Council's Code of Conduct, the following declaration of personal interest was made and the Member concerned remained in the room during the consideration of the item:

Member	Minute No.	Nature of Interest
Councillor Pugh	Minute No. 22 NHS Cheshire and Merseyside - Sefton Place Update	He and his wife are patients at Lincoln House Surgery.

20. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the Minutes of the meeting held on 3 September 2024, be confirmed as a correct record

21. NORTH WEST AMBULANCE SERVICE UPDATE REPORT

Further to Minute Number 4 of the meeting held on 18th June, Ian Moses, North West Ambulance Service NHS Trust (NWAS), attended the meeting, to present an update report on the North West Ambulance Service.

The report described to the Committee the way North West Ambulance Service (NWAS) Paramedic Emergency Services (PES) are delivered in Sefton, including 999 demand, call prioritisation and sorting, response time performance and operational challenges affecting these functions.

Members of the Committee asked questions/raised matters on the following issues:

- Response times data
- The number of mental health calls and the impact these have on the service in terms of hours spent on a call and the number of incidents attended by the Mental Health Car.
- Clarification on the data for category 2, 3 and 4 calls
- The likely impact of winter on the ambulance service
- The Patient Transport Service
- Work to reduce handover waiting times at hospitals
- Calls to falls patients and the details of any work being done with care homes and carers to prevent falls and to lift people who have fallen.
- Appreciation and thanks to the staff and service.

RESOLVED:

(1) That the report be noted, and Ian Moses be thanked for his attendance.

(2) That the Committee would like to receive a report annually from the North West Ambulance Service

(3) That a Committee visit to the North West Ambulance Service headquarters be arranged.

22. 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:

- Southport major incident recovery
- Womens Hospital Services in Liverpool Programme
- Closure of Lincoln House GP Surgery
- GP Collective Action
- GP Workforce Data

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

- The pyscholigical impact of the Southport incident
- The work with schools following the Southport incident
- Breakdown of GP workforce data between the North and South of the Borough would be useful.
- The learning taken from the Lincold House Surgery closure in terms of communications to patients
- When the case for change document would be published for the Liverpool Womens Hopsital

RESOLVED: That

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

(2) That an update on the pyschological impact of the Southport incident be brought to the next Committee meeting;

(3) Than an informal session on the work with Schools following the Southport incident be arranged and members of the Overview and Scrutiny Committee (Childrens Services and Safeguarding) be invited.

23. 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. Ambulance response times were also included within the data.

The Healthwatch representative queried if the friends and family data could be provided at a level which shows more detail by local area, instead of 'Place wide' data. It was confirmed this would be looked into.

RESOLVED:

(1) That the information on Health Provider Performance be noted.

(2) That the Place Director would investigate the issue of data being provided at a local area level.

24. ADULT SOCIAL CARE PERFORMANCE DATA REVIEW

Consideration was given to a report which provided an overview of Adult Social Care's performance against a number of required national and local metrics. The report was part of the regular cycle of reporting to the Committee and key information in terms of the preparation for Sefton's upcoming Care Quality Commission (CQC) assessment.

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

- It was noted that the reablement and quality of life figures were good, putting Sefton in the top quartile in England.
- The "Better at Home" programme and the work to reduce admissions in to care.
- Safeguarding data and the need to monitor under-reporting and ensure the quality team look at care homes which had not been inspected recently.
- Information about National Safeguarding Week between 18th-22nd November.

RESOLVED:

(1) That the contents of the report be noted;

(2) That it be agreed that regular updates continue to be provided to the Committee regarding the performance of Adult Social Care.

(3) That an informal session on safeguarding data be arranged.

25. 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 – Public Health and Wellbeing, attached to the report at Appendix A, outlined information on the following:

- Public Health Quarterly Dashboard
- Public Health Annual Report 2023
- Recommissioning of the Kooth Service
- Leisure Update

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

- Preparation for the The Care Quality Commission (CQC) Assurance and Assessment
- Safeguarding Adults Partnership Board update

- Better at Home Transformation Programme
- Strategic Commissioning
- New Directions
- Carers Strategy
- Falls Strategy
- Quality Assurance
- Work of the Learning Disability and Autism Team
- Adult Social Care Budget
- Adult Social Care Complaints, Compliments and MP Enquiries

Councillor Doyle, Cabinet Member – Public Health and Wellbeing and Councillor Moncur, Cabinet Member – Adult Social Care were in attendance to respond to any questions/comments by Members of the Committee.

RESOLVED:

That the Cabinet Member update reports be noted.

26. WORK PROGRAMME KEY DECISION FORWARD PLAN

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

- Invite the views of the Committee on the Work Programme for the remainder of the Municipal Year 2024/25;
- identify any items for pre-scrutiny by the Committee from the Key Decision Forward Plan;
- invite Committee Members to participate in informal briefing sessions during 2024/25;
- invite the views of the Committee on the draft Programme of informal briefings/workshop sessions for 2024/25;
- consider if there were any site visits that Committee Members would wish to undertake during 2024/25;
- receive an update on the Liverpool City Region Combined Authority Overview and Scrutiny Committee; and
- receive an update on the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee.

RESOLVED That

(1) the Work Programme for 2024/25, as set out in Appendix A to the report, be noted, along with any additional items to be included and thereon be agreed;

(2) the contents of the Key Decision Forward Plan for the period 1 September to 31 December 2024 be noted;

(3) all Members of the Committee be invited to participate in informal briefing sessions;

(4) the Programme of informal briefings/workshop sessions for 2024/25, as set out at Appendix B to the report, be noted;

(5) the following site visits for Committee Members be arranged to take place during 2024/25:

- Visit to Aintree Hospital or Royal Liverpool Hospital
- Visit to North West Ambulance Service Headquarters

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

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

NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

SHAPING CARE TOGETHER

Sefton Health Overview and Scrutiny Committee

Shaping Care Together Update

January 2025

Agenda Item 4

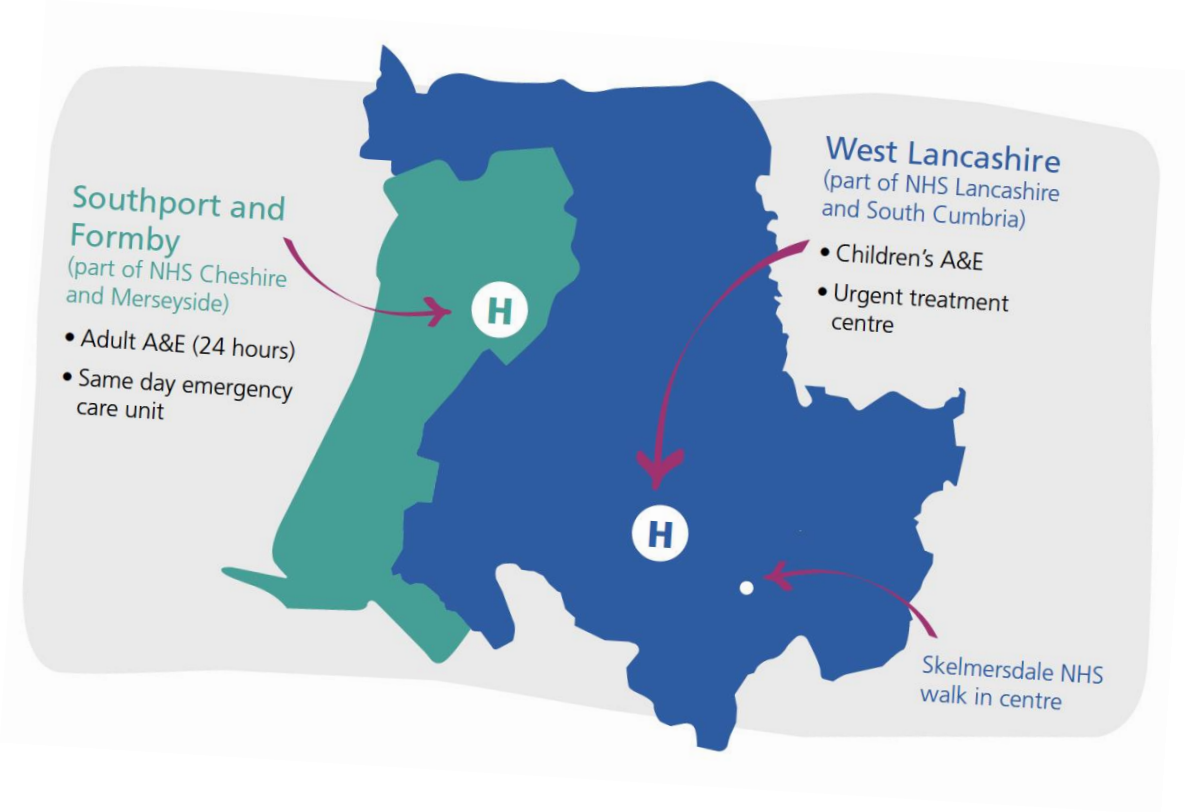
What we'll cover

- Background and Context
- Engagement update
- Emerging Themes
- Survey Demographics and responses
- Where are we in the Process
- Ask of HOSC

Background

Three NHS partners

- Deciding which services to offer, and where (commissioning)
  - NHS Cheshire and Merseyside ICB
  - NHS Lancashire and South Cumbria ICB
- Providing the services
  - Mersey and West Lancashire teaching Hospitals NHS Trust



A need to improve

2017	Clinical senate review	Trust unsustainable in current form
2019	Care Quality Commission rating	Requires improvement
2019-21	Identifying fragile services	Planning a way forward

Our focus

Seven fragile service areas

- Care for the frail and elderly
- Care for those who need urgent or emergency treatment
- Care for children
- Maternity care for pregnant women and new-born babies
- Care relating to women's reproductive and urinary systems (gynaecology)
- Sexual health care
- Planned care (for example, outpatient appointments)

The need for change

Five core drivers

Engagement Update and Emerging Themes

Background

Shaping Care Together is an NHS programme aimed at ensuring everyone in our communities across Southport, Formby and West Lancashire has access to the care they need through safe, high-quality services, today and in the future. The programme is looking first at how we offer services to those who need urgent or emergency care.

In July this year, we published our case for change, which outlines where the key challenges lie and why we need to change. This started the conversation around how services could be reorganised, but it didn't put forward any concrete proposals.

Before getting to that stage, we have a duty to listen to the views of people who rely on us or may be affected by how we offer our services. That's why, between July and October, we've been seeking the views of patients and public in a number of ways, which include a series of in-person and online public events, several focus groups, and our survey which attracted almost 3,000 responses.

This report provides an overview of the views, lived experiences and concerns of the people we heard from at our public events.

Our public events

Engaging in this way helps to ensure that any future redesign of services will be built around the needs of the people who live in the communities we serve. Our public event series helped us to:

- **Listen** to concerns, views, perspectives and ideas.
- **Inform** on programme scope, objectives and phasing and on how to get involved.
- **Engage** via Q&A sessions, surveys, suggestions cards and live conversations.
- **Record** views, suggestions and lived experiences.

Events were promoted via local radio and newspaper advertising, social media and email marketing, and on posters and leaflets across our hospital sites. Our network of voluntary and community groups were also used to help raise awareness and increase participation.

The event programme was a mix of public meetings in local community settings, online webinars and public roadshows in local shopping centres.

Ormskirk

Public meeting, Tues 10 Sept
The Ministry Centre, Aughton

Southport

Public meeting, Weds 18 Sept
Community Church Family Life Centre

Public roadshow, Sat 14 Sept
Marble Place Shopping Centre

Skelmersdale

Public roadshow, Sat 07 Sept
Concourse Shopping Centre

Banks*

Public meeting, Tues 24 Sept
The Hub, Banks

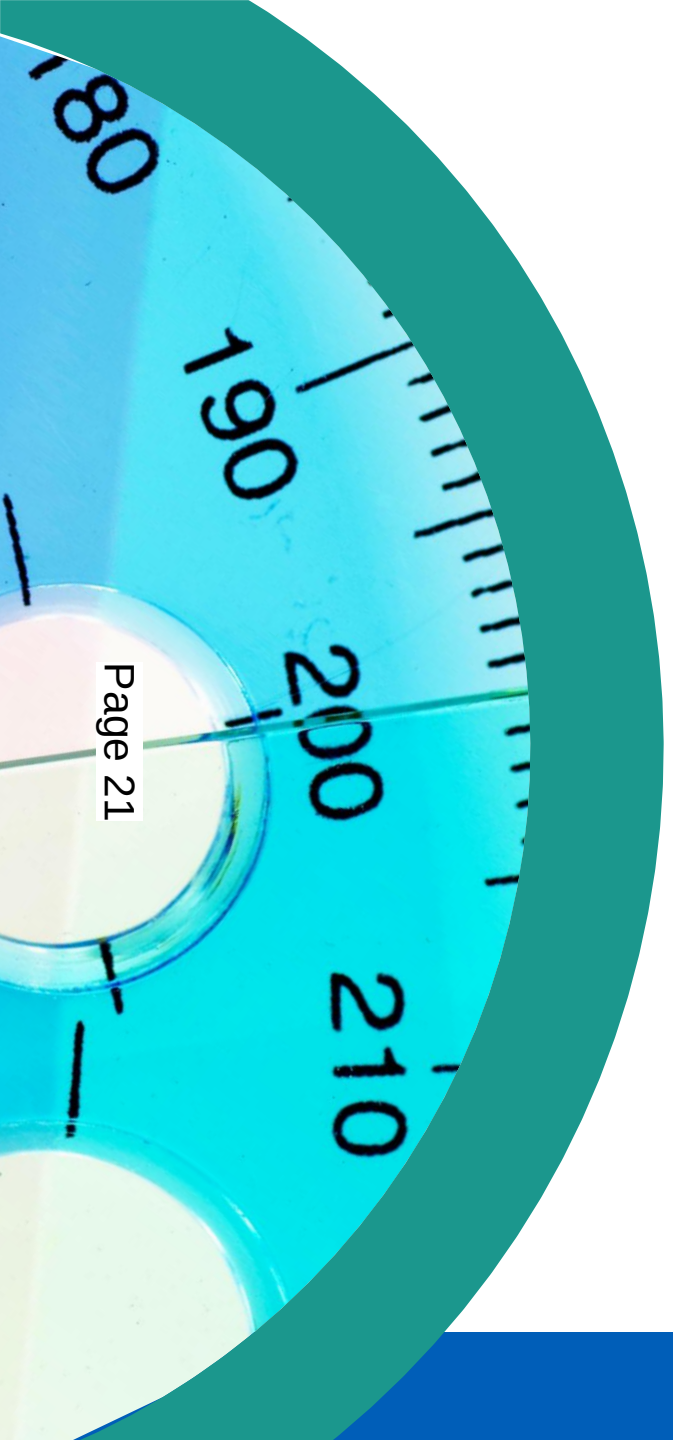
Formby

Public meeting, Mon 30 Sept
Holy Trinity Church

Online (2 webinars)

Public meetings, Tues 01 Oct
Morning / evening sessions via Zoom

**Part of the NHS Lancashire & South Cumbria 'Your health. Your future. Your say.' programme.*



Engagement metrics

Digital

Survey
2,930 responses

Website
11K+ visitors

Social media ads
101.6K+ reach
3,413 clicks

Digital documents
1200+ downloads

Offline

Radio ads Smooth NW
800K reach

Printed case for change
1000 distributed

Pharmacy bag ads
54K bags

Newspaper ads
Liverpool Echo, Ormskirk Advertiser

In person

Staff & public roadshows
600+ live conversations

Public meetings
5 meetings
200+ attending

Focus groups
5 session with patients, staff and VCFSE groups

300+ direct stakeholder contributions logged (in addition to the survey)

Note: Marketing was suspended between 2-26 August following the July 29 attacks in Southport.

Emerging themes

Some key themes emerging from public engagement events:

- Transport links are a barrier to access, especially in low car owning and more deprived areas.
- Future services needs to consider population change / new housing developments.
- People want 24/7 collocated Adults and Children's A&E services close to where they live.
- Some people asked for a (24/7) Walk-in-centre/Urgent Treatment Centre in their area.
- People said they often go to A&E because they can't get a GP appointment, and that primary care could do more to reduce the burden on A&E.
- Children's A&E should be 24 hours – Alder Hey should not be the closest overnight service.
- The programme must consider how to increase and retain the NHS workforce.
- People suggested that GPs may be referring non-emergency patients to A&E.
- Many people suggested collocating urgent and emergency services together on hospital sites.
- We need better provision of community services.
- Technology and AI can harness improvements / efficiency gains.
- More joined up records and better systems integration would help improve efficiency and reduce waste.
- Ambulance services need further investment - current waiting times are putting patients at risk.
- Care for rural communities must be considered.

Survey Demographics and Responses

Survey demographics (selected)

A selection of demographic data is presented in the tables. Data is also available for all protected characteristics, however, the sample size of some data sets is too small to be statistically relevant.

Area *	Total	% surveys	% pop	+/- pp
Southport	1273	44.0	40.3	+3.7
Formby	160	5.5	9.9	-4.4
Ormskirk	441	15.2	11.6	+3.6
Skelmersdale	516	17.8	15.0	+2.8
Rural / other	503	17.4	23.0	-5.6

* Geographic data is based on short postcode only and so contains a margin of error.

Demographic	Total	% surveys	% pop	+/- pp
Female	2319	81.3	-	+30+/-
Male	533	18.7	-	-30+/-
Under 45	635	21.0	-	
Over 45	2216	84	-	
Minority ethnic	49	1.7	3-4	-1.5+/-
White	2663	90.9	96-7	-5.5+/-
LTHC **	1356	46.3	-	-
NHS staff	517	17.6	-	-

** Long term health condition

Survey responses (quantitative)

Q2: Thinking about NHS urgent and emergency care services, which of the following are most important to you? Ranked in order of importance.

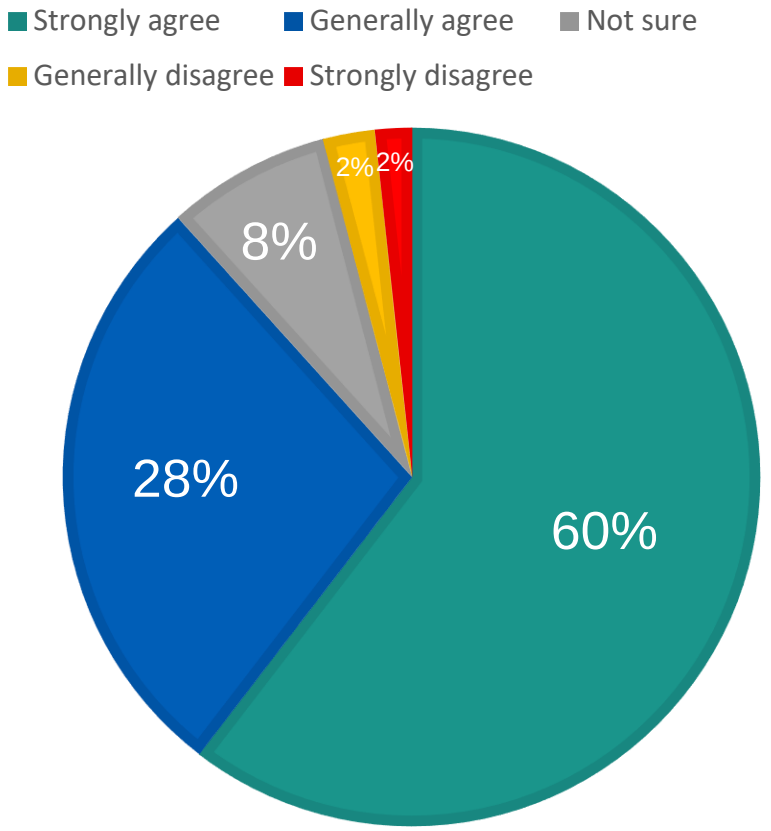
1. That I receive the best possible quality of care (3.0)
2. That medical safety always comes first (2.3)
3. That I am treated in a healthcare setting as close to home as possible (2.2)
4. That the specialists I need are there to help me (2.08)
5. That I can access the healthcare setting where I will be treated (1.9)

Survey responses (quantitative)

Q3: Our priorities for redesigning urgent and emergency care services are that we **provide everyone with safe and excellent care, today, and in the future**. Do you feel these are the right priorities?

88.3% either strongly or generally agree

4.1% generally or strongly disagree

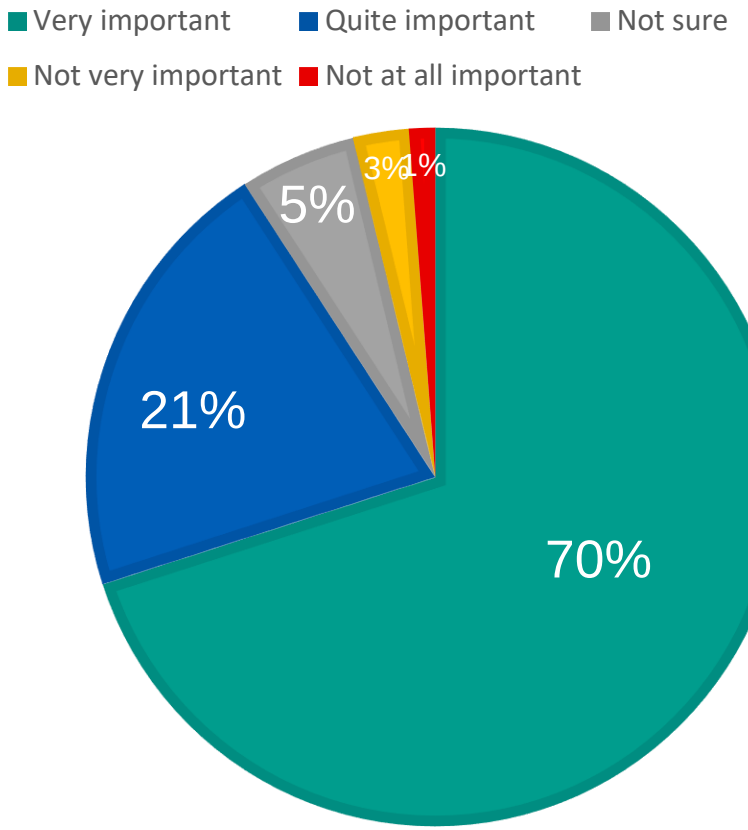


Survey responses (quantitative)

Q4: In your opinion, **how important is it that we set up urgent and emergency care services in a way that can help reduce waiting lists** across our local NHS?

90.8% find this very or quite important

3.7% find this not very or not at all important

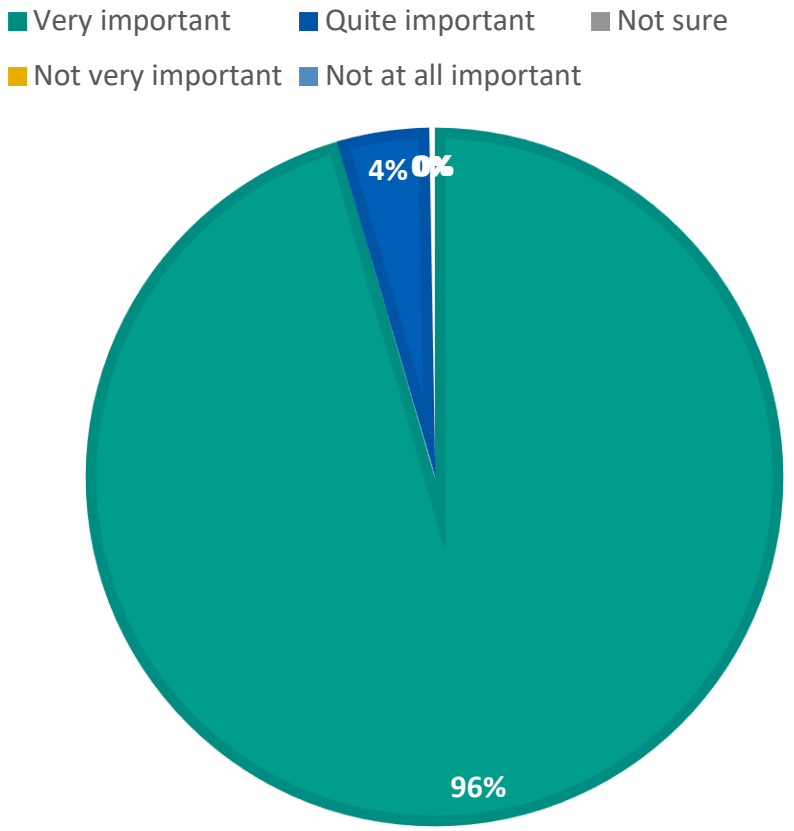


Survey responses (quantitative)

Q5: In your opinion, how important is it that urgent and emergency care is **available for everyone, all day, every day**?

99.7% find this very or quite important

0.1% find this not very or not at all important

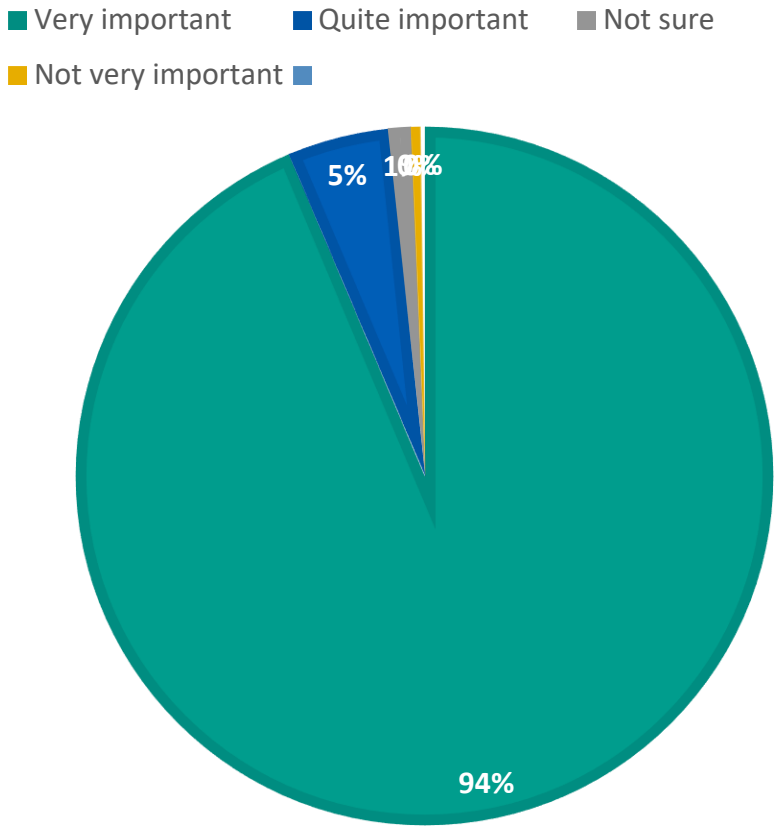


Survey responses (quantitative)

Q6: In your opinion, how important is it that **children and young people have the same access to emergency care as adults?**

98.4% find this very or quite important

0.6% find this not very or not at all important



Where are we in the Process

Getting to consultation

- Process set out in law and informed by NHS guidance
- We must be very thorough in respecting the process
- Currently in the appraisal phase
- Still a live process

Ask of HOSC

Summary

- Currently in a live process
- Extensive pre-consultation engagement has taken place
- Emerging themes give an overview of potential proposals to support decision making regarding substantial variation and requirement to formally consult with HOSC
- Lancashire HOSC have agreed Substantial variation in December

Ask of HOSC

- Agree that this programme will deliver substantial change/variation and requires formal consultation with HOSC
- If Sefton HOSC agree possible proposals could be an SDV then a JOSC will need to be formed

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Sefton Council

Consultation on NHS funded Gluten Free Prescribing Across Cheshire and Merseyside

Date of meeting:	07 January 2025
Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)
Report of:	NHS Cheshire and Merseyside ICB
Wards affected:	All
Exempt/confidential report:	No
Contact Officer:	Deborah Butcher
Tel:	
Email:	

1.0 Why is this item before the Committee?

1.1 The purpose of this report is to inform the Committee that the Board of NHS Cheshire and Merseyside Integrated Care Board (ICB), at its meeting on 28 November 2024,[1] approved the recommendation that the ICB commences a period of public consultation regarding the proposal to cease NHS funded gluten free prescribing (bread and bread mixes) across Cheshire and Merseyside.

1.2 The ICB has duty to engage with Local Authority Health and Overview Scrutiny Committees (HOSC) to seek confirmation as to whether the HOSC believes this proposal is a substantial change to NHS services. If this is confirmed by HOSC then this triggers the requirement for the ICB to formally consult with the HOSC, in line with the s.244 Regulations[2] of the NHS Act 2006 (as amended by the Health and Care Act 2022).

2.0 What is Scrutiny being asked to do?

2.1 The Committee is asked to:

- consider and determine whether the proposal represents a substantial development or variation.

3.0 EXECUTIVE SUMMARY

3.1 The Board of NHS Cheshire and Merseyside Integrated Care Board (ICB), at its meeting on 28 November 2024, has approved the recommendation that the ICB commences a period of public consultation regarding its proposal to cease NHS funded gluten free prescribing (bread and bread mixes) across Cheshire and Merseyside. The paper outlining the proposal and rationale is appended to this paper (Appendix One) and is available at www.cheshireandmerseyside.nhs.uk. Contained within this Appendix is the following that was considered by the Board:

- Cover paper

- Gluten Free Prescribing Options Appraisal document
- Communications and Engagement Plan
- Equality, Diversity and Inclusion Impact Assessment
- Quality Impact Assessment.

3.2 Currently across Cheshire and Merseyside there are differences in the prescribing availability of gluten free products for patients due to previous arrangements of the individual predecessor Clinical Commissioning Group (CCG) organisations. GP Practices within eight Places currently offer gluten free prescribing in line with the 2018 national Department of Health and Social Care (DHSC) consultation outcome, which was to reduce prescribing to bread and bread mixes only. It is of note that St Helens CCG and NHS Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above). For Cheshire West Place, the area that was covered by the former NHS Vale Royal CCG did not opt to withdraw gluten free prescribing, and as such there are still parts of Cheshire West where gluten free prescribing (for bread and bread mixes) can be undertaken (Winsford, Northwich and surrounding area). As the ICB has commissioning responsibilities for all of Cheshire and Merseyside patients, work has been undertaken to rectify this position and recommend a harmonised approach to gluten free prescribing.

3.3 In Cheshire and Merseyside, c13,000 patients have a diagnosis of coeliac disease or other conditions which requires management through a gluten free diet. Most people choose to purchase their gluten free foods at supermarkets or other retailers however 2,314 Cheshire and Merseyside patients receive gluten free bread and bread mixes via prescription. Of the gluten free prescriptions issued, 99% are exempt from prescription charges, with 73% being due to age (under 16 or 18 if in full time education, or over 60 years old) and over 60% of these being over the age of 60. Further data can be seen in Tables One, Two and Three.

3.4 Under the ICBs Reducing Unwarranted Variation Recovery programme, a number of options were considered in order to address the variation in gluten free prescribing. The option to maintain the current arrangements was not considered, due to the current unharmonised position, and the need to ensure equity across Cheshire and Merseyside. In order to achieve this, the two main options considered were to either fully prescribe across Cheshire and Merseyside at an estimated additional cost of £130k per year (increase annual spend on the service of c.£655k) or to withdraw prescribing completely, offering an estimated annual saving of £525k. The full options appraisal can be found in Appendix One of this report.

3.5 In the context of NHS Cheshire and Merseyside needing to consider how and where to allocate the fixed resources allocated by NHS England to best meet the healthcare needs of the population they serve, the Unwarranted Variation programme proposed to the Board of NHS Cheshire and Merseyside that gluten free prescribing is stopped across Cheshire and Merseyside due to the following rationale:

- availability of gluten free foods is much greater than it was when the original policies were implemented, and in the six years since the DHSC consultation. It should also be noted that bread is not classed as an essential food item and people can maintain a healthy diet without bread through choosing naturally gluten free foods
- whilst the cost of gluten free bread is still more expensive than non-gluten free there are other gluten free products (e.g. pasta) which are the same price. In addition, improved food labelling and increased awareness enables people to make informed and healthy choices
- Coeliac UK now say that 40% of ICBs have stopped or reduced gluten free prescribing. Our research shows that 32% have stopped completely, 61% prescribe bread and bread mixes and 6% offer to un

- consideration was given to prescribing to under 18s only, however, Cheshire and Merseyside data shows that over 60% of gluten free prescriptions are for patients 60 years old, and therefore could be seen as discriminatory against the older population
- gluten free prescriptions are in the main received by patients who have exemptions from payment, with the majority of this being due to age (73%). Because age exemption does not take into account financial capacity, it is difficult to evidence the individual financial impact on the impacted patients.
- withdrawing prescribing has already been implemented fully in St Helens and part of Cheshire West and to date we are not aware of any unforeseen health consequences
- ceasing ICB funded gluten free prescribing across Cheshire and Merseyside would enable achievement of a harmonised policy and remove existing unwarranted variation in access to these products based on the rationale set out in this document. In addition, it would harmonise the approach to prescribing other foods for conditions impacted by "standard" products e.g. lactose intolerance, as NHS Cheshire and Merseyside does not currently prescribe food alternatives for other food allergies / intolerances
- a number of neighbouring ICBs including Lancashire and South Cumbria and Shropshire, Telford and Wrekin have already stopped prescribing.

3.6 NHS Cheshire and Merseyside will commence its public consultation on 28 January 2025 for a 6-week period, with the closing date being the 11 March 2025. It is anticipated that the outcome of the consultation and the recommendation for the Board to consider and decide upon will be undertaken at the meeting of the Board on 29 May 2025. The Board will receive the results of the consultation and any feedback report/opinion of Local Authority Health Scrutiny at this meeting to help inform its deliberations and decision. Any formal response to the proposal/consultation by Local Authority HOSC would be requested to be provided prior to the start of May 2025 so as to help inform in a timely manner the final report to the Board of NHS Cheshire and Merseyside, however the exact date will need to be agreed with the HOSC.

3.7 As outlined within the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny)[3] regulations, and covered within the Cheshire and Merseyside protocol (Appendix Two) for the establishment of joint health scrutiny arrangements, where a proposal on changes to NHS services impact on more than one Local Authority area, it is for each individual authority to reach a view on whether the proposal is deemed to be a substantial development or variation for that Local Authority area, and where more than one Local Authority agrees that it does (for the same proposal) then regulations place a requirement on those local authorities to establish a joint overview and scrutiny committee for the purposes of considering it (the proposal). The Cheshire and Merseyside protocol deals with the proposed operation of such arrangements for the Local Authorities of Cheshire and Merseyside.

3.8 Subject to the decision of the Sefton HOSC, and that of the other Local Authority HOSCs in Cheshire and Merseyside, NHS Cheshire and Merseyside will make the necessary preparations to formally consult with the agreed scrutiny arrangements. The ICB is attending Local Authority HOSC meetings across Cheshire and Merseyside throughout December 2024, January 2025 and early February 2025 with regards these proposals.

4. BACKGROUND

4.1 Coeliac disease is an autoimmune condition associated with chronic inflammation of the small intestine, which can lead to malabsorption of nutrients. The complications of coeliac disease (which may or may not be present at diagnosis) can include osteoporosis, ulcerative jejunitis, malignancy (intestinal lymphoma), functional hyposplenism, vitamin D deficiency and iron deficiency. Other key information about coeliac disease includes:

- population screening studies sugg

he UK 1 in 100 people are affected.

- according to Coeliac UK, most people are diagnosed from 50 years old and coeliac disease is most common in people aged between 50-69 years old
- people with conditions such as type 1 diabetes, autoimmune thyroid disease, Down's syndrome and Turner syndrome are at a higher risk than the general population of having coeliac disease.
- first-degree relatives of a person with coeliac disease also have an increased likelihood of having coeliac disease.
- according to NICE the prevalence in females is higher than in males (0.6% compared to 0.4%). Cheshire and Merseyside data reflects this with 65% of patients diagnosed with coeliac disease being female.

4.2 Across Cheshire and Merseyside, we have the following data available.

Table One: Total number of patients, registered with a GP Practice, diagnosed with coeliac disease by Place and by age

	Age Range										
Place	**0-9**	**10-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-69**	**70-79**	**80-89**	**90+**	**Grand Total**
Liverpool	44	196	314	280	227	293	391	305	200	18	**2268**
Cheshire East	52	200	216	293	231	293	351	304	216	45	**2201**
Wirral	43	163	193	267	200	288	317	258	157	35	**1921**
Cheshire West	45	171	199	219	231	235	331	273	161	31	**1896**
Sefton	22	113	101	162	102	224	258	187	126	26	**1321**
Warrington	31	108	97	117	106	178	173	126	68	15	**1019**
Knowsley	12	83	79	87	87	132	151	100	61	12	**804**
St Helens	14	65	84	100	86	120	137	121	61	14	**802**
Halton	14	72	77	91	78	95	108	100	42	7	**684**
Grand Total	**277**	**1171**	**1360**	**1616**	**1348**	**1858**	**2217**	**1774**	**1092**	**203**	**12916**

Source: EMIS, November 2024

Table Two: Total number of patients, registered with a GP Practice, currently receiving gluten free bread and/or bread mix prescriptions

	Age Range											
Place	**0-9**	**10-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-69**	**70-79**	**80-89**	**90+**	**Grand Total**	**% of total coeliac patients in Place**
Liverpool	16	61	28	20	34	67	120	104	66	5	**521**	23%
Cheshire East	19	64	18	23	22	38	97	98	67	6	**452**	21%
Wirral	13	42	20	27	28	48	81	75	55	7	**396**	21%
Sefton	9	34	13	19	10	53	69	74	49	6	**336**	18%
Warrington	11	24	8	8	8	19	37	35	23	8	**181**	14%
Knowsley	5	22	11	11	9	21	32	35	24	2	**172**	17%
Halton	4	17	3	14	10	22	28	31	9	3	**141**	18%
Cheshire West	2	8	5	3	11	10	18	19	11	2	**89**	11%
St Helens	0	0	0	0	0	0	0	1	1	0	**2**	0%
Grand Total	**79**	**272**	**106**	**125**	**132**	**278**	**482**	**472**	**305**	**39**	**2290**	

Source: EMIS, November 2024

Table Three: Total Number of Prescriptions issued (September 2023 – September 2024)

Area	Number of prescriptions issued
Sefton Place Total	3202
South Sefton Primary Care Network	*1420*
PC24	*303*
Southport and Formby Primary Care Network	*1476*
Netherton Surgery	*2*
South Sefton GP Extra Service	*1*

Source: EMIS

4.3 Management of coeliac disease is a lifelong gluten free diet. Historically, availability of gluten free foods was limited and expensive, so patients obtained these products via prescribing, however, all major supermarkets now commonly stock a wide range of gluten free foods, and the price differential is reducing as demand grows.

4.4 It is difficult to evidence the impact of stopping gluten free prescriptions for bread and bread mixes and understanding the impact on affected patients. Whilst there are known risks to not adhering to a gluten free diet, which could have long term health impacts and lead to greater demand on wider health services, there is now greater availability of gluten free foods in supermarkets and other retailers (both in store and on-line), improved food labelling and greater awareness of the impact of non-adherence, which all support the patient to make good food choices for a healthy diet.

4.5 It should be noted that although gluten free bread and bread mixes are still more expensive, the cost of these products has been reducing. It is also worth noting that bread is not an essential food item and there are many naturally occurring gluten free foods. Additionally, gluten intolerance individuals do not need to eat wheat based products to maintain good health.

5.0 CONSULTATION AND ENGAGEMENT

5.1 The ICB is now engaging with Local Authority HOSCs across Cheshire and Merseyside to seek confirmation from each individual HOSC as to whether the HOSC believes this proposal triggers the requirement for the ICB to formally consult with them.

5.2 Subject to the decision of the Sefton HOSC, and that of the other Local Authority HOSCs in Cheshire and Merseyside, NHS Cheshire and Merseyside will make the necessary preparations to formally consult with the agreed scrutiny arrangements, and attend meetings on the date(s) arranged.

5.3 NHS Cheshire and Merseyside intends to begin a 6-week public consultation period from 28 January 2025, with the closing date being the 11 March 2025. The public consultation will present a single option – the cessation of NHS funded gluten free prescribing across Cheshire and Merseyside. The objectives of the consultation are:

- to inform patients, carers/family members, key stakeholders, and the public of proposed changes to gluten free prescribing.
- to engage with people who currently receiving gluten free bread and bread mixes on prescription, organisations which support them (where applicable), their carers/family members, and the wider public, to gather people's views about the proposed changes, including how individuals might be impacted.
- to use these responses to inform f[illegible]n-making around the proposal.

5.4 A clear consultation communication plan is being finalised, with the draft plan being available within Appendix One to this report. NHS Cheshire and Merseyside will produce clear and accessible public-facing information about the proposal, details of who is likely to be impacted and how, setting out the background to the issue and explaining why NHS Cheshire and Merseyside is proposing to make a change. This information will be accompanied by a questionnaire containing both qualitative and quantitative questions, designed to gather people's views and perspectives on the proposals. Both the information and questionnaire will be available in Easy Read format. All materials will be made available on the NHS Cheshire and Merseyside website, with printed versions and alternative formats/languages available on request (via email or telephone). People who are unable to complete the questionnaire will be able to provide their feedback over the telephone.

5.5 The consultation will be promoted across NHS Cheshire and Merseyside's internal and external communication channels. Wider partners and stakeholders, including providers of NHS services (hospitals, community and mental health providers and primary care), local authorities, Healthwatch, and voluntary, community, faith and social enterprise (VCFSE) organisations, will be asked to share information using their own channels, utilising a toolkit produced for this purpose.

5.6 To ensure that those who would be most impacted by any potential change have an opportunity to share their views, NHS Cheshire and Merseyside will seek to work with colleagues in general practice and local pharmacies, to ensure that those who currently receive gluten free bread and bread mixes on prescription are made aware that the consultation is underway.

5.7 While specific standalone events will not be organised as part of the consultation, if individual groups/networks request further information, NHS Cheshire and Merseyside will offer to attend meetings to provide additional briefings if required/appropriate.

5.8 NHS Cheshire and Merseyside recognise that it is important to understand the effectiveness of different routes for reaching people, so that this can be utilised for future activity, and the questionnaire will ask people to state where they heard about the engagement. We will summarise this information – along with other measures such as number of enquiries received and visits to the website page – in the final consultation report.

5.9 When the consultation closes, the findings will be analysed and compiled into a report by an independent external organisation. The feedback report will be used to inform final decision-making about the proposal, and will therefore be received by the Board of NHS Cheshire and Merseyside at its meeting on 29 May 2025. The outcome of this will be communicated using the same routes used to promote the consultation.

5.10 Any formal response to the proposal/consultation by Local Authority HOSC would be requested to be provided prior to the start May 2025 so as to help inform in a timely manner the final report to the Board of NHS Cheshire and Merseyside, however the exact date will need to be agreed with the HOSC.

6.0 FINANCIAL IMPLICATIONS

6.1 There are no financial implications for Warrington Council. If the ICB was to cease funding Gluten Free prescriptions, then this would result in an estimated annual saving of £525k.

7.0 EQUALITY IMPACT ASSESSMENT

7.1 Within Appendix One there is a link to the Equality and Quality Impact Assessments undertaken by NHS Cheshire and Merseyside ICB. There are no equality implications in relation to the ask contained / request outlined within the report to the Committee.

8.0 REASONS FOR RECOMMENDATIONS

8.1 For NHS Cheshire and Merseyside to understand better and plan accordingly how to inform and/or consult Local Authority HOSC across Cheshire and Merseyside, a decision is required by each Local Authority regarding whether:

- they determine that the proposal to cease NHS funded gluten free prescribing is to be classed as a substantial development or variation, and
- whether this triggers the need to establish a Joint HOSC in line with the Cheshire and Merseyside protocol.

9.0 RECOMMENDATIONS

9.1 The Committee is asked to:

- consider and determine whether the proposal represents a substantial development or variation
- note that, subject to the decision of the Sefton HOSC and that of the other seven Local Authority HOSCs that NHS Cheshire and Merseyside will need to inform and/or consult with the relevant health scrutiny arrangements on the consultation and its outcome

10.0 IMPLICATIONS AND COMMENTS

10.1 A substantial development or variation is not defined in legislation. Guidance has suggested that the key feature is that it should involve a major impact on the services experienced by patients and/or future patients. Paragraph 5.2.3 of the Cheshire and Merseyside Protocol outlines the following criteria that Local Authorities should consider to help them with their determination:

- *Changes in accessibility of services:* any proposal which involves the withdrawal or change of patient or diagnostic facilities for one or more speciality from the same location.

- *Impact on the wider community and other services:* this could include economic impact, transport, regeneration issues.

- *Patients affected:* changes may affect the whole population, or a small group. If changes affect a small group, the proposal may still be regarded as substantial, particularly if patients need to continue accessing that service for many years.

- *Methods of service delivery:* altering the way a service is delivered may be a substantial change, for example moving a particular service into community settings rather than being entirely hospital based.

- *Potential level of public interest:* proposals that are likely to generate a significant level of public interest in view of their likely impact

10.2 Where a substantial development or variation impacts on the residents within one local authority area boundary, only the relevant local authority health scrutiny function shall be consulted on the proposal. Where a proposal impacts on residents across more than one local authority boundary, the NHS body/health service provider is obliged to consult all those authorities whose residents are affected by the proposals in order to determine whether the proposal represents a substantial development or variation.

10.3 Those authorities that agree that any such proposal does constitute a substantial development or variation are obliged to form a joint HOSC for the purpose of formal consultation by the proposer of the development or variation. Whilst each local authority must decide individually whether a proposal represents a substantial development/variation, it is only the statutory joint health scrutiny committee which can formally comment on the proposals if more than one authority agrees that the proposed change is "substantial".

10.4 Determining that a proposal is not a substantial development/variation removes the ability of an individual local authority to comment formally on the proposal. Once such decisions are made, the ongoing obligation on the proposer to consult formally on a proposal relates only to those authorities that have deemed the proposed change to be "substantial" and this must be done through the vehicle of the joint committee. Furthermore, the proposer will not be obliged to provide updates or report back on proposals to individual authorities that have not deemed them to be "substantial"

References:

1. Papers for the 28 November 2024 meeting of the Board of NHS Cheshire and Merseyside ICB
https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/2024/28-november-2024/

2. National Health Service Act 2006, Section 244
https://www.legislation.gov.uk/ukpga/2006/41/section/244

3. Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, https://www.legislation.gov.uk/uksi/2013/218/contents/made

Appendices:

Appendix One: Gluten Free prescribing Paper to the Board of NHS Cheshire and Merseyside ICB, 28 November 2024

Appendix Two: Cheshire and Merseyside Protocol for the establishment of Joint Health Scrutiny Arrangements in Cheshire and Merseyside

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Proposal regarding ICB funded Gluten Free Prescribing across Cheshire and Merseyside

Agenda Item No: ICB/11/24/17

Responsible Director: Prof. Rowan Pritchard-Jones, Medical Director

NHS
Cheshire and Merseyside

Proposal regarding ICB funded Gluten Free Prescribing across Cheshire and Merseyside

1. Purpose of the Report

1.1 The purpose of the paper is to seek approval from the Board of NHS Cheshire Merseyside ICB to progress with the commencement of a period of public consultation, regarding ICB funded gluten free (GF) prescribing.

1.2 The approval will enable the commencement of a six-week consultation involving patients, public, staff and other key stakeholders, starting January 2025.

2. Executive Summary

2.1 Currently within NHS Cheshire and Merseyside there are differences in the prescribing of gluten free products for patients due to previous arrangements of the individual predecessor Clinical commissioning Group (CCG) organisations. As the ICB has commissioning responsibilities for all of Cheshire and Merseyside patients, work has been undertaken to rectify this position and recommend a harmonised approach to prescribing.

2.2 Across the 9 Places in Cheshire and Merseyside, there are GP Practices within 8 Places that currently offer gluten free prescribing in line with the 2018 national Department of Health and Social Care (DHSC) consultation outcome, which was to reduce prescribing to bread and bread mixes only. It is of note that St Helens CCG and NHS Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above). For Cheshire West Place, the area that was covered by the former NHS Vale Royal CCG did not opt to withdraw prescribing, and as such there are still parts of Cheshire West were gluten free prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area).

2.3 In Cheshire and Merseyside, over 13,300 patients have a diagnosis of coeliac disease or other conditions which requires management through a gluten free diet. Most people choose to purchase their gluten free foods at supermarkets or other retailers however 2,314 patients receive their gluten free bread and bread mixes via prescription. It should be noted that of the gluten free prescriptions issued, 99% are exempt from prescription charges, with 73% being due to age (under 16 or 18 if in full time education, or over 60 years old) and over 60% of these being over the age of 60.

2.4 Under the ICBs Unwarranted Variation Recovery programme, a number of options were considered in order to address the unwarranted variation. The option to maintain the current arrangements was not considered, due to the

current unharmonised position, and the need to ensure equity across Cheshire and Merseyside. In order to achieve this, the two main options considered were to either fully prescribe across Cheshire and Merseyside at an estimated additional cost of £130k per year (increase annual spend on the service of c.£655k) or to withdraw prescribing completely, offering an estimated annual saving of £525k. (The full options appraisal can be found in Appendix One of this report).

2.5 Initially the review of the current gluten free prescribing policies was undertaken as part of the Clinical Policy Harmonisation programme which involved a clinical working group who recommended to reinstate prescribing across all of Cheshire and Merseyside which is in line with the DHSC consultation outcome. However, this position was not supported by the ICBs Finance, Investment and Our Resources Committee due to the financial challenges faced by NHS Cheshire and Merseyside.

2.6 In the context of NHS Cheshire and Merseyside needing to consider how and where to allocate the fixed resources allocated by NHS England to best meet the healthcare needs of the population they serve, the Unwarranted Variation programme has proposed that gluten free prescribing is stopped across Cheshire and Merseyside due to the following rationale:

- availability of gluten free foods is much greater than it was when the original policies were implemented, and in the six years since the DHSC consultation. It should also be noted that bread is not classed as an essential food item and people can maintain a healthy diet without bread through choosing naturally gluten free foods
- whilst the cost of gluten free bread is still more expensive than non-gluten free there are other gluten free products (e.g. pasta) which are the same price. In addition, improved food labelling and increased awareness enables people to make informed and healthy choices
- Coeliac UK now say that 40% of ICBs have stripped or reduced prescribing. Our research shows that 32% have stopped completely, 61% prescribe bread and bread mixes and 6% offer to under 18s only
- consideration was given to prescribing to under 18s only, however, Cheshire and Merseyside data shows that over 60% of gluten free prescriptions are for patients 60 years old, and therefore could be seen as discriminatory against the older population
- gluten free prescriptions are in the main received by patients who have exemptions from payment, with the majority of this being due to age (73%). Because age exemption does not take into account financial capacity, it is difficult to evidence the individual financial impact on the impacted patients.
- withdrawing prescribing has already been implemented in St Helens and part of Cheshire West and to date we are not aware of any unforeseen consequences
- ceasing ICB funded gluten free prescribing across Cheshire and Merseyside would enable achievement of a harmonised policy and remove existing unwarranted variation in access to these products based on the rationale set out in this document. In addition, it would harmonise the approach to prescribing other foods for conditions impacted by “standard” products e.g.

lactose intolerance, as NHS Cheshire and Merseyside does not currently prescribe food alternatives for other food allergies / intolerances
- a number of neighbouring ICBs including Lancashire and South Cumbria and Shropshire, Telford and Wrekin have already stopped prescribing.

2.7 A decision to withdraw gluten free prescribing would require a public consultation, and which will also include engagement and/or consultation with our Local Authority colleagues through 8 of the 9 Local authority Health Overview and Scrutiny committees. Included in this report is the proposed engagement and consultation plan, subject to approval received from the Board (see Appendix Two).

2.8 The feedback from the consultation, together with that of the Local Authority Health Overview and Scrutiny Committees will inform the final proposal that will come to Board in 2025 for consideration and decision.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**
- **approve** the commencement of a consultation exercise with the public and stakeholders regarding the proposed option to withdraw ICB funded gluten free prescribing across all of Cheshire and Merseyside.

4. Reasons for Recommendations

4.1 A decision by the Board to withdraw ICB funded gluten free prescribing needs to be informed with evidence including the outcome and outputs of a consultation exercise with the public and key stakeholders. It is a legal requirement and duty on the ICB to engage and consult with the public as well as local Health Overview and Scrutiny arrangements.

5. Background

5.1 Currently NHS Cheshire and Merseyside has unwarranted variation in the prescribing of gluten free products across all Places. St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely prior to the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. For Cheshire West Place, the area that was covered by the former NHS Vale Royal CCG did not opt to withdraw prescribing, and as such there are still parts of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area).

5.2 Coeliac disease is an autoimmune condition associated with chronic inflammation of the small intestine, which can lead to malabsorption of nutrients. Population screening studies suggest that in the UK 1 in 100 people are

affected. The complications of coeliac disease (which may or may not be present at diagnosis) can include osteoporosis, ulcerative jejunitis, malignancy (intestinal lymphoma), functional hyposplenism, vitamin D deficiency and iron deficiency. People with conditions such as type 1 diabetes, autoimmune thyroid disease, Down's syndrome and Turner syndrome are at a higher risk than the general population of having coeliac disease. First-degree relatives of a person with coeliac disease also have an increased likelihood of having coeliac disease.

5.3 Management of coeliac disease is a lifelong gluten free diet. Historically, availability of gluten free foods was limited and expensive, so patients obtained these products via prescribing, however, all major supermarkets now commonly stock a wide range of gluten free foods and the price differential is reducing as demand grows. It should be noted that there have been a number of recent national news articles on the higher cost of these “free from” alternatives and the impact of withdrawing prescribing in context of cost-of-living increases.

5.4 Initially the former CCGs gluten free prescribing policies were reviewed as part of the Clinical Policy Harmonisation programme, the objective of which was to review existing policies and the latest evidence base to recommend a single set of policies which would enable all patients to have equitable access. Therefore, the option to continue with the current arrangements was discounted. The review of the gluten free prescribing policy involved a clinical working group who recommended to reinstate prescribing across all of Cheshire and Merseyside in line with the DHSC consultation outcome. However, as this would result in additional annual expenditure of c.£130k, this position was not supported by our Finance, Investments and Resources Committee due to the financial challenges faced by NHS Cheshire and Merseyside.

5.5 The review was then progressed under the Reducing Unwarranted Variation programme and the non-prescribing option was considered in context of the patient safety risks, and the requirement to support NHS Cheshire and Merseyside to deliver the financial objectives of the Recovery programme.

5.6 It is difficult to evidence the impact of stopping gluten free prescriptions for bread and bread mixes and understanding the impact on affected patients. Whilst there are known risks to not adhering to a gluten free diet, which could have long term health impacts and lead to greater demand on wider health services, there is now greater availability of gluten free foods in supermarkets and other retailers (both in store and on-line), improved food labelling and greater awareness of the impact of non-adherence, which all support the patient to make good food choices for a healthy diet.

5.7 The options appraisal paper was initially discussed with the Associate Directors of Quality where the proposal was acknowledged and supported for progression. It was subsequently presented to the Recovery Committee on 16 September 2024 and was then considered by the Strategy and Transformation (S&T) committee at the meeting on 19 September 2024. The S&T committee supported the recommendation to present the preferred option, to cease

prescribing to the Board and that we progress to a public consultation to inform the outcome. It is of note that the options appraisal was also reviewed and considered by the Clinical Effectiveness Group on 2 October 2024 and the group supported progressing consulting of the proposed preferred option to withdraw prescribing across Cheshire and Merseyside.

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective One: Tackling Health Inequalities in access, outcomes and experience

- The proposal seeks to remove unwarranted variation in access to prescribing for gluten free bread and bread mixes. It is of note that prescriptions are not available for other food allergies / intolerances, so this will further remove unwarranted variation. GF goods are much more widely available in supermarkets and other retailers both in store and on-line and therefore more accessible to patients. Food labelling has improved so patients are able to identify naturally gluten free foods, and there is greater awareness of the impact of not following a GF diet, so patients are more informed to make healthy diet choices. In addition, it would harmonise the approach to prescribing other foods for conditions impacted by "standard" products e.g. lactose intolerance.

Objective Two: Improving Population Health and Healthcare

- The ICB has a duty to consider how and where to allocate the fixed resources that it receives from NHS England, and this proposal to stop prescribing GF bread and bread mixes will enable the ICB to save an estimated £525k per year which could be allocated to more critical services.

Objective Three: Enhancing Productivity and Value for Money

- The ICB has a duty to consider how and where to allocate the fixed resources that it receives from NHS England, and this proposal to stop prescribing GF bread and bread mixes will enable the ICB to save an estimated £525k per year which will support delivery of the financial recovery plan or allow funds to be reallocated to more critical services.

Objective Four: Helping to support broader social and economic development

- This proposal does not directly contribute to this objective.

7. Link to achieving the objectives of the Annual Delivery Plan

This proposal is aligned to the annual delivery plan through the Effective Use of Resource element contributing to the delivery of clinical policy harmonisation and supporting the finance efficiency and value programme.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
Key to both the clinical policy harmonisation and unwarranted variation programmes is the focus on ensuring all Cheshire and Merseyside residents have equal access to services. In addition, sustainability of services must be considered when making decisions on how to spend limited resource. A QIA has been completed and reviewed by the Associate Directors of Quality who support the proposal to stop prescribing based on re-allocation of this resource to focus on other critical services. (The QIA is available in appendix four).

Theme Two: Integration
The proposal does not directly relate to this theme, however, in relation to the 'safe systems' quality statement, if supported by the Board the next step will be a public consultation which will enable the views of the population to help shape the outcome.

Theme Three: Leadership
If the proposal is supported by the Board, there will be a public consultation exercise through which we will work with wider partners and stakeholders, including providers of NHS services, local authorities, Healthwatch, and voluntary, community, faith and social enterprise (VCFSE) organisations to support us to engage with the right people. We will engage throughout with our Local Authority colleagues through the Health Overview and Scrutiny committees in the impacted Places. This relates to the 'partnerships and communities' quality standard.

9. Risks

9.1 It is difficult to evidence the impact of Coeliac patients not being able to access gluten free bread and bread mixes, but there are known risks to not adhering to a gluten free diet which could have long term health impacts and lead to greater demand on wider health services. An example given by Coeliac UK states it costs £195 a year per patient to support gluten free on prescription, but the average cost to the NHS of an osteoporotic hip fracture is £27,000.

9.2 Mitigation: A published DHSC Impact Assessment examines the issue of adherence in detail and concludes that adherence to a gluten free diet cannot be isolated to any single cause. Evidence shows that many factors are at play including product labelling, cost and information when eating out and managing social occasions. Adherence requires a range of knowledge and skills to avoid all sources of gluten. Gluten free foods are now much more readily available in supermarkets and other retailers, both in store and on-line, making them more accessible. In addition, there is improved food labelling across all foods and greater awareness of adherence to gluten free diet helping people to make healthy choices. It should be noted that although gluten free bread and bread mixes are still more expensive, the cost of these products has been reducing

over time and there are other GF foods at comparable prices to standard foods for example 500g of GF pasta being the same price as 500g of standard pasta. It is also worth noting that bread is not an essential food item and there are many naturally occurring GF foods.

9.3 There is a reputational risk to the ICB if the proposal to stop prescribing is accepted. Due to the current cost of living, there have been a number of national articles on the increased cost of "free from" foods despite them being much more available. In addition, 99% of the cohort of patients receiving prescriptions have an exemption in that they do not pay for prescriptions so could be seen that we are disadvantaging our most vulnerable population.

9.4 Mitigation: A public consultation would be held in those Places who currently prescribe, the outcome of which will inform the final decision. It should be noted that the ICB does not prescribe food products for other conditions that are associated with or affected by types of food.

10. Finance

10.1 If the proposal is supported by the Board and implemented following a public consultation exercise, this would offer the ICB an estimated annual saving of £525k and a cost avoidance of a further £130k (the estimated cost of harmonising prescribing across all Places).

10.2 The public consultation exercise would be led by NHS Cheshire and Merseyside's in-house communications and engagement team; however, it is anticipated that up to £12,000 one-off enabling funding will be required to support delivery. This would include analysis of consultation findings and production of a report to inform the final decision, and funding for additional formats, including easy read versions and other languages. It is standard practice for public consultation reports to be produced by an external organisation.

11. Communication and Engagement

11.1 A supporting comms and engagement plan is available in appendix two.

12. Equality, Diversity and Inclusion

12.1 An equality, diversity and inclusion assessment (EIA) was undertaken and can be viewed in appendix three.

13. Climate Change / Sustainability

13.1 This proposal does not directly relate the ICB green plan or net zero obligations.

14. Next Steps and Responsible Person to take forward

14.1 If the recommendation to progress consulting on our proposal for ICB funded gluten free prescribing, a public consultation exercise will be held, with proposed start date of January 14th 2025 continuing for six-weeks until Tuesday February 2025.

14.2 Engagement will commence with Local Authority Health Overview and Scrutiny committees to determine how best to engage and/or consult with them.

14.3 Feedback on the consultation will inform the final recommendation put to the which will be presented to a future Board meeting for Board decision.

14.4 The work will be taken forward by the Reducing Unwarranted Variation Programme Team under the direction of Anthony Leo as Senior Responsible Officer, Professor Rowan Pritchard-Jones as Clinical Lead and Natalia Armes as Programme Director.

15. Officer contact details for more information

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16. Appendices

Appendix One: Gluten Free Prescribing Options Appraisal document
Appendix Two: Communications and Engagement Plan
Appendix Three: Equality, Diversity and Inclusion Impact Assessment
Appendix Four: Quality Impact Assessment

Options Appraisal ICB funded Gluten Free products Prescribing across Cheshire and Merseyside

Contents

Glossary

Term	Definition
Coeliac Disease	Coeliac disease is a lifelong autoimmune disease caused by a reaction to gluten. Once diagnosed, it is treated by following a gluten free diet for life
Gluten	Gluten is a protein found in wheat, rye and barley.

Agenda Item 5
1 Executive Summary

Currently NHS Cheshire and Merseyside has unwarranted variation in the prescribing of gluten free products across all Places. St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (to note the footprint previously under Vale Royal CCG within Cheshire West Place still undertake some prescribing) prior to the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018.

In Cheshire and Merseyside, over 13,300 patients have a diagnosis of coeliac disease or other conditions which requires management through a gluten free diet. Most people choose to purchase their gluten free foods at supermarkets or other retailers however 2,314 patients receive their gluten free foods via prescription. It should be noted that of the prescriptions issued, 99% are exempt from prescription charges, with 73% being due to age (under 16 or 18 if in full time education, or over 60 years old) and over 60% of these being over the age of 60.

Under the Unwarranted Variation Recovery programme, a number of options were considered in order to address the unwarranted variation, but the 2 main options were to either fully prescribe across Cheshire and Merseyside at an estimated additional cost of £130k per year (increase annual spend on the service of c.£655k) or to withdraw prescribing completely offering an estimated annual saving of £525k.

Initially the review of the current gluten free prescribing policies was carried out under the Clinical Policy Harmonisation programme and involved a clinical working group who recommended reinstating prescribing across all of Cheshire and Merseyside which is in line with the DHSC consultation outcome. However, this position was not supported by our Finance, Investments and Resources Committee due to the financial challenges faced by NHS Cheshire and Merseyside.

In the context of the financial challenge facing NHS Cheshire and Merseyside, the Unwarranted Variation programme has reviewed all options and are proposing that gluten free prescribing is stopped due to the following rationale:

- Availability of gluten free foods is much greater than it was when the original policies were implemented, and in the six years since the DHSC consultation. It should also be noted that bread is not classed as an essential food item and people can maintain a healthy diet without bread through choosing naturally gluten free foods.
- Whilst the cost of gluten free bread is still more expensive than non-gluten free there are other products (e.g. pasta) which are the same price. In addition, improved food labelling and increased awareness enables people to make informed and healthy choices.
- Coeliac UK now say that 40% of ICBs have stopped or reduced prescribing, our research shows that 32% have stopped completely, 61% prescribe bread and bread mixes and 6% offering to under 18s only.
- Consideration was given to prescribing to under 18s only, however, C&M data shows that over 60% of the population receiving prescriptions are over 60 years and therefore could be seen as discriminatory against the older population.
- Gluten free products are in the main received by patients who have exemptions from payment, with the majority of this being due to age (73%) and because exemption does not take into account financial capacity, it is difficult to evidence the individual financial impact on the impacted patients.
- Withdrawing prescribing has already been implemented in St Helens and part of Cheshire West and to date we are not aware of any unforeseen consequences.
- NHS Cheshire and Merseyside do not currently prescribe food alternatives for other food allergy / intolerances e.g. lactose intolerance.
- A number of our ICB neighbours including Lancashire and South Cumbria and Shropshire, Telford and Wrekin have already stopped prescribing.

A decision to withdraw gluten free prescribing would require a public consultation in 8 of the 9 Places including engagement with our Local Authority colleagues through Oversight and Scrutiny committees.

The options appraisal paper was initially discussed with the Associate Directors of Quality where the proposal was acknowledged and supported for progression. It was subsequently presented to the Recovery Committee on 16th September and was then considered by the Strategy and Transformation (S&T) committee at the meeting on 19th September. The S&T committee supported the recommendation to present the preferred option, to cease prescribing to the Board for approval to progress to a public consultation to inform the final decision.

It is of note that the options appraisal was also reviewed and considered by the Clinical Effectiveness Group on 2nd October and the group supported progress of the proposed option to withdraw prescribing across Cheshire and Merseyside.

The Board is asked to approve the recommendation to progress a proposal for a non-prescribing option for gluten free bread and bread mixes in order to commence a public consultation starting in January 2025. The feedback from this exercise, together with that of our Oversight and Scrutiny Committees will inform the decision whether to continue with this recommended option. In addition, the Board is asked to receive the feedback from this exercise at the first available board meeting.

2 Background

Currently NHS Cheshire and Merseyside has unwarranted variation in the prescribing of gluten free products across all Places. St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely prior to the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. Further information about this consultation and the revised regulation subsequently put in place is available on the NHS England website (NHS England » Prescribing Gluten-Free foods in Primary Care: Guidance for Clinical Commissioning Groups – frequently asked questions). For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area).

Coeliac disease is an autoimmune condition associated with chronic inflammation of the small intestine, which can lead to malabsorption of nutrients. Population screening studies suggest that in the UK 1 in 100 people are affected. The complications of coeliac disease (which may or may not be present at diagnosis) can include osteoporosis, ulcerative jejunitis, malignancy (intestinal lymphoma), functional hyposplenism, vitamin D deficiency and iron deficiency. People with conditions such as type 1 diabetes, autoimmune thyroid disease, Down's syndrome and Turner syndrome are at a higher risk than the general population of having coeliac disease. First-degree relatives of a person with coeliac disease also have an increased likelihood of having coeliac disease.

Management of coeliac disease is a lifelong GF diet. Historically, availability of GF foods was limited and expensive, so patients obtained these products via prescribing, however, all major supermarkets now commonly stock a wide range of GF foods and the price differential is reducing as demand grows. It should be noted that there have been a number of recent national news articles on the higher cost of these “free from” alternatives and the impact of withdrawing prescribing in context of cost-of-living increases.

Initially the former CCGs gluten free prescribing policies were reviewed as part of the Clinical Policy Harmonisation programme and involved a clinical working group who recommended to reinstate prescribing across all of Cheshire and Merseysi

h the DHSC consultation outcome.

However, as this would result in additional annual expenditure of C.£130k, this position was not supported by our Finance, Investments and Resources Committee due to the financial challenges faced by NHS Cheshire and Merseyside

The review was then progressed under the Unwarranted Variation programme and the non-prescribing option was considered in context of the patient safety risks, and the requirement to support NHS Cheshire and Merseyside to deliver the financial objectives of the Recovery Programme.

It is difficult to evidence the impact of stopping GF prescriptions and understanding whether the impacted patients would continue to follow a GF diet. Whilst there are known risks to not adhering to a GF diet, which could have long term health impacts and lead to greater demand on wider health services, there is greater availability of GF foods in supermarkets and other retailers, improved food labelling and greater awareness of the impact of non-adherence, which all support the patient to make good food choices for a healthy diet.

The options appraisal paper was initially discussed with the Associate Directors of Quality where the proposal was acknowledged and supported. It was subsequently presented to the Recovery Committee on 16th September and was then considered by the Strategy and Transformation (S&T) committee at the meeting on 19th September. The S&T committee supported the recommendation to present the preferred option, to cease prescribing to the Board and that we progress to a public consultation to inform the outcome. In addition, the Clinical Effectiveness Group also supported progression of the proposed option on 2nd October.

3 Approach

The gluten free prescribing policy was initially reviewed under the Clinical Policy Harmonisation Programme (CPH) the objective of which was to review existing policies and the latest evidence base to recommend a single set of policies which would enable all patients to have equitable access. The review of the gluten free prescribing policy focused on the published evidence base DH&SC and Coeliac UK recommendations with input from clinicians, dieticians and pharmacists and was led by the CPH Steering Group which includes commissioners, GP, Pharmacist and public health leads. An options appraisal was carried out to consider a number of options to harmonise the prescribing position and an EIA and QIA were developed to consider all options. Therefore, the option to continue with the current arrangements was discounted.

The CPH programme recommended that the harmonised policy be to implement gluten free prescribing in accordance with DHSC guideline, however, this comes at an additional annual cost of C.£130k and this was not able to be supported by the Finance, Investment and Resources Committee at the time. It is of note that this work was placed on hold, due to the financial pressures and pre-election activity so it was brought into the scope of the Reducing Unwarranted Variation Recovery Programme (noting that 3 members are consistent with the previous Clinical Policy Steering Group) and review has also been completed by the Deputy Medical Director and Clinical Lead for Reducing Unwarranted Variation (RUV) Programme.

In the context of the ICB financial recovery plan, the RUV programme carried out a further review which considered Cheshire and Merseyside data, prices and availability of GF foods in supermarkets and other retailers, both instore and on-line, improvements in food labelling and increased information via websites on how to maintain a GF diet. Following discussions on these findings with Place Clinical Directors and Associate Directors of Quality, the Reducing Unwarranted Variation Steering group **is recommending as a financial decision, prescribing is stopped across Cheshire and Merseyside** and this view is supported by the Deputy Medical Director and Programme Clinical Lead.

The group recognised that this goes against the latest published guidance, however, it should be noted that this is now 6 years old, and this is not a medicine or prescription for an essential food item (as it is for bread or bread mixes only). In addition, the group noted that this is a similar stance as taken with other food allergies / intolerances and dietary requirements where we do not offer alternative food items by prescription and increasing affordable gluten free products are available at supermarkets. This

recommendation would result in a financial saving of circa. £525k and avoid additional expenditure of £130k.

3.1 Current Cheshire and Merseyside Activity and Spend on Gluten Free Prescribing

Across Cheshire and Merseyside, 8 Places still have a Policy that includes GF prescribing at an annual cost of circa £525k for the year 2023/2024. Prior to the establishment of the ICB, two of the former CCGs (St Helens and West Cheshire) withdrew GF prescribing as a cost cutting policy, although it is of note that GP practices in the former Vale Royal CCG footprint still prescribe as shown within the table below.

Cheshire and Merseyside - Gluten Free Prescribing 2023/24

				per 1,000 Wtd Pop.	
Row Labels	Sum of Items	Sum of Actual Cost	Weighted Pop	Items	Actual Cost
Sefton	3816	£87,559	310666	12.28	£281.84
CHESHIRE EAST	4909	£97,731	429865	11.42	£227.35
Knowsley	2156	£46,220	196251	10.99	£235.52
Halton	1551	£32,413	149417	10.38	£216.93
Wirral	3724	£77,017	385940	9.65	£199.56
Liverpool	5953	£122,669	646320	9.21	£189.80
Warrington	1953	£41,160	232237	8.41	£177.23
CHESHIRE WEST & CHESTER	939	£19,396	410116	2.29	£47.29
St Helens	20	£413	231122	0.09	£1.79
Grand Total	**25021**	**£524,579**	**2991933**	**8.36**	**£175.33**

Gluten Free Prescribing Exemption in Cheshire and Merseyside

In Cheshire and Merseyside over 13,300 patients have a diagnosis of coeliac disease, with only 17.4% (2,314) receiving prescription gluten free food.

The table below details the breakdown of GF prescriptions across Cheshire and Merseyside and shows that 99% of prescriptions issued are currently exempt from prescription charges.

	Chargeable at Current Rate		Exempt	
Row Labels	Number of Items	Proportion	Number of Iter	Proportion
Cheshire East	21	1.03%	2020	98.97%
Cheshire West	11	2.72%	393	97.28%
Halton	6	0.93%	637	99.07%
Knowsley	5	0.57%	869	99.43%
Liverpool	24	0.96%	2465	99.04%
Sefton	5	0.32%	1556	99.68%
St Helens		0.00%	10	100.00%
Warrington	6	0.76%	785	99.24%
Wirral	14	0.93%	1488	99.07%
Cheshire and Merseyside	92	0.89%	10223	99.11%

Of these exemptions, 73% is due to age (under 16 or 18 if in full time education, or over 60 years old), with the majority being over the age of 60.

According to Coeliac UK, most people are diagnosed from 50 years old and coeliac disease is most common in people aged between 50-69 years old.

Row Labels	Exempt	
	Number of Items	Proportion
Aged 60 Or Over	6253	61.17%
No Declaration/Declaration Not Specific	1950	19.07%
Under 16 / Aged 60 Or Over	898	8.78%
Pre-Payment Certificate	315	3.08%
Aged 16-18 And In Full Time Education	311	3.04%
Medical Exemption	287	2.81%
Income Support	87	0.85%
Universal Credit	64	0.63%
HC2 Charges	19	0.19%
NHS Tax Credit Exemption Certificate	19	0.19%
Maternity Exemption	15	0.15%
Income Based Job-seekers Allowance	3	0.03%
HRT Pre-payment Certificate	1	0.01%
Pension Guarantee Credit	1	0.01%
Unassigned		0.00%

3.2 Current Prescribing Approaches across England (where available)

Coeliac UK state that 40% of ICBs have stopped or reduced prescribing. Where the information was published, our research shows that 32% have stopped completely with 61% prescribing bread and bread mixes, 6% prescribing to under 18s only and 6% prescribe bread only. (see appendix E).

The table below shows the policy stance of local ICBs:

Prescribe bread & bread mixes	Do not prescribe – all ages
• Greater Manchester – all ages • Staffordshire – for those under age of 18 only	• Lancashire and South Cumbria • Shropshire, Telford and Wrekin

3.3 Guiding principles:

- To reduce unwarranted variation and harmonise access to services across Cheshire and Merseyside.
- Use the latest evidence base to develop harmonised policies
- Consider sustainability of Cheshire and Merseyside ICB in context of financial requirements

3.4 Strategic Context

The main objectives identified are:

Objective 1	
Objective	Tackling health inequality, improving outcomes and access to services
Current Arrangement	7* of 9 Places currently offer gluten free prescribing in line with the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. It is of note that for the remaining 2 Places, St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above). *For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area). In addition, there are other patients who are diagnosed with food related allergies / intolerance conditions who do not receive prescriptions to

Objective 1	
	manage their diet and therefore could be argued that those patients are disadvantaged by a prescribing option.
Gap/Business Needs	In order to harmonise the position across C&M, there are 2 options, one to implement prescribing across all 9 Places at a potential additional cost of £130k per year; a total estimated cost of £655k per year or to withdraw prescribing across all 9 places at a potential saving of £525k per year.
Objective 2	
Objective	Enhancing quality, productivity and value for money
Current Arrangement	7* of 9 Places currently offer gluten free prescribing in line with the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. It is of note that for the remaining 2 Places, St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above). *For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area). In addition, there are other patients who are diagnosed with food related allergies / intolerance conditions who do not receive prescriptions to manage their diet and therefore could be argued that those patients are disadvantaged by a prescribing option. There is a risk to patient safety if patients do not follow a GF diet (quality) and potential impact on wider services in the future.
Gap/Business Needs	In order to harmonise the position across C&M, there are 2 options, one to implement prescribing across all 9 Places at a potential additional cost of £130k per year; a total estimated cost of £655k per year or to withdraw prescribing across all 9 places at a potential saving of £525k per year.

4 Options and considerations

No	Description	Outcome	EIA Feedback*	QIA Feedback*	Financial Impact
1	Do nothing ***-discounted option***	Inequity of prescribing for patients across C&M	No EIA completed	No change to current situation, but unwarranted variation across C&M	Current **annual spend of circa £525,000** will be maintained
2	NHS C&M adopt prescribing to national guidelines across all Places	Harmonised C&M policy in line with evidence base. Public involvement exercise could be minimal as there has already been a full consultation by DHSC.	In line with DHSC EIA guidance following extensive public consultation and EIA completion (see appendix F). If not prescribed will be contrary to national published guidance, however, this EIA is now 8 years old. Minimal equality impact identified. (see appendix A)	Equity across C&M and improves access to patients in the Places who do not currently receive prescribed gluten free goods. **Overall Risk rating: 1 Green – Low risk** (see appendix B)	Estimated increase in spend of £130,000. **Estimated annual spend £655,000**
3	NHS C&M to withdraw prescribing across all Places	Harmonised C&M policy contrary to published guidance however, this is now 6 years old. Public consultation exercise would be required in 8 Places	A number of groups of patients could be at risk of dietary neglect as clear links were identified between: - age (those aged under 16, those aged 16, 17 and 18 in full time education, and those aged 60 or over are eligible for prescription exemptions) - Gender (reported cases of coeliac disease are two to three times higher in women than men), -pregnancy and maternity (e.g. Poorly controlled coeliac disease in pregnancy can increase the risk of developing pregnancy-related complications) (see appendix C)	Withdrawal of prescribing would impact those patients who receive free prescriptions who are likely to be vulnerable due to low income, holding medical certificates which implies wider health needs and age. There is a risk in this current economic climate that people on low income would consume non-GF bread and bread mixes which could have longer term health impacts and therefore increase health inequalities. (see appendix D)	Most current spend would cease leading to an estimated saving of £525,000 with further estimated cost avoidance of £130k **Estimated annual spend £0**

No	Description	Outcome	EIA Feedback*	QIA Feedback*	Financial Impact
			- Families on low income (due to eligibility for exemptions from prescription charges)	**Overall Risk rating: 4 Amber – moderate**	
4	Prescribe to under 18s only – ***discounted option***	Harmonised policy but only for young people, therefore inequity of access for patients across C&M. Public consultation would be required in all 9 Places.	This option is against published guidelines (& this would benefit less than 15% of the C&M population receiving GF prescriptions). A number of groups of patients could be at risk of dietary neglect as clear links were identified between: - age and in particular those aged 60 or over are eligible for prescription exemptions - Children and young people are not financially independent so this option would support them to adhere to a GF diet - Gender (reported cases of coeliac disease are two to three times higher in women than men), -pregnancy and maternity (e.g. Poorly controlled coeliac disease in pregnancy can increase the risk of developing pregnancy-related complications) - Families on low income (due to eligibility for exemptions from prescription charges)	Withdrawal of prescribing would impact those patients who receive free prescriptions who are likely to be vulnerable due to low income, holding medical certificates which implies wider health needs and age. There is a risk in this current economic climate that people on low income would consume non-GF bread and bread mixes which could have longer term health impacts and therefore increase health inequalities. Whilst this option would support younger people, they make up less than 15% of the C&M population receiving GF prescriptions.	Based on 10% of current spend estimated costs would be £50,000 - £60,000 per annum. This results in a saving of £465,000 - £475,000

4.1 Risks, Constraints & Dependencies

The following risks, constraints and dependencies have been highlighted as part of the development of the case for change.

Risks

The following risks have been identified with the achievement of the programme outcomes:

Risk	Mitigating actions
It is difficult to evidence the impact of Coeliac patients not being able to access Gluten Free (GF) bread and bread mixes, but there are known risks to not adhering to a GF diet which could have long term health impacts and lead to greater demand on wider health services. An example given by Coeliac UK states it costs £195 a year per patient to support GF on prescription, but the average cost to the NHS of an osteoporotic hip fracture is £27,000.	A published DHSC Impact Assessment examines the issue of adherence in detail and concludes that adherence to a GF diet cannot be isolated to any single cause. Evidence shows that many factors are at play including product labelling, cost and information when eating out and managing social occasions. Adherence requires a range of knowledge and skills to avoid all sources of gluten. Gluten free foods are now much more readily available in supermarkets, with clear gluten free labelling. It should be noted that although GF bread and bread mixes are still more expensive the cost of these products has been reducing over time and there are other GF foods at comparable prices to standard foods for example 500g of GF pasta being the same price as 500g of standard pasta. It is also worth noting that bread is not an essential food item and there are many naturally free GF foods e.g. potatoes, rice. If the option to stop prescribing was accepted, signposting on how to adhere to a gluten free diet would be made available on the ICB website and GPs would continue to monitor these patients as usual. Also engagement with supermarkets in Cheshire and Merseyside would be undertaken to advise of the change in prescribing with a request for them to manage their stock levels accordingly.
Risk	**Mitigating actions**
There is a reputational risk to the ICB if the option to withdraw prescribing is accepted. Due to the current cost of living, there have been a number of national articles on the increased cost of “free from” foods despite them being much more available. In addition, 99% of the cohort of patients receiving prescriptions have an exemption in that they do not pay for prescriptions so	The ICB does not prescribe for other conditions that are associated with, or affected by the types of food they eat, so this would result in a fairer approach for these patients. A public consultation exercise would be held in those Places who currently prescribe in line with the approach in St Helens and the relevant area of Cheshire West.

could be seen that we are targeting our most vulnerable population.	
If the option to re-instate prescribing is accepted, there is a financial risk to the ICB in that an additional £130k per year would be required to support this, meaning an estimated annual spend of £655k. This may result in other critical funded services not being funded as a consequence of the further cost pressure.	Place based Medicines Management teams would review prescribing quantities to ensure they are in line with Coeliac UK guidance. This may mitigate some of the cost. Noting that this option is not the recommended option of the Reducing Unwarranted Variation Steering Group.

Constraints

- The review is being undertaken in context of the recovery programmes.
- Due to the significance of the change, a public consultation exercise would be required if any option to withdraw prescribing was accepted. In addition, it would be necessary to engage and consult with the Oversight and Scrutiny Committees in all affected Places. A Joint OSC meeting would need to be formed, composed of the Local Authorities where the population would be impacted. The availability and timing of these meeting would be largely dictated by the Local Authorities. This would impact the timing of benefits delivery.
- Engagement/communication would also be required with local MPs.
- Consideration is needed regarding any delays to benefits delivery caused by the potential for 'call in' to the SoS for Health & Care of any proposed service change – members of the public or organisations can write to the Secretary of State at any stage of the process.

Dependencies

- NHS Cheshire and Merseyside's communications and engagement team is currently focused on a number of pieces of public involvement work. Any public involvement requirements around gluten-free prescribing will need to be considered alongside existing work plans.
- Public involvement activity has resource implications. It is standard practice to commission independent analysis and reporting of feedback from public consultation, aside from any additional requirements around delivery of consultation activity. There is a need to scope out the requirements and identify the necessary budget.

5 Options Appraisal and Financial Case

For completeness a range of options have been considered as part of the case for change, a brief description of full range of options is below:

Option 1: Do nothing – 8 of 9 Places prescribe GF products, St Helens and part of Cheshire West do not prescribe (Option discounted)

Pros	Cons
• The financial position of the ICB does not change.	• There is unwarranted variation across Cheshire and Merseyside in unequal access to GF bread and bread mixes for our patients. • There is an increased risk of challenge by Equalities and Human Rights commission re inequality in service access. • Financial impact remains at circa £525k per annum.

Option 2: Implement Prescribing of bread and bread mixes across whole of Cheshire and Merseyside

Pros	Cons
• Harmonised access to GF bread and bread mixes across C&M • In line with evidence base • Supported by Quality and EDI Teams and Clinicians • Review of the quantities prescribed in each Place could mitigate the additional cost	• Additional estimated annual cost of £130k making a total of estimated annual cost £655k per annum • This may impact the ability to support other areas of need due to financial constraints across the Integrated Care System. • There are other patients who suffer from other food allergies or intolerances who do not receive prescribed food goods, this option could be seen as increasing inequity for these patients.

Proposed next steps and estimated timeframe for Option 2:

1) Recovery Committee (September 16th) and Strategy & Transformation Committee (STC) (19th September) supported recommendation to withdraw prescribing
2) The recommendation from STC to be considered and decision to be ratified by Board – 28th November 24
3) Public Involvement exercise in St Helens and Cheshire (West Vale Royal GP Practices) (working assumption is this would be a communications exercise)
4) Harmonised policy to be launched across all Places – no change for 8 of 9 – December 24

Option 3: Withdraw Prescribing across whole of Cheshire and Merseyside

Pros	Cons
• Harmonised access to GF products across C&M • Financial benefit to the ICB of £525k per annum • Increased fairness in prescribing policies as NHS does not provide food on prescription for other groups of patients who conditions are associated with, or affected by, the type of food they eat.	• Contrary to the latest published guidance, however, this is now 8 years old and the prices of GF goods have been reducing, therefore would be purely financial rationale • Concerns identified through the EIA and QIA process particularly around the impact on vulnerable patients (particularly age) and for those patients on low income the risk of increasing health inequalities. • Consultation required in 8 places. Time delay and potential cost to develop outcomes report. • Risk of negative publicity for ICB particularly in local press. • Increased risk of challenge by EHRC (as per above) • Increased risk of judicial review raised by individuals/organisations

Proposed next steps and estimated timeframe for Option 3:

1) Recovery Committee (September 16th and Strategy & Transformation Committee (19th September) support recommendation
2) Public consultation plan and materials to be developed.
3) The preferred option (subject to public consultation), and public consultation plan, to be approved by Board – 28th November 24
4) Public consultation exercise 8 weeks (subject to further discussion around timings and resources) – January 25 to February 25
5) Feedback and analysis report on consultation completed (approx. 4 weeks required) – March 25
6) Engagement with OSC on feedback from consultation exercise – to be confirmed
7) Feedback on consultation exercise presented to Board. Board asked to decide on whether to proceed with no GF prescribing approach – to be confirmed
8) Feedback on consultation exercise and Board decision presented to OSC - TBC
9) Subject to outcomes of public consultation and final decision-making, policy launch & benefits realisation start – to be confirmed

Option 4: Prescribe to under 18s only (Option discounted)

Pros	Cons
• Harmonised approach to prescribing of GF bread and bread mixes across C&M • Financial benefit to the ICB of £465,000 - £475,000 per annum • Would support the younger coeliac patients to follow a correct diet until adulthood.	• Contrary to evidence base • Concerns identified through the EIA and QIA process around the impact on vulnerable patients particularly age (as over 60% of issued GF prescriptions are due to patients being aged 60+) and for those adult patients on low income as there is a risk of increasing health inequalities • Would require public engagement in all 9 Places • Risk of negative publicity for ICB particularly in local press. • This option does not provide a service for the majority of patients who are currently receiving GF prescriptions (15% under 19yo) • Increased risk of challenge by EHRC (as per above) • Increased risk of judicial review raised by individuals/organisations

5.1 Financial Case: Following the initial options assessment, Options 1 and 4 have been discounted.

Options	Description (*Committed costs)	Non-recurrent Year 1	Non-recurrent Year 2	Recurrent costs (Annual)	Comments
Option 1: Do nothing – 8 of 9 Places prescribe GF products, St Helens and part of Cheshire West do not	£525,000	£525,000	£530,000	£538,000 (yr 3)	Based on ONS population growth projection
Option 2: Implement Prescribing across whole of Cheshire and Merseyside	£650,000	£650,000	£661,700	£672,287 (yr 3)	Based on ONS population growth projection, however, could increase if cost of products or activity increases. Place prescribing Teams would also review prescribing quantities to ensure all in line with guidance.
Option 3: Withdraw Prescribing across whole of Cheshire and Merseyside	-£525,000	-£525,000	-£525,000	-£525,000	Provides a consistent approach to prescribing for food intolerances. Whilst this does not adhere to published guidance, this is now 6 years old. It is of note that the £525k is a cash releasing saving with a further cost avoidance of £130k.
Option 4: Prescribe to under 18s only	-£465,000 - £475,000	-£465,000 - £475,000	-£465,000 - £475,000	-£465,000 - £475,000	Not in line with published guidance and does not reflect the need of C&M demographics

6 Recommendation

In the context of the Recovery Programme and following further review and the formation of this options appraisal, the Reducing Unwarranted Variation Steering Group recommend the progression to public consultation of option 3, to withdraw prescribing of bread and bread mixes. This recommendation has also been discussed by the Deputy Medical Director and Associate Directors of Quality, and also with the Clinical Effectiveness Group who also support based on the QIA risk scores and EIA.

The context of this recommendation is that availability of GF foods has increased since the original policies were implemented, and whilst the cost of GF bread and bread mixes is still higher, some GF products (e.g. pasta) is the same price. Food labelling is much improved supporting patients to make healthy choices, and in addition, this is not a prescribed medication and bread and bread mixes are not considered an essential food item.

In addition, the withdrawal of prescribing of GF foods has already been implemented in St Helens and part of Cheshire West and so far, we are unaware of any unforeseen consequences; and NHS Cheshire and Merseyside do not prescribe products for other food alternatives for other food allergy / intolerances.

It should be noted that 99% of GF prescriptions issued are subject to payment exemption, the reason for the majority (73%) is that of age. A number of our ICB neighbours including Lancashire and South Cumbria and Shropshire, Telford and Wrekin have already stopped prescribing.

In accordance with the framework methodology established as part of the decommissioning policy, this has been undertaken for Gluten Free prescribing and the output is as follows:

The combined impact of the individual criterion scores, when put through the Prioritisation Framework tool is an overall score of 4.86. This equates to an overall assessment of “Consider Decommission / discontinue” indicating that this investment carries a relatively low priority within the context of financial recovery. (see appendix G).

The options appraisal paper was initially discussed with the Associate Directors of Quality where the proposal was acknowledged and supported. It was subsequently presented to the Recovery Committee on 16th September and was then considered by the Strategy and Transformation (S&T) committee at the meeting on 19th September. The S&T committee supported the recommendation to present the preferred option, to cease prescribing to the Board and that we progress to a public consultation to inform the outcome.
The recommendation to withdraw prescribing is also supported by the Recovery Committee and the Strategy and Transformation Sub-Committee based on the financial case and the QIA and EIA feedback. It is of note that the options appraisal was also reviewed and considered by the Clinical Effectiveness Group on 2nd October and the group supported progress of the proposed option to withdraw prescribing across Cheshire and Merseyside.

6.1 The Ask:

The Board are asked to:

- **approve** the recommendation put forward by the Reducing Unwarranted Variation Steering Group and supported by the Recovery Committee and Strategy and Transformation sub-committee to progress a proposal for a non-prescribing option for gluten free bread and bread mixes in order to commence a public consultation starting in January 2025. The feedback from this exercise, together with that of our Oversight and Scrutiny Committees will inform the decision whether to continue with this recommended option.

Appendices

Appendix A – EIA for option 2 – prescribe across all Places

Appendix A EIA Clin070 GlutenFree S

Appendix B – EIA for option 3 – stop prescribing across all Places

Appendix%20B%20revised%20EIA%20Glut

Appendix C – QIA for option 2 –- prescribe across all Places

Appendix%20C%20CM%20ICB%20QIA%2(

Appendix D – QIA for option 3 – stop prescribing across all Places

Appendix%20D%20NHS%20Cheshire%20a

Appendix E – National Gluten Free Prescribing Offers (where available)
https://westcheshireway.glasscubes.com/share/s/62deuiccpflvuqvc4kedtu31qo

Appendix F – DHSC EIA
https://assets.publishing.service.gov.uk/media/5a823231e5274a2e87dc1a59/Equality_impact_assessment_-_GF_food.pdf

Appendix G – NHC C&M Decommissioning Framework review
https://westcheshireway.glasscubes.com/share/s/ku6ksdqu610ekti92nuci6rj07
https://westcheshireway.glasscubes.com/share/s/v8g9ga836ob739m35697hq4d1e

Gluten-free prescribing proposal

Draft plan for public consultation

Introduction and background

Gluten free (GF) products are sometimes prescribed to individuals who suffer from coeliac disease.

Updated national guidance on prescribing of GF products was introduced in 2018, with the intention of reducing previous variation in what was prescribed. The new guidance meant that GF products that fell outside the category of a bread or a mix were no longer prescribed at NHS expense. Local commissioners were encouraged to align their local policies with the amended regulations, but could also choose to restrict further by selecting bread only, mixes only or choose to end prescribing of all GF foods, if they felt this was appropriate for their population.

As the successor body to nine former clinical commissioning groups (CCGs), NHS Cheshire and Merseyside inherited each CCG's commissioning policies, including those for GF prescribing. Currently, there is not a single approach to prescribing of GF products across Cheshire and Merseyside. Seven areas or 'Places' (Cheshire East, Halton, Knowsley, Liverpool, Sefton, Warrington and Wirral) offer gluten free bread and bread mixes on prescription to eligible patients, while St Helens and Cheshire West do not offer this (although there are still some parts of Cheshire West where prescribing is undertaken – Winsford, Northwich, Middlewich and surrounding area).

On 28 November 2024, the Board of NHS Cheshire and Merseyside will be asked to give the go-ahead for a public consultation about a proposal to end ICB funded gluten free prescribing across Cheshire and Merseyside.

This document outlines NHS Cheshire and Merseyside's plan for holding a public consultation on this proposal from 14 January to 25 February 2025, pending the Board's approval. It should be read alongside the following paper being presented to Board: *Proposal for ICB funded Gluten Free Prescribing across Cheshire and Merseyside*, which contains additional background and rationale for the proposed change.

Objectives

The public consultation will present a single option – the cessation of GF prescribing across Cheshire and Merseyside. The objectives of the consultation are:

- To inform patients, carers/family members, key stakeholders, and the public of proposed changes to gluten free prescribing.

- To engage with people who currently receiving gluten free bread and bread mixes on prescription, organisations which support them (where applicable), their carers/family members, and the wider public, to gather people's views about the proposed changes, including how individuals might be impacted.

- To use these responses to inform final decision-making around the proposal.

Legal and statutory context

The main duties on NHS bodies to make arrangements to involve the public are set out in the National Health Service Act 2006, as amended by the Health and Care Act 2022 (section 14Z45 for integrated care boards.

Involvement also has links with separate duties around equalities and health inequalities (section 149 of The Equality Act 2010 and section 14Z35 of the National Health Service Act 2006). As part of our work, we need to involve people with protected characteristics, social inclusion groups and those who experience health inequalities.

The courts have established guiding principles for what constitutes a fair consultation exercise, known as the Gunning principles. These are:

1. Consultation must take place when the proposal is still at a formative stage.

2. Sufficient information and reasons must be put forward for the proposal to allow for intelligent consideration and response.

3. Adequate time must be given for consideration and response.

4. The product of consultation must be conscientiously taken into account.

Methods of engagement and materials

NHS Cheshire and Merseyside will produce clear and accessible public-facing information about the proposal, details of who is likely to be impacted and how, setting out the background to the issue and explaining why NHS Cheshire and Merseyside is proposing to make a change.

This information will be accompanied by a questionnaire containing both qualitative and quantitative questions, designed to gather people's views and perspectives on the proposals. Both the information and questionnaire will be available in Easy Read format. All materials will be made available on the NHS Cheshire and Merseyside website, with printed versions and alternative formats/languages available on request (via email or telephone). People who are unable to complete the questionnaire will be able to provide their feedback over the telephone.

The consultation will be promoted across NHS Cheshire and Merseyside's internal and external communication channels. Wider partners and stakeholders, including providers of NHS services (hospitals, community and mental health providers and primary care), local authorities, Healthwatch, and voluntary, community, faith and social enterprise (VCFSE) organisations, will be asked to share information using their own channels, utilising a toolkit produced for this purpose.

To ensure that those who would be most impacted by any potential change have an opportunity to share their views, NHS Cheshire and Merseyside will seek to work with colleagues in general practice and local pharmacies, to ensure that those who currently receive gluten free bread and bread mixes on prescription are made aware that the consultation is underway.

While specific events will not be organised as part of the consultation, if individual groups/networks request further information, NHS Cheshire and Merseyside will offer to attend meetings to provide additional briefings if required/appropriate.

Audiences

The following is an overview of key groups who we will seek to engage and/or communicate with during the consultation, either as a party with a direct interest or as a means of promoting the consultation to a wider audience.

Internal/NHS

- NHS Cheshire and Merseyside Integrated Care Board (ICB)
- NHS C&M staff
- General practice
- Primary care networks (PCNs)
- Local medical committees
- Local pharmacy committees
- NHS England

External

- General public in Cheshire and Merseyside
- People in Cheshire and Merseyside who currently receive prescriptions for GF bread and bread mixes (approx. 2,300)
- Local authorities
- Champs Public Health Collaborative
- MPs
- Local voluntary, community, faith and social enterprise organisations (VCFSEs)
- Local Healthwatch organisations
- Local/regional media outlets
- Coeliac UK (Liverpool, Cheshire and Warrington branches)

Governance and approvals

This plan has been developed by NHS Cheshire and Merseyside's Communications and Engagement team, which will also be responsible for leading public consultation activity. The plan will be presented to the Board of NHS Cheshire and Merseyside for approval before consultation commences.

Local authority scrutiny

NHS commissioners must consult local authorities when considering any proposal for a substantial development or variation of the health service. Subject to the board's approval of this plan, NHS Cheshire and Merseyside will commence discussions with each of the relevant local authorities.

Responding to enquiries

Members of the public will be directed to contact engagement@cheshireandmerseyside.nhs.uk with any enquiries about the consultation (a phone number will also be supplied). NHS Cheshire and Merseyside's Patient Experience

Team will be briefed on the engagement so that any enquiries that come through central routes can be directed appropriately.

Analysis, reporting and evaluation

When the consultation closes, the findings will be analysed and compiled into a report by an external supplier. The feedback received will be used to inform final decision-making about the proposal, and will therefore be received by a future meeting of the Board of NHS Cheshire and Merseyside. The outcome of this will be communicated using the same routes used to promote the consultation.

It's important to understand the effectiveness of different routes for reaching people, so that this can be utilised for future activity, and the questionnaire will ask people to state where they heard about the engagement. We will summarise this information – along with other measures such as number of enquiries received and visits to the website page – in the final consultation report.

ENDS

NHS
Cheshire and Merseyside

Equality Analysis Report
Pre-Consultation/ Post-Consultation/Full Report* *(Use the same form but delete as applicable. If it is post-consultation it needs to include consultation feedback and results)*

Cheshire & Merseyside wide

Start Date:	October 2024	
Equality and Inclusion Service Signature and Date:	Nicky Griffiths	30 October 2024
Sign off should be in line with the relevant ICB's Operational Scheme of Delegation (*amend below as appropriate)		
***Place/ ICB Officer Signature and Date:**	Katie Bromley	30 October 2024
***Finish Date:**		
***Senior Manager Sign Off Signature and Date**		
***Committee Date:**	28th November 2024	

1. Details of service / function:
Guidance Notes: Clearly identify the function & give details of relevant service provision and or commissioning milestones (review, specification change, consultation, procurement) and timescales.
In 2016 – 2017 the Department of Health and Social Care undertook a review of prescribing for gluten free products and following a public consultation recommended that prescribing was limited to bread and bread mixes only. When gluten free prescribing was first introduced, the availability of these foods was limited, however, all major supermarkets and other retailers stock gluten free foods both in store and on-line. In addition, food labelling has improved, and awareness has increased which means people are able identify which foods contain gluten and choose healthy options. Currently in Cheshire and Merseyside 7* out of 9 Places offer Gluten Free Prescribing for patients with diagnosed coeliac disease in line with DHSC guidelines (*St Helens CCG and part of Cheshire West CCG stopped prescribing around 5 years ago). Therefore, there is inequity across Cheshire and Merseyside. NHS Cheshire and Merseyside was created in July 2022 and, as the statutory body, took over commissioning responsibilities from the 9 former CCGS. NHS C&M has to consider how to use the fixed resource allocation from NHS England to enable them to fulfil their

duties and have to decide how and where to allocate resources to best meet the healthcare needs of the population they serve.

Under the Policy Harmonisation programme, and based on the DHSC consultation and clinical opinion, the recommendation was to re-instate prescribing for bread and bread mixes however this would result in an estimated additional annual spend of £130k. However, because of the need for NHS Cheshire and Merseyside to consider how they allocate funding to ensure it is being allocated to areas of highest risk, a review has been undertaken regarding the continuation of spend on gluten free prescribing and a recommendation to Board to stop gluten free prescribing is being presented. This would of course be subject to a public consultation exercise in order to inform the final decision.

A number of other ICBs have stopped prescribing, one of our neighbouring ICBs Lancashire and South Cumbria do not offer this service, and as an ICB we do not prescribe other food products for patients with other food intolerances or allergies.

What is the **legitimate aim** of the service change / redesign

For example

- Demographic needs and changing patient needs are changing because of an ageing population.
- To increase choice of patients
- Value for Money-more efficient service
- Public feedback/ Consultation shows need/ no need for a service
- Outside commissioning remit of ICB/NHS
-

- To ensure a harmonised approach across Cheshire and Merseyside to prescribing food products for patients with coeliac disease and with other food intolerances / allergies
- To support the ICB to achieve financial savings - stopping prescribing across 8 places which would offer an estimated saving of £525k per year.
- To carry out a public consultation exercise to inform the final decision on gluten free prescribing

2. Change to service.

Currently 7* out of 9 Places offer Gluten free prescribing for bread and bread mixes, St Helens and Cheshire West CCG opted to stop this prior to the DHSC consultation. *For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area).

The proposal would stop prescribing across all of Cheshire and Merseyside. This proposal is based on the much wider availability of gluten free goods, which has increased in the 6 years since the DHSC consultation, the clearer food labelling which makes healthy choices easier and whilst bread is still more expensive that non gluten free options, the difference in price has reduced and bread is not required for a healthy diet.

3. Barriers relevant to the protected characteristics

Guidance note: describe where there are potential disadvantages.
Primarily this will affect patients with coeliac disease and related conditions. However, the eligibility criteria states that gluten free products will be commissioned for patients diagnosed as suffering from established gluten-sensitive enteropathies, including dermatitis herpetiformas and coeliac disease. Other impact on protected characteristic groups will be no different to that on other members of the public who suffer with this disease. Awareness raising about alternative gluten free available foods will be available via GPs. There is no evidence to suggest that any protected group has higher prevalence of gluten intolerance. Diabetics and patients with food allergies are the most immediate comparator where alternative foods are not prescribed by the NHS. Gluten intolerance patients do not need to eat wheat based products to maintain good health. Poorly controlled coeliac disease in pregnancy can increase the risk of developing pregnancy-related complications, such as giving birth to a low birth weight baby. However, if pregnant women adhered to Gluten Free diet and their disease is under control then pregnancy related risk would be similar to pregnant women without coeliac disease. Pregnant women with coeliac disease get advice on managing their condition from both General Practitioners and hospital doctors. Coeliac disease is 3 times more common in women than in men and so any policy changes will affect women more than men. This assessment recognises that advice needs to be given to the public on healthy eating for patients with coeliac disease and we need to particularly reach out to women with healthy eating messages - this may help to mitigate against some patients with coeliac disease may not adhere to gluten free diet. Consideration should also be given to older people (who tend to be less mobile) or less mobile people (e.g. due to physical disability) are more likely to find it difficult to source gluten free foods.

Protected Characteristic	Issue	Remedy/Mitigation
Age	Coeliac UK have identified that it is key for younger people to have the right diet and have in the past supported stopping prescribing for all but under 18s. According to Coeliac UK, the majority of people are diagnosed from 50 years old	C&M data shows that less than 12% of prescriptions are allocated on the basis of being under 18s, and therefore prescribing to just this group could be

	and it is most common in people aged between 50 – 69 years. C&M data shows that 60% of GF prescriptions are allocated because patients are aged 60 and above and therefore our older age population may feel disadvantaged by stopping prescribing or prescribing for just under 18s. However, although only 11% of gf prescriptions are allocated to children and young people, they are not financially independent, and this data does not take into account their parents' financial capacity. According to Coeliac UK, non-adherence to a gluten free diet puts patients at a higher risk of long-term complications, including osteoporosis, ulcerative jejunitis, intestinal malignancy, functional hyposplenism, vitamin D deficiency and iron deficiency. This could lead to patients requiring additional care and support from NHS. An example given by Coeliac UK states it costs £195 a year per patient to support GF on prescription, but the average cost to the NHS of an osteoporotic hip fracture is £27,000.	seen as discriminatory for the older population. GF products are much more widely available in supermarkets and other outlets both in store and on-line, and improved food labelling means that patients are able to make more informed decisions about a healthy diet. In addition, bread is not necessary for a healthy diet as there are gluten free alternatives e.g. GF pasta, rice, potatoes etc. GP would continue to monitor patients and information is widely available on how to avoid gluten and follow a healthy diet.
Disability (you may need to discern types)	Currently, patients can get free NHS prescriptions if, at the time the prescription is dispensed, they: • have a continuing physical disability that prevents them from going out without help from another person and have a valid MedEx • hold a valid war pension exemption certificate and the prescription is for an accepted disability. People with coeliac disease, amongst these groups of people, may therefore be negatively impacted as a result of this proposal. People in this cohort may feel that this has a detrimental effect on their finances and so on their overall quality of life. • People with learning difficulties may find the GF labelling confusing and could be at greater risk of not adhering to a GF	Many supermarkets now have outlets on-line offering home deliveries which would support those with mobility issues to access GF products. GPs could offer prescriptions through the Individual Funding Request (IFR) process if their patient could demonstrate exceptionality. GP would continue to monitor patients

	diet without these products being prescribed. • Patient with mobility issues may struggle to get to shops to buy GF foods.	
Gender reassignment	No greater impact	
Marriage and Civil Partnership	No greater impact	
Pregnancy and maternity	Poorly controlled coeliac disease in pregnancy can increase the risk of developing pregnancy-related complications, such as giving birth to a low-birth weight baby.	Only 0.15% of the prescription exemptions are because of maternity exemption which implies the number of patients impacted is minimal. If pregnant women adhered to Gluten Free diet and their disease is under control then pregnancy related risk would be similar to pregnant women without coeliac disease. Pregnant women with coeliac disease get advice on managing their condition from both GPs and hospital doctors. The prescription exemption applies to pregnant women from the time they are pregnant to one year after either the due date or delivery date. This equality group will have short term effect.
Race	No greater impact	
Religion and belief	No greater impact	

Sex	According to NICE the prevalence in females is higher than in males (0.6% compared to 0.4%). C&M data reflects this with 65% of patients being female. This could result in females being more impacted than men, and they feel that this has a detrimental effect on their finances and so on their overall quality of life.	Food labelling is much improved and supports people to make healthy choices. In addition, bread is not necessary for a healthy diet as there are gluten free alternatives e.g. GF pasta, rice, potatoes etc. There are many websites with information on how to remain GF. GP would continue to monitor patients
Sexual orientation	No greater impact	
Whilst currently out of scope of Equality legislation it is also important to consider issues relating to socioeconomic status to ensure that any change proposal does not widen health inequalities. Socioeconomic status includes factors such as social exclusion and deprivation, including those associated with geographical distinctions (e.g. the North/South divide, urban versus rural). *Examples of groups to consider include:* *refugees and asylum seekers, migrant, unaccompanied child asylum seekers, looked-after children/ care leavers, homeless people, prisoners and young offenders, veterans, people who live in deprived areas, People living in remote, and rural locations.* *Health inclusion groups* *https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/* *For a more in-depth assessment of health inequalities please use the HEAT toolkit* https://www.gov.uk/government/publications/health-equity-assessment-tool-heat		
refugees and asylum seekers	No greater impact	
Looked after children and care leavers	Children and young people in care are not financially independent and often rely on GF specific products.	
Homelessness	No greater impact	
worklessness	No greater impact	
People who live in deprived areas	No greater impact	
carers	No greater impact	
Young carers	No greater impact	
People living in remote, rural and island locations	There is a risk that people in more remote areas will not have the same access to	Many supermarkets offer on-line shopping and deliver to homes,

	supermarkets with gluten free alternatives to bread. People in this cohort may feel that this has a detrimental effect on their finances and so on their overall quality of life.	and bread is not necessary for a healthy diet as there are gluten free alternatives e.g. GF pasta, rice, potatoes etc. GP would continue to monitor patients
People with poor literacy or health Literacy	No greater impact	
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	No greater impact	
Sex workers	No greater impact	
People or families on a low income	There is a risk that people or families on low income will not be able to adhere to a gluten free diet because the cost of GF bread and bread mixes compared to a standard loaf and flour is higher. People on low income who choose to purchase gluten free products because they can no longer obtain them on prescription may feel that this has a detrimental effect on their finances and so on their overall quality of life. The financial capacity of patients over 60 receiving prescription payment exemptions due to age is unknow and therefore still a risk that they will be impacted because of low income. Children and young people are at risk from not being able to adhere to a GF diet if the cost is too expensive. According to Coeliac UK a weekly gluten free food shop can be as much as 20% more expensive than a standard weekly food shop	C&M data shows that less than 2% of the prescription exemptions are because the patient is in receipt of tax credit or income based job seekers allowance. Whilst the cost of bread and flour is more expensive, there are other GF products e.g. pasta which is the same price as standard, and there are other natural GF foods. There are websites with information on how to maintain a GF diet. GP would continue to monitor patients
People with addictions and/or substance misuse issues	No greater impact	
SEND / LD	No greater impact	
Digital exclusion	No greater impact	

4. What data sources have you used and considered in developing the assessment?

NHS England Guidance: 'Prescribing Gluten-Free Foods in Primary Care: Guidance for CCGs' NICE guidance regarding coeliac disease: https://www.nice.org.uk/guidance/qs134, Department of Health & Social Care website, Coeliac UK website, C&M prescribing data
5. Involvement: consultation/ engagement
Guidance note: How have the groups and individuals been consulted with? What level of engagement took place? (If you have a consultation plan insert link or cut/paste highlights)
No engagement has taken place yet as the work to date has been an options appraisal to recommend an ICB proposal. This EIA is part of paper to ICB Board meeting to establish support for a non-prescribing option and at that point, if appropriate, public consultation would be initiated in order to inform the final decision.
6. Have you identified any key gaps in service or potential risks that need to be mitigated
Guidance note: Ensure you have action for who will monitor progress. Ensure smart action plan embeds recommendations and actions in Consultation, review, specification, inform provider, procurement activity, future consultation activity, inform other relevant organisations (NHS England, Local Authority).

Risk	Required Action	By Who/ When
If the option to withdraw prescribing is accepted, there is a risk that patients who previously received prescriptions will not adhere to a GF diet which could have significant health implications for them and will potentially increase demand (& cost) on future NHS Services. An example given by Coeliac UK states it costs £195 a year per patient to support GF on prescription, but the average cost to the NHS of an osteoporotic hip fracture is £27,000.	A published DHSC Impact Assessment examines the issue of adherence in detail and concludes that adherence to a GF diet cannot be isolated to any single cause. Evidence shows that many factors are at play including product labelling, cost and information when eating out and managing social occasions. Adherence requires a range of knowledge and skills to avoid all sources of gluten. Gluten free foods are now much more readily available in supermarkets, with clear gluten free labelling and greater awareness on healthy eating choices. Whilst bread and bread mixes are still more expensive that non GF products (according to Coeliac UK a gluten free loaf of bread is on average 4.3 times more expensive than a standard gluten containing loaf) it can be said that the cost of these products has been reducing over time and there are other GF products that are comparable prices to standard goods (e.g.500g of GF pasta is the same price as 500g of pasta containing gluten). In	Medical Directorate would ensure this happened following a decision

	addition, there are naturally free gluten free products e.g. rice, potatoes. In C&M the majority of patients receiving GF Prescriptions are exempt from charges, with over 70% of this being due to age. Because this exemption does not take into account financial capacity it is difficult to evidence what the individual financial impact on the impacted patients would be. It should be noted that there are less than 2% of prescription exemptions identified as being on tax credits or income support. If the option to stop prescribing was accepted, information on how to adhere to a gluten free diet would be made available and GPs would continue to monitor these patients as usual.	
There is a reputational risk to the ICB if the option to withdraw prescribing is accepted. Due to the current cost of living, there have been a number of national articles on the increased cost of "free from" foods despite them being much more available. In addition, 99% of the cohort of patients receiving prescriptions have an exemption in that they do not pay for prescriptions so could be seen that we are disadvantaging our most vulnerable population.	See above regarding non-GF options. In addition, the ICB does not prescribe for other conditions that are associated with, or affected by the types of food they eat, so this would result in a fairer approach for these patients. A public consultation exercise would be held in those Places who currently prescribe in line with the approach taken in St Helens and West Cheshire CCG before a final decision is made.	n/a

7. Is there evidence that the Public Sector Equality Duties will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)
PSED Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act: (check specifically sections 19, 20 and 29)
PSED Objective 2: Advance Equality of opportunity. (check Objective 2 subsection 3 below and consider section 4)
Analysis post consultation
PSED Objective 2: Section 3. sub-section a) remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.
Analysis post consultation
PSED Objective 2: Section 3. sub-section b) take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
Analysis post consultation
PSED Objective 2: Section 3. sub-section c) encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.
Analysis post consultation
PSED Objective 3: Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (consider whether this is engaged. If engaged consider how the project tackles prejudice and promotes understanding -between the protected characteristics)
Analysis post consultation
Health Inequalities: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);
[ENTER RESPONSE HERE]
PSED Section 2: Consider and make recommendation regards implementing PSED in to the commissioning process and service specification to any potential bidder/service provider (private/ public/charity sector)
Analysis post consultation
8. Recommendation to Board
Guidance Note: will PSED be met?
[ENTER RESPONSE HERE]
9. Actions that need to be taken
[ENTER RESPONSE HERE]

QUALITY IMPACT ASSESSMENT					
Project Name	Gluten Free Prescribing – Option 3 All Places Withdraw Gluten Free Prescribing				
Verto/PMO reference		Date of QIA	10/07/24	Date QIA reviewed	Stage 1 (local) 21/08/2024 Stage 2 (regional) 06/09/24
Name of Project Manager	Katie Bromley	Name of Programme manager	Natalia Armes	Clinical Lead	Rowan Pritchard Jones
Confirm date discussed at PDG or appropriate Place forum.	n/a ICB Wide Recovery Programme	Is this QIA part of an options appraisal?	Yes	Is the place of care expected to change?	n/a
Is this a permanent or temporary change? (e.g., a GRANT or a PILOT scheme?)	Permanent	If temporary – what are the expected timescales?	n/a	What will happen to the cohort of patients in progress when the service ends?	They will have to fund their own Gluten Free products
It is a nationally, or regionally, mandated service?	No	Is it identified as clinically essential?	No	Is it a statutory service? Y/N and details	No
Confirm if a Digital Impact Assessment has been undertaken	n/a	Confirm if a DPIA is required. (Remember this on **all** the data involved – not just the data held by NHS C&M)	n/a	An EIA is advised. Confirm if it has been undertaken.	Yes
Number of patients affected	2570 (23/24 data)	**Mitigated quality risk if project progresses.**	Moderate - 4	**Mitigated Quality risk if project is NOT Progressed**	Low - 1
Current costs	£520,000	Proposed costs	£0	Does it impact on another C&M Place?	8 of 9 Places: Liverpool Wirral Sefton

					Knowsley Warrington Halton Cheshire East Cheshire West (excluding GP practices in Cheshire West CCG footprint)

Background and overview of the proposals *(can be copied from PID on Verto or from National/Regional commissioning guidance)*

In 2016 – 2017 the Department of Health and Social Care undertook a review of prescribing for gluten free products and following a public consultation recommended that prescribing was limited to bread and bread mixes only.
When gluten free prescribing was first introduced, the availability of these foods was limited, however, all major supermarkets and other retailers stock gluten free foods both in store and on-line. In addition, food labelling has improved, and awareness has increased which means people are able identify which foods contain gluten and choose healthy options.

Currently in Cheshire and Merseyside 7* out of 9 Places offer Gluten Free prescribing for patients with diagnosed coeliac disease in line with the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. It is of note that for the remaining 2 Places, St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above).
*For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area. Therefore, there is inequity of access to these products across Cheshire and Merseyside.

NHS Cheshire and Merseyside was created in July 2022 and, as the statutory body, took over commissioning responsibilities from the 9 former CCGS. NHS C&M has to consider how to use the fixed resource allocation from NHS England to enable them to fulfil their duties and have to decide how and where to allocate resources to best meet the healthcare needs of the population they serve.

Under the Policy Harmonisation programme, and based on the DHSC consultation and clinical opinion, the recommendation was to re-instate prescribing for bread and bread mixes however this would result in an estimated additional annual spend of £130k. However, because of the need for NHS Cheshire and Merseyside to consider how they allocate funding to ensure it is being allocated to areas of highest risk, a review has been undertaken regarding the continuation of spend on gluten free prescribing and a recommendation to Board to stop gluten free prescribing is being presented. This would of course be subject to a public consultation exercise in order to inform the final decision.

The purpose of the QIA is to help articulate the risks to patients as it is hard to evidence the impact of withdrawing Gluten Free prescribing.

Risks if the project did not go ahead.

If this option was not supported, this would leave unwarranted variation in access to these services.

Patient safety

Please confirm the specific patient groups affected. Advise the impact on health inequalities	There are over 13,300 patients diagnosed with Coeliac Disease and other conditions which would deem them eligible for gluten free prescribing. Most patients choose to purchase their GF products themselves, however, 2,314 patients receive their GF bread and bread mixes through a prescription. Currently 99% of patients currently receiving Gluten Free prescriptions are exempt from charges. The highest categories are as follows: Aged 60 or over – 61% Under 18 – 12% Pre-payment certificate – 3% Medical Exemption – 3% Non specified Declaration – 19% The data shows the biggest impact would be to patients over 60.		
	Positive impact Improved patient safety, such as reducing the risk of adverse events is anticipated	Neutral Impact May have an adverse impact on patient safety. Mitigation is in place or planned to mitigate this impact to acceptable levels	Negative impact Increased risk to patient safety. Further mitigation needs to be put in place to manage risk to acceptable level
Explain how the project minimises the risk of harm and impacts patients. Include any risks	This would save the ICB over £500,000 per annum which could be spent on other priorities.	The majority of patients receiving prescriptions are exempt from charges, and this is mainly due to age. Because this exemption does not take into account financial capacity it is difficult to evidence that these patients would not be able to afford to purchase their own GF bread and mixes. The 2 CCGs that have withdrawn prescribing have advised that they have not experienced an increase in patients presenting with issues relating to not following a GF diet.	It is difficult to evidence the impact of Coeliac patients not being able to access Gluten Free (GF) bread and bread mixes, but there are known risks to not adhering to a GF diet which could have long term health impacts and lead to greater demand on wider health services. According to Coeliac UK, non-adherence to a gluten free diet puts patients at a higher at a higher risk of long-term complications, including osteoporosis, ulcerative jejunitis, intestinal malignancy, functional hyposplenism, vitamin D deficiency and iron deficiency. This could lead to patients requiring additional care and support from NHS.

Explain how the project may impact upon adults at risk and children and provide assurance that safeguarding process are in place with the provider		A gluten free diet may be maintained with items such as potatoes and rice, and bread is not essential	The patient groups that will be most impacted by this decision are older adults (over 60yo) and young people (under 18 & in full time education). These patient groups may potentially be at greater risk (incl. osteoporosis / long term conditions for younger patients) if they do not adhere to a GF diet. It is of note, however, this policy only relates to bread and bread mixes and bread is not an essential food item as there are gluten free alternatives e.g. GF pasta, rice, potatoes etc. and improved labelling on food and website with information on how to maintain a healthy GF diet. Due to the current cost of living, there have been a number of national articles on the cost of "free from" foods despite them being much more available. In addition, 99% of the cohort of patients receiving GF prescriptions have an exemption in that they do not pay for prescriptions so could be seen that we are disadvantaging our most vulnerable population. Because 73% of these exemptions are due to age, and this exemption does not take into account financial capacity, it is difficult to evidence that these patients would not be able to afford to purchase their own GF bread and mixes
Describe the impact on processes for reducing and	n/a	n/a	n/a

preventing patient harms and Healthcare Associated Infections? (e.g., falls, pressure ulcers, MRSA / CDI, VTE, etc)			

Clinical Effectiveness			
Please confirm how the project uses the best, knowledge based, research	The review of GF prescribing was carried out initially by Pharmacists and Dieticians, with support from other clinicians as part of the CPH Steering Group and was then continued under the ICB Unwarranted Variation Programme due to the financial constraints. Evidence from Dept. Health & Social Care, Coeliac UK was also reviewed. The recommendation from DH&SC is now to prescribe only bread and bread mixes, however, in the "Prescribing Gluten-Free Foods in Primary Care: Guidance for CCGs" document, published following the consultation in 2018 it does state "CCGs may further restrict the prescribing of GF foods by selecting bread only, mixes only or CCGs may choose to end prescribing of GF foods altogether".		
	Positive impact Clinical effectiveness will be improved resulting in better outcomes anticipated for patients	Neutral impact May have an adverse impact on clinical effectiveness. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in clinical effectiveness. Further mitigation needs to be put in place to manage risk to acceptable level
Explain if/how the project improves hospital flow or improves length of stay		These patients would not be treated in a hospital environment, so no impact on length of stay.	
Describe the impact on			It is difficult to evidence the impact of Coeliac patients not being able to access

clinical outcomes and how this will be monitored.			GF bread and bread mixes, but there are known risks to not adhering to a GF diet which could have long term health impacts (e.g. osteoporosis, ulcerative jejunitis, intestinal malignancy, functional hyposplenism, vitamin D deficiency and iron deficiency), and lead to greater demand on wider health services. However, availability of gf products has improved, as has food labelling. Patients would continue to be supported by their GPs as usual. Feedback from the 2 CCGs who have withdrawn prescribing have not reported any unforeseen consequences.
Does the project result in a higher likelihood of clinical recovery?			If patients cannot afford or cannot get to a supermarket to buy their own GF bread and bread mixes, there could be a negative impact on their long term health.
Does the project provide better access to wider care pathways?			No this would end prescribing
Does the project follow the latest NICE guidance/other relevant best practice evidence?			No. DH&SC and Coeliac UK guidance recommend prescribing bread and bread mixes
Describe the feedback of clinical leads	A number of clinicians have expressed support for the withdrawal, some noting that they have seen requests reduce over the last couple of years potentially due to wider availability of GF products in shops.	Where Clinical Leads support the withdrawal of prescribing, they have noted a potential financial impact to lower income patients.	The Dieticians who were part of the Clinical Policy Harmonisation programme did not support stopping prescribing through concern over those patients who may not follow a GF diet if not prescribed. However, feedback from those Places who have withdrawn

			prescribing is that they have not experienced unforeseen consequences. GPs would continue to support patients and information on how to maintain a GF diet is widely available

Patient Experience			
Please confirm the specific patient groups affected and how they are impacted.	A policy not to prescribe gluten free products may have an impact on vulnerable patients because gluten free products, while readily available in supermarkets, are more expensive that standard products, and some patients may not be able to access supermarkets easily.		
	Positive impact Improved patient and carer experience anticipated	Neutral impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels
Explain how the project will impact on the experience of care and better access to services	Not prescribing GF products will save over £500k which can be invested in other services. In addition, GF products are also the only food product that is offered on prescription, but there are other food allergies that don't have this offer, so could argue that stopping prescribing further reduces unwarranted variation.	This option withdraws prescribing and therefore does not impact access to services, however for patients who currently receive prescriptions they may reflect that experience of care is impacted by this, but access to supporting services is unchanged.	

Describe any consultation or engagement with the population that has occurred or is planned.		Public consultation would take place following a decision from the ICB Board as to whether withdrawing prescriptions would be considered	
Describe any change of location or setting of care.	n/a	n/a	n/a

Have any risks been identified in the following areas? (please list risk and escalation process)				
Area	Risk identified	If escalated, identify where escalated to	Date escalated	Mitigations put in place
Staff Experience	no			
Service Delivery	no			
Disinvestment	no			
Contingency plans	no			
Interdependency	no			
Sustainability	no			

RISKS where the project is progressed				
	Comment to explain rationale (include mitigations where applicable)	Likelihood of risk (L) (see table below)	Risk Impact / Consequence (C) (see table below)	Multiplication Total L x C
Quality risk to progress project	If the option to withdraw prescribing is accepted, there is a risk that patients who previously received prescriptions will not adhere to a GF diet due to affordability of free from products, which could have significant health implications for them and will potentially increase demand on health services as a result. There is a risk that this will widen health inequalities in deprived areas.	2	3	6
MITIGATED RISK to progress project				
Quality risk to progress project	In line with Cheshire West CCG actions when they stopped prescribing, we would improve the information and advice available to patients with coeliac disease that will help them to have a healthy, nutritious and balanced diet with all the necessary vitamins and minerals. Coeliac patients can still eat all naturally gluten-free foods such as meat, fish, fruit, vegetables, rice, and potatoes. We will provide advice to the following: Coeliac UK website for guidance and advice NHS Choices Website BBC website on gluten free diet The Eatwell Guide - NHS). Engage with supermarkets within C&M footprint to advise of prescribing decision with ask of them to manage their stock levels.	2	2	4

RISKS if project is NOT progressed				
	Comment to explain rationale (include mitigations where applicable)	Likelihood of risk (L)	Risk Impact / Consequence (C)	Multiplication Total for not progressing project

		See table below	See table below	L x C
Quality risk if project does not proceed	If the option to withdraw prescribing is not supported, then C&M have unwarranted variation in access to these products. The alternative option is to re-instate prescribing, however, there is a financial risk to the ICB in that an additional £130k would be required to support this and a total estimated annual expenditure of £650k.	1	1	1
MITIGATED RISK if project is NOT progressed				
Mitigated quality risk to progress project	Place based Medicines Management teams would review prescribing quantities to ensure they are in line with Coeliac UK guidance. This may mitigate some of the cost.	1	1	1

Summary

Decision made	Score	Mitigated score	Impact
Progress	6	4	moderate
Not progress	1	1	Low
Score summary (add to front page)			
Negligible and Low risk	Moderate risk	Major risk	Catastrophic risk
1-3	4 to 6	8- 12	13- 25

Risk Impact Score Guidance

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL
5	Catastrophic (>75%)	**Safety** - multiple deaths due to fault of ICB OR multiple permanent injuries or irreversible health effects OR an event affecting >50 people. **Quality** – totally unacceptable quality of clinical care OR gross failure to meet national standards. **Health Outcomes & Inequalities** – major reduction in health outcomes and/or life expectancy OR major increase in health inequality gap in deprived areas or socially excluded groups **Finance** – major financial loss - >1% of ICB budget OR 5% of delegated place budget **Reputation** – special measures, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence major impact on trust and confidence of stakeholders
4	Major (50% > 75%)	**Safety** - individual death / permanent injury/ disability due to fault of ICB OR 14 days off work OR an event affecting 16 – 50 people. **Quality** – major effect on quality of clinical care OR non-compliance with national standards posing significant risk to patients. **Health Outcomes & Inequalities** – significant reduction in health outcomes and/or life expectancy OR significant increase in health inequality gap in deprived areas or socially excluded groups **Finance** - significant financial loss of 0.5-1% of ICB budget OR 2.5-5% of delegated place budget **Reputation** - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public significant impact on trust and confidence of stakeholders
3	Moderate (25% > - 50%)	**Safety** - moderate injury or illness, requiring medical treatment e.g., fracture due to fault of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Quality** – significant effect on quality of clinical care OR repeated failure to meet standards **Health Outcomes & Inequalities** – moderate reduction in health outcomes and/or life expectancy OR moderate increase in health inequality gap in deprived areas or socially excluded groups **Finance** - moderate financial loss - less than 0.5% of ICB budget OR less than 2.5% of delegated place budget

		Reputation - conditions imposed by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction moderate impact on trust and confidence of stakeholders
2	**Minor (<25%)**	**Safety** - minor injury or illness requiring first aid treatment **Quality** – noticeable effect on quality of clinical care OR single failure to meet standards **Health Outcomes & Inequalities** – minor reduction in health outcomes and/or life expectancy OR minor increase in health inequality gap in deprived areas or socially excluded groups **Finance** - minor financial loss less than 0.2% of ICB budget OR less than 1% of delegated place budget **Reputation** - some criticism slight possibility of complaint or litigation but minimum impact on ICB minor impact on trust and confidence of stakeholders
1	**Negligible (<5%)**	**Safety** - none or insignificant injury due to fault of ICB **Quality** – negligible effect on quality of clinical care **Health Outcomes & Inequalities** – marginal reduction in health outcomes and/or life expectancy OR marginal increase in health inequality gap in deprived areas or socially excluded groups **Finance** - no financial or very minor loss **Reputation** - no impact or loss of external reputation

The likelihood of the risk occurring must then be measured. Table 2 below should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood, it is important to take into consideration the existing controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

Table 2 - Risk Likelihood Score Guidance

1	2	3	4	5
Rare The event could only occur in exceptional circumstances (<5%)	**Unlikely** The event could occur at some time (<25%)	**Possible** The event may well occur at some time (25%> -50%)	**Likely** The event will occur in most circumstances (50% > 75%)	**Almost certain** The event is almost certain to occur (>75%)

The impact and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

Table 3 - Risk Assessment Matrix (level of risk)

LIKELIHOOD of risk being realised	**IMPACT (severity)** of risk being realised				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost Certain (5)	5	10	15	20	25

Low Risk	Moderate Risk	High Risk	Extreme Risk	Critical Risk

Risk Proximity

A further element to be considered in the risk assessment process is risk proximity. Risk proximity provides an estimate of the timescale as to when the risk is likely to materialise. It supports the ability to prioritise risks and informs the appropriate response in the monitoring of controls and development of actions.

A pragmatic approach to the use of risk proximity which supports leadership, decision making and reporting is used and is therefore determined to be applied to all Risks.

The proximity scale used is below:

Proximity and timescale for dealing with the risk	Within the current quarter	Within the financial year	Beyond the financial year
Rating	A	B	C

Likelihood, impact and proximity are dynamic elements and consequently all three must be reviewed and reassessed frequently in order to prioritise the response.

Sign off process			
Name	Role	Signature	Date
Katie Bromley	Project lead		4/9/24
Sinead Clarke	Clinical lead		4/9/24
Natalia Armes	Programme manager		4/9/24
	PMO lead		
Once signed off by all above, then the QIA is submitted to QIA review group			

This section to be completed following review at the QIA review group					
Name	Role	Approved	Rejected	Signature	Date
ADs of Quality	QIA review group chair (after group meeting)	Yes			6/9/24
Denise Roberts (supported by Maxine Dickinson)	AD of Quality	Yes			21/08/24
	C&M ICB QIA lead (if necessary)				

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PROTOCOL FOR THE ESTABLISHMENT OF JOINT HEALTH SCRUTINY ARRANGEMENTS IN CHESHIRE AND MERSEYSIDE

1. INTRODUCTION

1.1 This protocol has been developed as a framework for the operation of joint health scrutiny arrangements across the local authorities of Cheshire and Merseyside. It allows for:

- scrutiny of substantial developments and variations of the health service; and,
- discretionary scrutiny of local health services.

1.2 The protocol provides a framework for health scrutiny arrangements which operate on a joint basis only. Each constituent local authority should have its own local arrangements in place for carrying out health scrutiny activity individually.

2. BACKGROUND

2.1 The relevant legislation regarding health scrutiny is:

- Health and Social Care Act 2012,
- The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013; and
- The Health and Care Act 2022.

This is supplemented by relevant guidance:

- Local Authority Health Scrutiny (DHSC, updated 2024)
- Statutory guidance: "Reconfiguring NHS services – ministerial intervention powers" (DHSC, 2024).

2.2 In summary, the statutory framework authorises local authorities individually and collectively to:

- review and scrutinise any matter relating to the planning, provision and operation of the health service; and,
- consider consultations by a relevant NHS commissioning body or provider of NHS-funded services on any proposal for a substantial development or variation to the health service in the local authority's area.

2.3 Ultimately the regulations place a requirement on relevant scrutiny arrangements to reach a view on whether they are satisfied that any proposal that is deemed to be a substantial development or variation is in the interests of the health service in that area. In instances where a proposal impacts on the residents of one local authority area exclusively,

this responsibility lays with that authority's health scrutiny arrangements alone.

2.4 Where such proposals impact on more than one local authority area, each authority's health scrutiny arrangements must consider whether the proposals constitute a substantial development or variation or not. The regulations place a requirement on those local authorities that agree that a proposal is substantial to establish, in each instance, a joint overview and scrutiny committee for the purposes of considering it. This protocol deals with the proposed operation of such arrangements for the local authorities of Cheshire and Merseyside.

2.5 Whilst it is recognised that the previous power of a health scrutiny committee or joint health scrutiny committee to refer a service change proposal to the Secretary of State for Health and Social Care has been removed, such committees will now possess the ability to request formally that the Secretary of State "call-in" a service change proposal. The ability to "call-in" a proposal should only be used in exceptional circumstances where all efforts to resolve issues locally have been exhausted.

3. PURPOSE OF THE PROTOCOL

3.1 This protocol sets out the framework for the operation of joint scrutiny arrangements where:

a) an NHS commissioning body or health service provider consults with more than one local authority on any proposal it has under consideration, for a substantial development/variation of the health service;

b) joint scrutiny activity is being carried out on a discretionary basis into the planning, provision and operation of the health service.

3.2 The protocol covers the local authorities of Cheshire and Merseyside including:

- Cheshire East Council
- Cheshire West and Chester Council
- Halton Borough Council
- Knowsley Council
- Liverpool City Council
- St. Helens Metropolitan Borough Council
- Sefton Council
- Warrington Borough Council
- Wirral Borough Council

3.3 Whilst this protocol deals with arrangements within the boundaries of Cheshire and Merseyside, it is recognised that there may be occasions

when consultations/discretionary activity may affect adjoining regions/ areas. Arrangements to deal with such circumstances would have to be determined and agreed separately, as and when appropriate.

4. PRINCIPLES FOR JOINT HEALTH SCRUTINY

4.1 The fundamental principle underpinning joint health scrutiny will be co-operation and partnership with a mutual understanding of the following aims:

- To improve the health of local people and to tackle health inequalities (outcome-focussed);
- To ensure that scrutiny activity adopts an appropriate balance between a focus on future service delivery and a focus on responding to immediate concerns/ issues (balanced)
- To represent the views of local people and ensure that these views are identified and integrated into local health service plans, services and commissioning (inclusive);
- To scrutinise whether all parts of the community are able to access health services and whether the outcomes of health services are equally good for all sections of the community (evidence-informed); and,
- To work with NHS bodies and local health providers to ensure that their health services are planned and provided in the best interests of the communities they serve, taking into account any potential impact on health service staff (collaborative).

5. SUBSTANTIAL DEVELOPMENT OF /VARIATION TO SERVICES

5.1 Requirements to consult

5.1.1 All relevant NHS bodies and providers of NHS-funded services[1] are required to consult local authorities when they have a proposal for a substantial development or substantial variation to the health service.

5.1.2 A substantial development or variation is not defined in legislation. Guidance has suggested that the key feature is that it should involve a major impact on the services experienced by patients and/or future patients.

[1] This includes NHS England and any body commissioning services to the residents of Cheshire and Merseyside, plus providers such as NHS Trusts, NHS Foundation Trust and any other relevant provider of NHS funded services which provides health services to those residents, including public health.

5.1.3 Where a substantial development or variation impacts on the residents within one local authority area boundary, only the relevant local authority health scrutiny function shall be consulted on the proposal.

5.1.4 Where a proposal impacts on residents across more than one local authority boundary, the NHS body/health service provider is obliged to consult all those authorities whose residents are affected by the proposals in order to determine whether the proposal represents a substantial development or variation.

5.1.5 Those authorities that agree that any such proposal does constitute a substantial development or variation are obliged to form a joint health overview and scrutiny committee for the purpose of formal consultation by the proposer of the development or variation.

5.1.6 Whilst each local authority must decide individually whether a proposal represents a substantial development/variation, it is only the statutory joint health scrutiny committee which can formally comment on the proposals if more than one authority agrees that the proposed change is "substantial".

5.1.7 Determining that a proposal is not a substantial development/variation removes the ability of an individual local authority to comment formally on the proposal.. Once such decisions are made, the ongoing obligation on the proposer to consult formally on a proposal relates only to those authorities that have deemed the proposed change to be "substantial" and this must be done through the vehicle of the joint committee. Furthermore the proposer will not be obliged to provide updates or report back on proposals to individual authorities that have not deemed them to be "substantial".

5.1.8 For the avoidance of doubt, if only one authority amongst a number being consulted on a proposal deem it to be a substantial change, the ongoing process of consultation on the proposal between the proposer and the remaining authority falls outside the provisions of this protocol.

5.2 Process for considering proposals for a substantial development/variation

5.2.1 In consulting with the local authority in the first instance to determine whether the change is considered substantial, the relevant NHS commissioning body / provider of NHS-funded services is required to:

- Provide the proposed date by which it requires comments on the proposals
- Provide the proposed date by which it intends to make a final decision as to whether to implement the proposal
- Publish the dates specified above

- Inform the local authority if the dates change[2]

5.2.2 NHS commissioning bodies and local health service providers are not required to consult with local authorities where certain 'emergency' decisions have been taken. All exemptions to consult are set out within regulations.[3]

5.2.3 In considering whether a proposal is substantial, all local authorities are encouraged to consider the following criteria:

- *Changes in accessibility of services:* any proposal which involves the withdrawal or change of patient or diagnostic facilities for one or more speciality from the same location.

- *Impact on the wider community and other services:* This could include economic impact, transport, regeneration issues.

- *Patients affected:* changes may affect the whole population, or a small group. If changes affect a small group, the proposal may still be regarded as substantial, particularly if patients need to continue accessing that service for many years.

- *Methods of service delivery:* altering the way a service is delivered may be a substantial change, for example moving a particular service into community settings rather than being entirely hospital based.

- *Potential level of public interest:* proposals that are likely to generate a significant level of public interest in view of their likely impact.

5.2.4 These criteria will assist in ensuring that there is a consistent approach applied by each authority in making their respective decisions on whether a proposal is "substantial" or not. In making the decision, each authority will focus on how the proposals impacts on its own area/ residents.

6. OPERATION OF A STATUTORY JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

6.1 General

6.1.1 A joint health overview and scrutiny committee will be made up of each of the constituent local authorities that deem a proposal to be a substantial development or variation. This joint committee will be

[2] Section 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
[3] Section 24 *ibid*

formally consulted on the proposal and, in exceptional circumstances, formally request that the Secretary of State to "call-in" a proposal, where local consultation has failed to resolve significant outstanding issues.

6.1.2 A decision as to whether the proposal is deemed substantial shall be taken within a reasonable timeframe and in accordance with any deadline set by the lead local authority (see section 6.6), following consultation with the other participating authorities.

6.2 Powers

6.2.1 In dealing with substantial development/variations, any statutory joint health overview and scrutiny committee that is established can:

- require relevant NHS bodies and health service providers to provide information to and attend before meetings of the committee to answer questions
- make comments on the subject proposal by a date provided by the NHS body/local health service provider
- make reports and recommendations to relevant NHS bodies/local health providers
- require relevant NHS bodies/local health service providers to respond within a fixed timescale to reports or recommendations
- carry out further negotiations with the relevant NHS body where it is proposing not to agree to a substantial variation proposal.

6.2.2 A joint health overview and scrutiny committee has the ability to request the Secretary of State to "call-in" a service change proposal where it has not been possible to resolve significant outstanding issues during the course of local consultation. The ability to request the "call-in" of a proposal should only be exercised in exceptional circumstances where all possible efforts to resolve the matter locally have been exhausted, as outlined in 6.2.3 and 6.2.4 below.

6.2.3 Where a committee has made a recommendation to a NHS commissioning body/local health service provider regarding a proposal and the NHS body/provider disagrees with the recommendation, the local health service provider/NHS body is required to inform the joint committee and attempt to enter into negotiation to try and reach an agreement.

6.2.4 In any circumstance where a committee disagrees with a proposal for a substantial variation, there will be an expectation that negotiations will be entered into with the NHS commissioning body/local health service provider in order to attempt to reach agreement.

6.2.5 Where local authorities have agreed that the proposals represent substantial developments or variations to services and agreed to enter into joint arrangements, it is only the joint health overview and scrutiny committee which may exercise these powers.

6.2.5 An ad-hoc statutory joint health overview and scrutiny committee established under the terms of this protocol may only exercise the powers set out in 6.2.1 to 6.2.4 above in relation to the statutory consultation for which it was originally established. Its existence is time-limited to the course of the specified consultation and it may not otherwise carry out any other activity.

6.3 Membership

6.3.1 The participating local authorities must ensure that those Councillors nominated to a joint health overview and scrutiny committee produce a membership that reflects the overall political balance across the participating local authorities. However, political balance requirements for each joint committee established may be waived with the agreement of all participating local authorities, should time and respective approval processes permit.

6.3.2 A joint committee will be composed of Councillors from each of the participating authorities within Cheshire and Merseyside in the following ways:

- where 4 or more local authorities deem the proposed change to be substantial, each authority will nominate 2 elected members

- where 3 or less local authorities deem the proposed change to be substantial, then each participating authority will nominate 3 elected members.

  (Note: In making their nominations, each participating authority will be asked to ensure that their representatives have the experience and expertise to contribute effectively to a health scrutiny process)

Local authorities who consider change to be 'substantial'	**No' of elected members to be nominated from each authority**
4 or more	2 members
3 or less	3 members

6.3.3 Each local authority will be obliged to nominate elected members through their own relevant internal processes and provide notification of those members to the lead local authority at the earliest opportunity.

6.3.4 To avoid inordinate delays in the establishment of a relevant joint committee, it is suggested that constituent authorities either arrange for delegated decision-making arrangements to be put in place to deal with such nominations at the earliest opportunity, or to nominate potential

representatives annually as part of annual meeting processes to cover all potential seat allocations.

6.5 Quorum

6.5.1 The quorum of the meetings of a joint committee shall be one third of the full membership of any Joint Committee, subject to the quorum being, in each instance, no less than 3.

6.5.2 There will be an expectation for there to be representation from each authority at a meeting of any joint committee established. The lead local authority will attempt to ensure that this representation is achieved.

6.6 Identifying a lead local authority

6.6.1 A lead local authority should be identified from one of the participating authorities to take the lead in terms of administering and organising a joint committee in relation to a specific proposal.

6.6.2 Selection of a lead authority should, where possible, be chosen by mutual agreement by the participating authorities and take into account both capacity to service a joint health scrutiny committee and available resources. The application of the following criteria should also guide determination of the lead authority:

- The local authority within whose area the service being changed is based; or
- The local authority within whose area the lead commissioner or provider leading the consultation is based.

6.6.3 Lead local authority support should include a specific contact point for communication regarding the administration of the joint committee. There will be an obligation on the key lead authority officer to liaise appropriately with officers from each participating authority to ensure the smooth running of the joint committee.

6.6.4 Each participating local authority will have the discretion to provide whatever support it may deem appropriate to their own representative(s) to allow them to make a full contribution to the work of a joint committee.

6.7 Nomination of Chair/ Vice-Chair

The chair/ vice-chair of the joint health overview and scrutiny committee will be nominated and agreed at the committee's first meeting.

6.8 Meetings of a Joint Committee

6.8.1 At the first meeting of any joint committee established to consider a proposal for a substantial development or variation, the committee will also consider and agree:

- The joint committee's terms of reference;
- The procedural rules for the operation of the joint committee;
- The process/ timeline for dealing formally with the consultation, including:
    - the number of sessions required to consider the proposal; and,
    - the date by which the joint committee aims to reach its final conclusion on the proposal – which should be in advance of the proposed date by which the NHS commissioning body/service provider intends to make its final decision on it.

6.8.2 All other meetings of the joint committee will be determined in line with the proposed approach for dealing with the consultation. Different approaches may be taken for each consultation and could include gathering evidence from:

- NHS commissioning bodies and local service providers;
- patients and the public;
- voluntary sector and community organisations; and
- NHS regulatory bodies.

6.9 Reports of a Joint Committee

6.9.1 A joint committee is entitled to produce a written report which may include recommendations. As a minimum, the report will include:

- An explanation of why the matter was reviewed or scrutinised.
- A summary of the evidence considered.
- A list of the participants involved in the review.
- An explanation of any recommendations on the matter reviewed or scrutinised.

The lead authority will be responsible for the drafting of a report for consideration by the joint committee.

6.9.2 Reports shall be agreed by the majority of members of a joint committee and submitted to the relevant NHS commissioning body/health service provider.

6.9.3 Where a member of a joint health scrutiny committee does not agree with the content of the committee's report, they may produce a report

setting out their findings and recommendations which will be attached as an appendix to the joint health scrutiny committee's main report.

7. DISCRETIONARY HEALTH SCRUTINY

7.1 More generally, the Health and Social Care Act 2012 and the 2013 Health Scrutiny Regulations provide for local authority health scrutiny arrangements to scrutinise the planning, provision and operation of health services.

7.2 In this respect, two or more local authorities may appoint a joint committee for the purposes of scrutinising the planning, provision and operation of health services which impact on a wider footprint than that of an individual authority's area.

7.3 Any such committee will have the power to:

- require relevant NHS commissioning bodies and health service providers to provide information to and attend before meetings of the committee to answer questions.
- make reports and recommendations to relevant NHS commissioning bodies/local health providers.
- require relevant NHS commissioning bodies/local health service providers to respond within a fixed timescale to reports or recommendations.

7.4 Ordinarily, a discretionary joint committee would not have the ability to request the Secretary of State for Health and Social Care "call-in" a service change proposal. However, please note section 8.3 below.

7.5 In establishing a joint committee for the purposes of discretionary joint scrutiny activity, the constituent local authorities should determine the committee's role and remit. This should include consideration as to whether the committee operates as a standing arrangement for the purposes of considering all of the planning, provision and operation of health services within a particular area or whether it is being established for the purposes of considering the operation of one particular health service with a view to making recommendations for its improvement. In the case of the latter, the committee must disband once its specific scrutiny activity is complete.

7.6 In administering any such committee, the proposed approach identified in sections 6.3 – 6.9 of this protocol should be followed, as appropriate.

8. SCRUTINY OF CHESHIRE AND MERSEYSIDE INTERGRATED CARE SYSTEM

8.1 Further to this protocol and in particular section 7 above, the nine local authorities have agreed to establish a discretionary standing joint health scrutiny committee in response to the establishment of the Cheshire and Merseyside Integrated Care System.

8.2 A separate Joint Scrutiny Committee Arrangements document has been produced in line with the provisions of this protocol to outline how the standing joint committee will operate.

8.3 In summary, the "Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee" has the following responsibilities:

- To scrutinise the work of the Integrated Care System in relation to any matter regarding the planning, provision and operation of the health service at footprint level only; and
- To consider the merits of any service change proposals that have been deemed to be a substantial variation in services by all nine authorities.

9. CONCLUSION

9.1 The local authorities of Cheshire and Merseyside have adopted this protocol as a means of governing the operation of joint health scrutiny arrangements both mandatory and discretionary. The protocol is intended to support effective consultation with NHS commissioning bodies or local health service providers on any proposal for a substantial development of or variation in health services. The protocol also supports the establishment of a joint health overview and scrutiny committee where discretionary health scrutiny activity is deemed appropriate.

9.2 The protocol will be reviewed regularly, and at least on an annual basis to ensure that it complies with all current legislation and any guidance published by the Department of Health and Social Care.

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Report Title Here	Cheshire & Merseyside ICB – Sefton Place Update
Date of meeting:	7 January 2025
Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)
Report of:	NHS Cheshire and Merseyside ICB – Sefton Place
Wards affected:	All
Exempt/confidential report:	No
Contact Officer:	Deborah Butcher
Tel:	0151 317 8456
Email:	Deborah.butcher@sefton.gov.uk

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 2025

Mental health support and integration

(for more information contact: angela.clintworth@cheshireandmerseyside.nhs.uk)

- Currently within Sefton we average approximately 6 patients per week who are deemed Clinically Ready for Discharge (CRFD) with Mersey Care NHS Foundation Trust (MCFT) reporting 80> for their provider footprint.
- MH Capacity & Flow Meetings - as a system we meet on a weekly basis with MCFT, North and Mid Mersey Place representatives, LA representatives and NWAS to review sitrep data and support the Trust in accelerating patient discharges where possible. This forum also enables us to identify any issues/trends that need to be addressed strategically from a place/pan-place perspective with housing/accommodation availability being a key issue. There are also MADE meetings that take place on a weekly basis with operational staff that supports patient flow also. The ICB has recently taken over chairing responsibility for these meetings and we are starting to evidence an increase in discharge arrangements due to the meetings being more solution focused.
- In respect of the above we have an established Strategic Housing Commissioning Group which is led by Sefton Council's Housing Department, which meets monthly to address our specific housing/accommodation needs across health and social care, which informs our strategy locally and the work that is currently being undertaken across Cheshire & Merseyside, as part of the TCP/MH Programme to develop provision that facilitates timely discharge and prevents hospital admission at place.
- We have commissioned an integrated mental health recovery service at place (Woodlands) which provides 11 beds and 2 emergency respite beds to support timely discharge and prevent hospital admission and we are working in partnership with Sefton's Housing Department and their Housing Options Team to further develop pathways that will support capacity and flow.
- We are currently working in partnership with the ICB, Adult Social Care and Housing to develop a complex mental health accommodation-based service for individuals who are homeless as part of the Complex Lives Work Programme.
- We are also progressing plans to commission an integrated ACES (Adverse Childhood Experiences) Programme. The integrated ACES support will incorporate learning from both Council and PCN led initiatives which will enable us to increase and enhance the service offer, providing greater reach across our communities including children and young people through a family-based approach.
- We are also working in partnership with the Council's Adult Social Care Department to develop a joint reviewing/commissioning strategy for both Mental Health and Learning Disabilities that will enable us to review current commissioned activity, ensuring we have appropriate services at place that will support assessed need and address any gaps in current service provision.

- We are currently reviewing the Mental Health Recovery Team which is an integrated resource hosted by Adult Social Care's Community Mental Health Team, to understand if we need to expand this resource. The Team provides 12-week short-term intensive reablement support to accelerate hospital discharge or promote recovery from mental illness and improve quality of life. The team consists of 4.5 support workers who work across both north and south Sefton and sit within CMHT's and are managed by Adult Social Care Team Managers. The team achieve really positive outcomes with 66% of individuals accessing the service during 23/24 no longer requiring long term support.

South Sefton Primary Care Network

(for more information contact: rachel.stead@southseftonpcn.nhs.uk)

South Sefton Primary Care Network (PCN) won PCN of the Year for significantly improving capacity and access for patients, adding over 20,000 appointments into general practice via their South Sefton Access Service, all the while remaining responsive to local priorities, patient needs and patient voice.

Latest NHS Cheshire and Merseyside Board meeting

The next NHS Cheshire and Merseyside Board meeting takes place on 30 January 2025 9.30am to 12.30pm. Location: The Ballroom, Bootle Town Hall, Oriel Road, Bootle, L20 7AE

All Board meetings held in public are live-streamed via our YouTube channel to enable those who are unable to attend in person to observe the meeting, with recordings of these meetings also made accessible via our Meeting and Event Archive.

You can find the link to the NHS Cheshire & Merseyside YouTube channel here https://www.youtube.com/@NHSCandM/streams

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/

Report Title Here	Health Provider Performance Dashboard
Date of meeting:	7 January 2025
Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)
Report of:	NHS Cheshire and Merseyside ICB – Sefton Place
Wards affected:	All
Exempt/confidential report:	No
Contact Officer:	Deborah Butcher
Tel:	0151 317 8456
Email:	Deborah.butcher@sefton.gov.uk

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

Main Provider Performance December 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

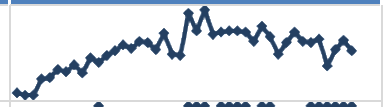
NHS Cheshire and Merseyside

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-24	72.58%	72.30%	73.04%	78% by March 2025	
Cancer 28 Day FDS (MWLTH from July 23)	Sep-24	71.00%	71.4%	74.9%	77% by March 2025	
Cancer 62 Day - combined new from Oct-23 (MWLTH from July 23)	Sep-24	78.18%	73.0%	67.3%	85%	
Cancer 31 Day - combined new from Oct-23 (MWLTH from July 23)	Sep-24	90.04%	93.3%	90.6%	96%	
RTT -18 Weeks Incomplete (MWLTH from July) snapshot	Sep-24	57.82%	56.20%	58.50%	92%	
C.Difficile (MWLTH) cumulative YTD	Sep-24	47	-	-	2024-25 Target </=113	
MRSA (MWLTH) cumulative YTD	Sep-24	1	-	-	zero tolerance	
Ambulance Category 1 Mean 7 minute response time (NS Place Level)	Sep-24	00:09:04	00:07:41 (NWAS)	00:08:25	<=7 Minutes	
Ambulance Category 1 90th Percentile 15 minute response time (NS Place Level)	Sep-24	00:16:46	00:13:10 (NWAS)	00:14:58	<=15 Minutes	
Ambulance Category 2 Mean 18 minute response time (NS Place Level)	Sep-24	00:41:29	00:28:52 (NWAS)	00:36:02	<=30 Minutes	
Ambulance Category 2 90th Percentile 40 minute response time (NS Place Level)	Sep-24	01:27:03	00:59:45 (NWAS)	01:16:20	<=40 Minutes	
Ambulance Category 3 90th Percentile 120 minute response time (CCG Level)	Sep-24	07:44:52	04:37:14 (NWAS)	05:51:39	<=120 Minutes	
Ambulance Category 4 90th Percentile 180 minute response time (NS Place Level)	Sep-24	07:24:31	04:24:33 (NWAS)	05:51:39	<=180 Minutes	
Mental Health: IAPT 16.8% Access (NS Place Level)	Oct-24	1.22%	-	-	1.59% per month Qtr 1-3 1.83% per month Qtr 4	
Mental Health: IAPT 50% Recovery (NS Place Level)	Oct-24	58.7%	-	-	50%	
Mental Health: IAPT waiting <6 weeks (NS Place)	Oct-24	96%	-	-	75%	
Mental Health: IAPT waiting <18 weeks (NS Place)	Oct-24	99%	-	-	95%	

Mersey & West Lancashire Teaching Hospital NHS Trust

Friends & Family

NHS
Cheshire and Merseyside

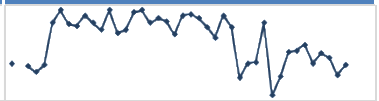
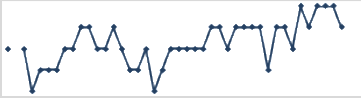
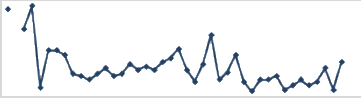
Measure	Time Period	MWLTH	C&M	National (Target)	Trend
Inpatient – Response Rate	Sep-24	34.5%	29.5%	22.1%	
Inpatient Recommended	Sep-24	95.0%	92.0%	94.0%	
Inpatient Not Recommended	Sep-24	3.0%	3.0%	3.0%	
A&E – Response Rate	Sep-24	17.5%	15.5%	10.2%	
A&E Recommended	Sep-24	86.0%	78.0%	79.0%	
A&E Not Recommended	Sep-24	9.0%	15.0%	13.0%	

Sefton Place – South Sefton

Key Performance Area	Time Period	Performance	C&M	National	Target	Trend
A&E 4 hour Waits, All Types (LUHFT)	Oct-24	68.28%	72.30%	73.04%	78% by March 2025	
Cancer 28 Day FDS (LUHFT)	Sep-24	67.56%	71.4%	74.9%	77% by March 2025	
Cancer 62 Day - combined new from Oct-23 (LUHFT)	Sep-24	70.51%	73.0%	67.3%	85%	
Cancer 31 Day - combined new from Oct-23 (LUHFT)	Sep-24	86.60%	93.3%	90.6%	96%	
RTT -18 Weeks Incomplete (LUHFT) Snapshot	Sep-24	52.29%	56.20%	58.50%	92%	
C.Difficile (LUHFT) cumulative YTD	Sep-24	111	-	-	2024-25 Target </=156	
MRSA (LUHFT) cumulative YTD	Sep-24	3	-	-	zero tolerance	
Ambulance Category 1 Mean 7 minute response time (SS Place Level)	Sep-24	00:07:30	00:07:41 (NWAS)	00:08:25	<=7 Minutes	
Ambulance Category 1 90th Percentile 15 minute response time (SS Place Level)	Sep-24	00:11:58	00:13:10 (NWAS)	00:14:58	<=15 Minutes	
Ambulance Category 2 Mean 18 minute response time (SS Place Level)	Sep-24	00:41:22	00:28:52 (NWAS)	00:36:02	<=30 Minutes	
Ambulance Category 2 90th Percentile 40 minute response time (SS Place Level)	Sep-24	01:22:49	00:59:45 (NWAS)	01:16:20	<=40 Minutes	
Ambulance Category 3 90th Percentile 120 minute response time (SS Place Level)	Sep-24	07:19:16	04:37:14 (NWAS)	05:51:39	<=120 Minutes	
Ambulance Category 4 90th Percentile 180 minute response time (SS Place Level)	Sep-24	10:30:34	04:24:33 (NWAS)	05:51:39	<=180 Minutes	
Mental Health: IAPT 16.8% Access (SS Place Level)	Oct-24	1.22%	-	-	1.59% per month Qtr 1-3 1.83% per month Qtr 4	
Mental Health: IAPT 50% Recovery (SS Place Level)	Oct-24	50.0%	-	-	50%	
Mental Health: IAPT waiting <6 weeks (SS Place)	Oct-24	98%	-	-	75%	
Mental Health: IAPT waiting <18 weeks (SS Place)	Oct-24	100%	-	-	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	Sep-24	22.1%	29.5%	22.1%	
Inpatient Recommended	Sep-24	93.0%	92.0%	94.0%	
Inpatient Not Recommended	Sep-24	4.0%	3.0%	3.0%	
A&E – Response Rate	Sep-24	18.0%	15.5%	10.2%	
A&E Recommended	Sep-24	71.0%	78.0%	79.0%	
A&E Not Recommended	Sep-24	22.0%	15.0%	13.0%	

NWAS – Paramedic Emergency Services (PES) Summary

Data Source: Provider Level (NWAS)

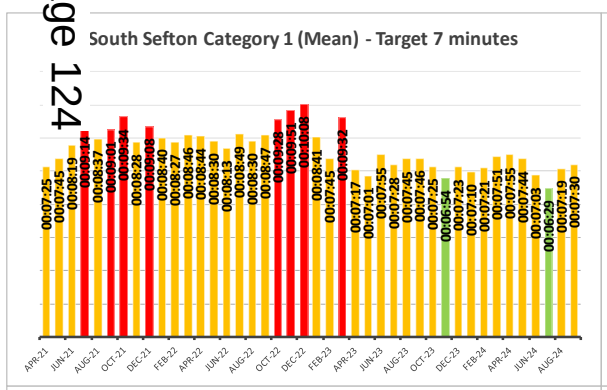
Agenda Item 7

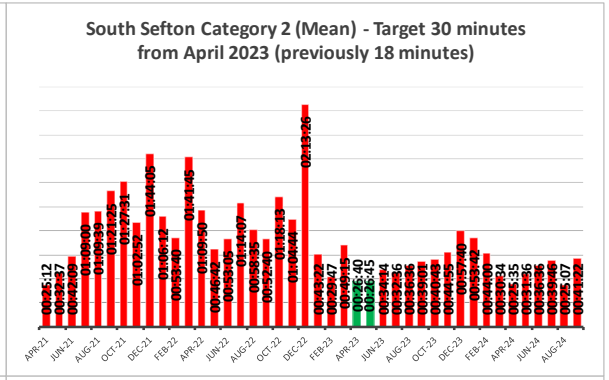
Dashboard

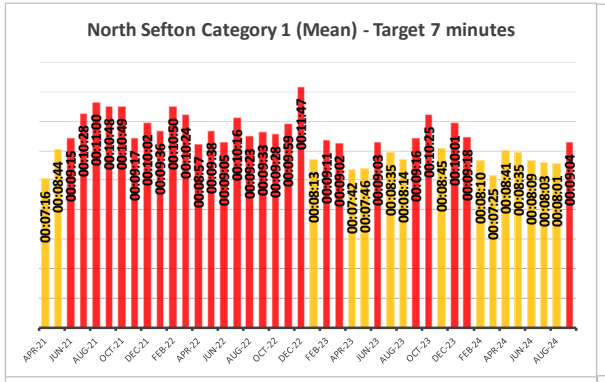
Key	Risk Data	▲ Low	▲ Moderate	▲ High
		Ⓟ Published	Ⓛ Local	Ⓧ Not available

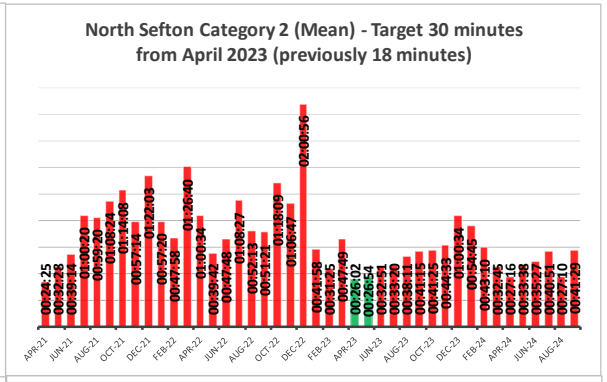
Sep-24	Cat 1 (Mean)	Cat 2 (Mean)	Cat 3 (90th Percentile)	Cat 4 (90th Percentile)
Target	00:07:00	00:30:00	02:00:00	03:00:00
South Sefton	00:07:30	00:41:22	07:19:16	10:30:34
North Sefton	00:09:04	00:41:29	07:44:52	07:24:31
NWAS	00:07:41	00:28:52	04:37:14	04:24:33
Risk	▲	▲	▲	▲
Data	Published	Published	Published	Published

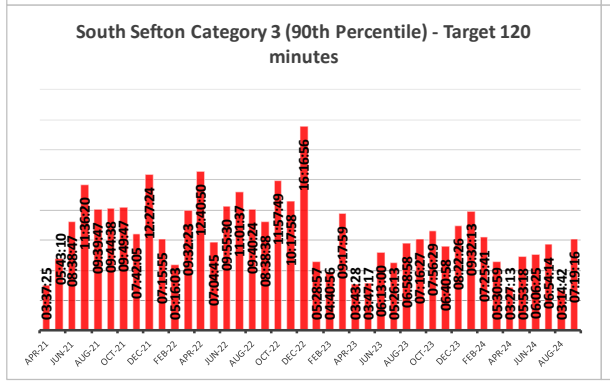
Performance Charts

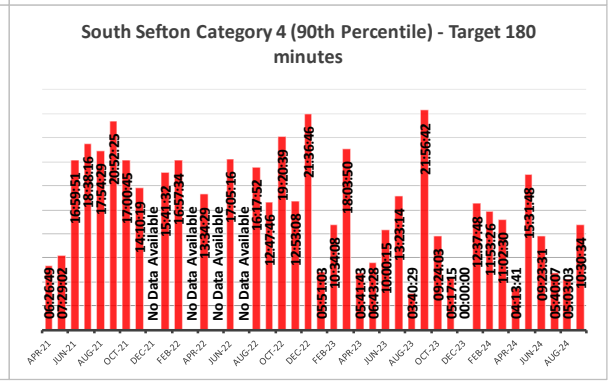


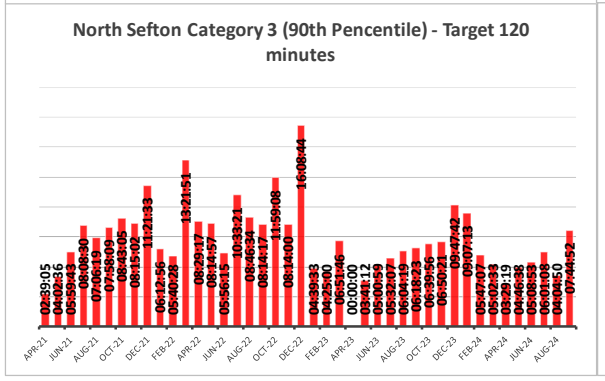


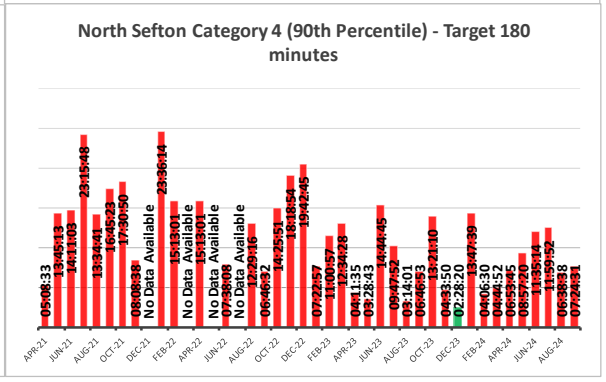












Sefton Council

Report Title	Right Care, Right Person Briefing
Date of meeting:	7th January 2025
Report to:	Overview and Scrutiny (Adult Social Care and Health)
Report of:	Southport Community Mental Health Team
Wards affected:	All
Exempt/confidential report:	No

Brief Summary/Purpose of Report:

The aim of this report is to provide an update regarding Right Care Right Person (RCRP).

Legal Background

RCRP is an operating model for Police and Partners to ensure that calls for service are responded to by those with the right skills and expertise to provide the best possible service.

It is designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person (with the right skills, training, and experience) to best meet their needs. It is also a response to the increased demand on Police for tasks that do not necessarily require a police response.

At the centre of the RCRP approach is a new threshold for the police response to a mental health-related incident. This arises from duties under the Human Rights Act 1998 to protect individuals from harm caused by others or harm caused by the person themselves. The police owe responsibility to take all reasonable measures to assist where there is either:

- a real and immediate risk to the life of a person (European Convention on Human Rights (ECHR) Article 2)
- a real and immediate risk of that person being subject to serious harm or other inhumane treatment (ECHR Article 3)

The risks of harm where a duty can arise generally comes from the criminal acts of a third party – but not always. A duty to act would only arise if a threat included all of the following.

- For a duty to arise under Article 2 the threat must be of death. A threat of injury, even serious, is not enough to create a risk of death.
- Threats or risks that do not qualify under Article 2 may still qualify under Article 3. A duty may arise under Article 3 where there is a threat of serious injury, inhumane or degrading treatment. For example, a serious sexual assault would qualify as

conduct breaching Article 3, even if no injury resulted from the attack.

- For both Articles 2 and 3, the threat or risk must be real and immediate. That means the threat must be present and continuing. Threats are not defined as real and immediate if they are conditional on other events happening or are said to occur at some point in the non-immediate future.

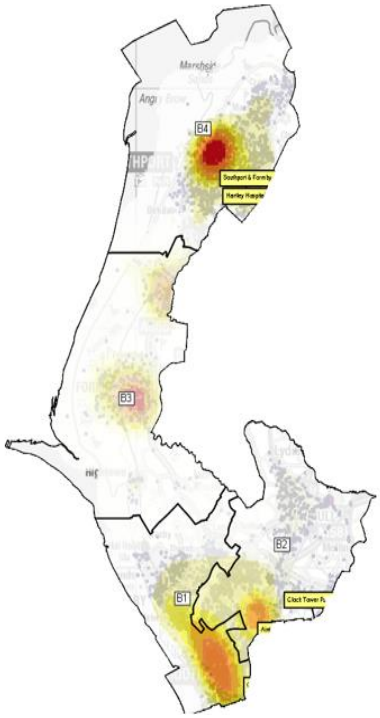
- The threat has to be against a specific and identifiable person or group of persons. Generalised threats do not give rise to a duty.

RCRP is a national initiative but there have been differences in implementation across the country. Merseyside Police have worked collaboratively with partners including Sefton Council, Merseycare, Northwest Ambulance Service and Hospitals.

This new threshold effectively means that police are responding to less mental health related incidents than previously however the intention of RCRP is that other more appropriate services would be responding.

Merseyside data

Sefton Analysis



Neighbourhood	Volume of Concern for Welfare	%
B1	2,985	34%
B2	2,122	24%
B3	653	8%
B4	2,906	34%
Total	8,666	100%

Beat	Volume of Concern for Welfare
B111	958
B263	434
B121	332
B421	311
B455	306
B171	292
B443	287

Hour	Volume of Concern for Welfare	%
00	348	4.0%
01	275	3.2%
02	233	2.7%
03	178	2.1%
04	138	1.6%
05	130	1.5%
06	116	1.3%
07	124	1.4%
08	182	2.1%
09	270	3.1%
10	350	4.0%
11	443	5.1%
12	487	5.6%
13	469	5.4%
14	442	5.1%
15	508	5.9%
16	557	6.4%
17	516	6.0%
18	521	6.0%
19	498	5.8%
20	487	5.6%
21	449	5.2%
22	504	5.8%
23	428	4.9%
Total	8,653	100%

This data shows the demands on Police prior to the introduction of RCRP.

- Merseyside Police had a total of 47,168 concern for welfare incidents in 2022/23.

- For 2022/23 there were 8,666 concerns for welfare raised with Merseyside Police within Sefton.

- 46% of welfare concerns were recorded as directly related to mental health concerns.

- Merseyside Police deployed to 67% of welfare checks requested across

Merseyside, equating to 5806 deployments within Sefton.

I have asked Merseyside Police for any data following the introduction of RCRP. We would expect it to show a decrease in both the number of calls received and the number of deployments.

Merseyside Implementation

RCRP is being implemented in 3 phases within Merseyside:

April 2024 Phase 1: Concern for Welfare/ Walkout of Healthcare facilities unexpectedly

This phase is now in place. A *RCRP Checklist and Escalation Guidance* document for Adult Social Care (ASC) staff has been implemented (see appendix 2).
A presentation to all ASC staff has been completed (see appendix 1) and will be revisited annually to ensure practice remains appropriate.
I have not been made aware of any serious incidents arising from police refusal to attend calls from ASC staff.
I am aware that Merseycare have experienced some issues in relation to police support where there is a dispute in terms of the threshold for intervention. It was anticipated that Merseycare would see a significant impact, particularly where police will no longer complete welfare checks or respond to patients who voluntarily leave A&E.
Merseyside Police have maintained a supportive stance towards Mental Health Act Assessments where there are risks, this is not the norm throughout the country where AMHP services report significant issues in terms of accessing police support for dangerous patients since the implementation of RCRP.
The Local Authority have implemented changes to practice where necessary, the primary one being that Careline (assistive technology) alerts are now responded to by Sefton Arc visiting in the first instance, rather than them calling the police.
Merseyside Police have feedback that the engagement from Sefton Council has been "really positive".
We have not seen an increase in MHAA referrals since April.

October 2024 Phase 2: AWOL MHA patients
Phase 2 is not expected to have much direct impact for the Local Authority. The main impact will be on Merseycare procedures and support in terms of how they manage AWOL patients. I have continued to attend multiagency meetings.

March 2025 Phase 3: s.135/s.136 including transport and support upon arrival at the Place of Safety
Phase 3 is likely to have an impact upon patients being transported to hospital. The Ambulance waiting times are currently significantly above target and Merseyside Police were our most used conveyance option for community patients during the last 12 months.

NHSE Guidance on the implementation of RCRP was released in November 2024 (see appendix 3). This includes a recommendation for multi-agency training which is already in place across Merseyside and is attended by Sefton AMHPs.

There are regular multiagency meetings in relation to RCRP matters, this includes:

Weekly capacity and flow meeting with RCRP as a standing agenda item

6 weekly s.136 meetings with RCRP as a standing agenda item

Regular police led RCRP briefings

Monthly AMHP Lead meetings which Police attend to discuss any issues

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Appendices:

The following appendices are attached to this report:

1) Appendix A Presentation to frontline ASC staff

2) Appendix B ASC Checklist and Escalation Guidance

3) Appendix C NHS Guidance on implementation

Sefton Council

Right Care Right Person

Concern for Safety – Adult Social Care Response Checklists:

Background:

Right Care Right Person (RCRP) is a national operating model which provides clarity on the role and responsibilities of all agencies when there are concerns for a person's welfare but the Police are not the appropriate agency to respond. RCRP seeks to ensure the public are provided with the right care, responded to by the right person with the right skills, and training and experience to best meet their needs. It aims to ensure people who call the Police get the best possible support and service.

Whilst the Police will continue to respond to situations where there is a real and immediate risk to life or of serious harm, the Police will no longer respond to situations where the concerns do not meet this threshold (see Appendix C).

Purpose:

This checklist is to provide practical guidance to adult social care staff where there is a concern for a person's safety (ie concern for welfare). The checklist covers 6 scenarios:

A) Where the individual is known already to Adult Social Care
B) Where the individual is known already to another health or welfare agency
C) Where a concerned member of the public contacts the Police with a concern over a person's safety.
D) Where a concerned member of the public contacts Adult Social Care with a concern over a person's safety and the individual concerned is not already known to Adult Social Care.
E) Concern for safety for people whose location is unknown (whether or not known to Adult Social Care).
F) Concerns for safety that meet the Police criteria under RCRP.

If, having followed the appropriate checklist there is disagreement over responsibility please follow the escalation process in Appendix A.

A) Where the individual is known already to Adult Social Care

1) Where a social care team has a concern over the safety of a person already known, that team will take responsibility for making enquiries into the welfare/safety of the individual.
2) If there is concern about the risk of suicide, please use the attached Suicide Risk Guidance – see Appendix B. If the Person is in a public place and is displaying symptoms of a mental disorder then the Police may have powers under S136 of the Mental Health Act to take the person to a place of safety.
3) The worker responsible for making the enquiries will review the Liquid Logic record to assess the level of risk to inform the next step.
4) The worker will check other relevant systems as appropriate.
5) The worker will check with any other agency known to Adult Social Care which is also involved with the individual to inform and assess the level of risk.
6) The worker will attempt to contact the person by phone or by any other means familiar to the person such as email, etc.
7) Depending on the circumstances, a decision should be made in discussion with a line manager about how many times they should ring, at which intervals and over what period of time e.g. a worker may agree to try phoning hourly over the morning. If the worker is unable to successfully contact the individual the worker will consider contacting the following:

    - Family
    - Neighbours
    - GP
    - Any other relevant agency including 3rd sector if appropriate.

8) If a visit is required it is recommended that a risk assessment is completed, and that workers visit in twos if appropriate.
9) If another agency is involved, consider a joint visit with a member of that agency such as CPN/drug and alcohol worker/housing support worker/care agency.
10) If a visit is carried out but there is no response, a decision should be made about whether to make a second attempt to visit. Regardless of the decision,

make appropriate checks (e.g. speak to neighbours, look through windows to check not on the floor/unresponsive etc).

11) Put a note through the door to explain that you have been trying to speak to the person.
12) Consider further contacting the Merseycare Crisis Line and updating the Local Authority Emergency Duty Team if necessary.
13) If the worker is unsure if reporting a concern for safety is appropriate, they should discuss this with their Manager and consult the Merseyside Police RCRP checklist (Appendix C) to consider if there is a Policing purpose or power for attendance.
14) If the worker believes that the circumstance of the referral meets the criteria for Concerns for Safety in line with the Merseyside Police guidance, then it should be reported by calling 101 or 999 if it is an emergency e.g. if there is concern that there is an immediate risk to life.
15) Once all reasonable steps as outlined above have been taken and no contact has been made, and there is concern that the person is in the house and unable to respond (e.g. due to being unconscious) escalate to a line manager and consideration should be given to contacting NWAS and/or the Police to discuss the threshold for forced entry.

B) Where the individual is known already to another health or welfare agency

1) Where the individual is known already to another health or welfare agency then that agency will **take the lead** in making the enquiries into the safety of the individual. This will include primary care, such as a district nurse, but the role of the GP will need to be discussed with him/her. Depending on their level of involvement it may not be possible for the GP to take on this responsibility.
2) If the other health or welfare agency makes a reasonable request for **support** from Adult Social Care (i.e. asking for someone to go with a member of that agency to attempt a visit), then the Manager or Senior Practitioner for the Adult Access team will consider this request based on an assessment of risk from the information shared by the lead agency.

C) Where a concerned member of the public contacts the Police with a concern for a person's safety.

1) The Police will undertake their deployment toolkit to determine whether or not it meets the threshold for Police response.

2) The Police will advise the member of the public what the next best course of action may be.

D) Where a concerned member of the public contacts Adult Social Care with a concern for safety and the individual concerned is not already known to Adult Social Care

1) The Customer Contact Centre will undertake the same checks as outlined in section A.
2) If the Customer Contact Centre finds out that the individual is known to another agency, then that agency will be expected to take the lead in undertaking further enquiries to the safety of the person.
3) If the Adult Contact team cannot identify another agency involved with the individual then the team will refer to Adult Access to undertake the same actions as if the person were known and consider a joint visit to the person's home, once all other checks have been exhausted (see section A)

E) Concerns for safety checks for people whose location is unknown (whether or not known to Adult Social Care)

1) Adult social care does not have a search and rescue capability. The Customer Contact Centre, Adult Access or relevant community team, if known, will undertake the checks listed in section A) from 1-7.
2) This check will include A&E
3) Consideration may be given to undertaking a home visit if there is evidence that the person may now have returned. Risk should be considered and whether this visit should be made by 2 people.
4) If efforts to contact the person or establish their whereabouts have been unsuccessful, and a concern still exists, then consider if they are a missing person. Contact the Police via 101 and make a Missing from Home report. Answer the questions asked by the Police and inform them of all the checks made so far so that work is not duplicated. This helps support the Police risk assessment and where it is appropriate the Police will commence an investigation.

F) Concerns for safety that meet the Police criteria under RCRP

1) Merseyside Police has a responsibility to deal with core policing matters. The following are core roles of the Police:

- To protect life and property. Where it is considered that there is an immediate, real and substantial risk to the life and/ or a risk of serious injury to the person or any other person. In the case of a child, there is a reasonable belief that the child is suffering or is at risk of suffering immediate and significant harm as set out in Section 47 of the Children's Act 1989.
- Prevention and investigation of crime. The circumstances mean there is a reasonable belief that a crime has been, is being or is about to be committed.
- To keep the King's peace.

2) If a practitioner is concerned about the welfare of a child, individual or family and meets the criteria of a concern for safety in line with the Merseyside Police guidance, then it should be reported by calling 101 (or 999 if an emergency).
3) If a practitioner is unsure if a Police Concern for Safety Check is appropriate, they should discuss this with their manager and consult the Merseyside Police RCRP guidance to consider if there is a Policing purpose or power for attendance. See Appendix C.
4) If a practitioner contacts the Police and the Police say they do not feel deployment is appropriate but having followed all the above stages, the practitioner disagrees they should say "I'd like to trigger an escalation".

Appendix A

Escalation Procedures:

Merseyside Police: have a 2 stage escalation process which can be triggered if there is a disagreement between the caller and the call handler regarding Police deployment. This can be triggered by advising that there is a disagreement and “I’d like to trigger an escalation”.

Disagreements between agencies: The safeguarding system within Merseyside takes collective responsibility for the welfare and safety of all its residents.

Effective communication is vital when responding to concerns for safety.

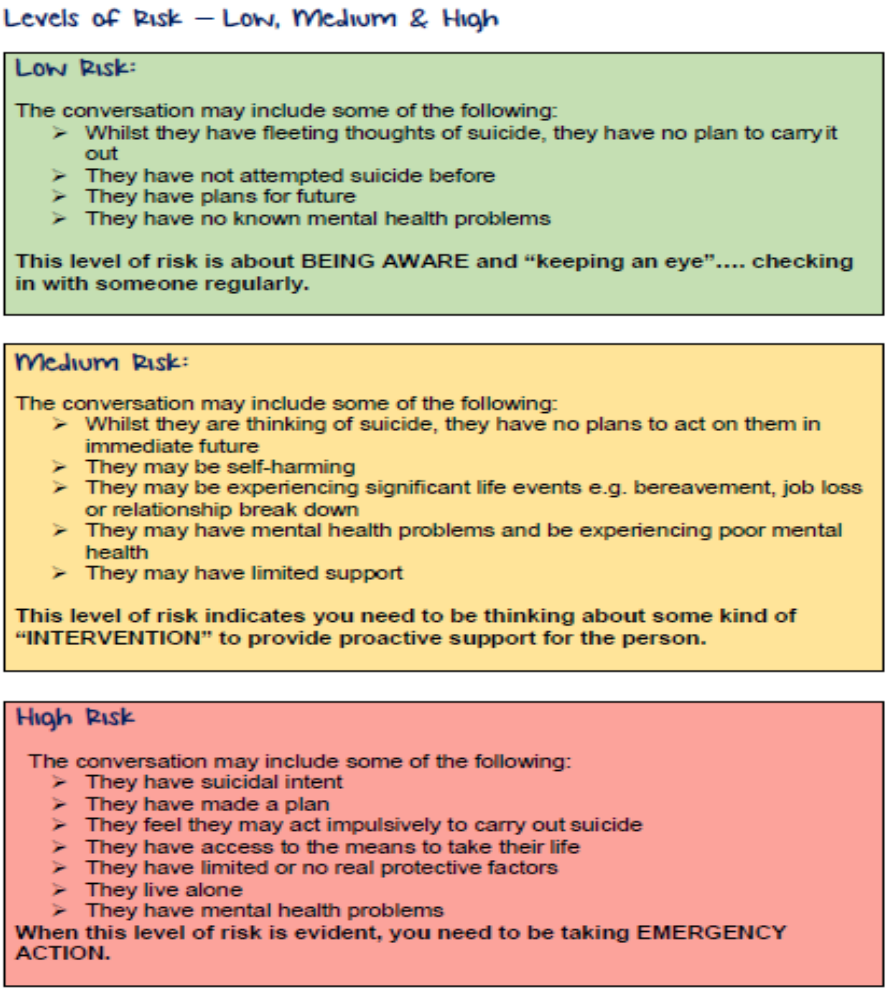
Concerns for safety must never be left unresolved. Where there is a concern on the part of any individual professional that the system is not working effectively to resolve a concern for safety then the following escalation process should be followed:

Stage one Initial attempts to resolve low level problems should be made between practitioners and agencies when a disagreement arises. It should be recognised that differences in status and/or experience may affect the confidence of some workers to pursue this without support. However, all members of staff have a professional duty to raise concerns about the safety and well-being of service users and to act promptly.

Stage Two Any worker who feels that a decision is not safe or is inappropriate, and/or where it has not been possible to resolve the disagreement through Stage One discussion, must escalate their concerns as soon as possible to their supervisor/manager. Their line manager should then raise the concerns with the relevant opposite manager.

Stage Three If the problem is not resolved at stage two, the respective supervisors/managers must escalate the concern to their senior managers e.g. Head of Service to escalate to the relevant designated leads such as for the ICB, local authority, Police, NWAS who may also be involved and prepared to intervene to resolve the unresolved concern for safety.

Appendix B: Guidance if there is a suicide risk.



Appendix C: Merseyside Police RCRP Decision making considerations

Decision-Making Toolkit Considerations

- Is there an immediate risk to life / serious harm?
- Is there a 'present and continuing' risk to any other person, other than the subject?
- Is a crime suspected of being committed?
- Are the police required to provide a physical restraint to save life?
- Is the location of the individual known? – Have reasonable enquiries been made to establish the whereabouts?
- Who is reporting the concern? Member of the Public/Partner Agency
- Is the subject under 18-years. Is there an immediate safeguarding risk to prevent significant harm?

NHS England

Guidance on implementing the National Partnership Agreement: Right Care, Right Person

Avoiding unwarranted police involvement in mental health care by improving access to personalised mental health support

Publication reference: PRN01145

To help you navigate this document please find some links below to key sections

- Introduction - This guidance aims to support the implementation of the NPA:RCRP and covers principles for implementation, multi-agency working, and the four phases of RCRP implementation.
- Guiding principles for implementation - This section outlines the importance of working in partnership, personalisation, least restriction, addressing health inequalities, and using local intelligence to ensure successful implementation of RCRP
- Effective multi-agency working - This section provides guidance on establishing effective multi-agency governance and delivery structures, and on the cross-cutting areas that partners will need to work together on for enable effective implementation of the NPA:RCRP.
- Implementing the Right Care Right Person Partnership - This section provides practical support on how to respond to welfare calls (phase 1), support for people who leave acute hospitals before completing treatment (phase 2a), and people who absent from inpatient services (phase 2b). It also sets practical support on conveyance of people with mental health needs (phase 3), and timely handovers to healthcare following use of Section 136 (phase 4).

Lived experience foreword

This foreword has been written by 2 members of an Advisory Network that provides advice and direction to NHS England's Mental Health Programme. While independent of NHS England, members of the Advisory Network seek to shape NHS England's work on mental health, drawing on their diverse experiences of a range of mental health needs, social determinants of health and mental health services. Within this foreword, the Advisory Network members do not claim to speak for all lived experiences and/or perspectives but seek to reflect the pain that some of their community feels about police involvement in mental health care.

People with mental health needs have a range of reactions when the police attend during mental health crisis. It can be reassuring or helpful but, for many, it is uncomfortable and can sometimes cause long-term trauma and physical harm. Here is an example of a carer describing what went wrong when the police were involved in responding to her husband who was in mental health crisis:

> "He [husband] has dementia, he's in his 70s, he didn't know what was happening but still the officers shoved him to the ground and cuffed him. He was shouting, he was confused, and they wouldn't let me help." – White carer in her early 80s

People with mental health needs, particularly those who also have a learning disability or are autistic, are not always treated with respect, compassion or dignity when they come into contact with the police. Furthermore, certain groups of people, including Black men and people from other ethnic minorities, experience particularly poor experiences in their interactions with the police and criminal justice system. They frequently express feeling dehumanised and that their mental health crisis is being criminalised. Here is an example of a Black man describing his cousin's experience when things have gone wrong:

> "My cousin has paranoia, schizophrenia and other health issues. In the past, he was known to possess firearms, which means whenever the police respond when he's in crisis, they send the firearms squad. They never consider the fact he is no longer a threat and what he needs is mental health support. It's so distressing to watch him experience this unacceptable treatment." – Black man in his 30s

Right Care, Right Person (RCRP) is a crucial step towards reducing unwarranted police involvement in mental health care – something people with lived experience have fought for, for decades. This is an opportunity to influence both **when** the police engage in mental health care and **how**. In doing this we urge systems to keep in mind that people with mental

health needs are members of the communities the police serve – and we are more likely to be the victims than the perpetrators of crime. Where police do need to be involved in the care process, the reasons for this need to be explained to the person and efforts should be made to include the person in decision-making. This quote demonstrates why this approach is required:

> "When I was experiencing crisis, I had sensory overload, being autistic I was struggling with communication and emotional dysregulation. The police wouldn't listen to me, they just threatened me with arrest." – South Asian teen.

Working with those with lived experience needs to be central to health systems' implementation of RCRP. Partnering with a range of organisations and communities, RCRP must take a human rights-based approach to mental health care - creating safe and respectful services that offer compassionate support, promote shared decision-making and tailor care to people's individual needs. It cannot be emphasised enough how essential collaboration with individuals receiving services, their families and carers, and other grassroots organisations is in working towards this goal.

This guidance is the beginning of a commitment to change practice, and to do so in a way that reduces the harms that people with mental health needs can currently experience. Services must listen and learn from past experiences, such as those highlighted by the STOPSIM campaign, about how to create an appropriate role for the police in mental health care, and empower health staff to deliver person-centred and trauma-informed care. Above all, services must continue to learn lessons and build on the changes outlined in the Mental Health Units (Use of Force) Act, so that tragic cases, such as those of Olaseni (Seni) Lewis and Colin Holt in 2010, do not occur again.

We would like to express our gratitude to our policing, health, social care and voluntary, community, faith and social enterprise (VCFSE) colleagues for their collaborative efforts in developing this guidance. Their open and supportive approach has facilitated the creation of this guidance, which will help ensure that people with mental health needs receive compassionate and supportive care from the right service.

Written by 2 lived experience advisors who provide independent advice and direction to NHS England's Mental Health Programme

Contents

1. Introduction

Across the NHS, there is agreement that people of all ages with mental health needs require timely access to mental health support that is compassionate, personalised and meets their needs. The NHS Long Term Plan has transformed community mental health services, helping more people to live well in their communities, and has expanded the availability of varied models of mental health crisis care, including support offered by VCFSE organisations. We are proud of this improvement across mental health services in England but know there is still much more to do to ensure that people are less likely to reach crisis and, when they do, that they can access the right support.

In improving the quality of mental health support, it is important that the right agency responds to and supports people - when someone needs mental health care, it is not right that they only receive a police response. While police involvement in the response may be warranted in some situations, police officers generally do not have specialist mental health training or skills; and their involvement can be distressing to the person and potentially result in the increased use of force and the criminalisation of mental health problems. We know, for example, that police involvement can have harmful consequences for people from racialised and ethnically diverse communities, particularly Black people, and autistic people (Baker et al. 2019; National Police Chiefs' Council (NPCC) and College of Policing, 2022; Collins et al. 2022).

To ensure that people are receiving timely access to a mental health specialist, and that the police are only involved where this is appropriate, the National Partnership Agreement (NPA): Right Care, Right Person (RCRP) was published in July 2023, signed by NHS England, the Department of Health and Social Care (DHSC), the Home Office, and national policing organisations. This NPA:RCRP is an all-age agreement for England that commits to reducing the unwarranted involvement of police in supporting people with mental health needs.

This does not mean total withdrawal of police support. The police still have responsibilities to protect and serve everyone in the community, including people with mental health needs, who are more likely to be the victim than the perpetrator of crimes. The police will continue to respond where their involvement is warranted; that is, where the threshold for a police response to a mental health-related incident is met, as set out in the NPA:RCRP (see section 1.2). The police will also continue to fulfil their existing legal and statutory duties, including in relation to the Mental Health Act and safeguarding children and adults (see section 2).

We know implementing the NPA:RCRP is the right thing to do to improve the experiences and outcomes for people requiring mental health support; there is broad agreement about this from people with lived experience of mental health problems as well as those who work in the NHS. It is however a major change for health services, including mental health services, which are already under significant pressure and experiencing a rise in the number and complexity of mental health presentations.

For this reason, NHS England has been clear that implementation of the NPA:RCRP needs to put people's wellbeing and safety first, ensuring they do not fall through the gaps between services. We recognise that no additional funding has been provided for RCRP delivery, yet it involves the health service taking on significant additional activity. Therefore, it is critical that the timelines for each phase of delivery are agreed on the basis that there is a safe pathway in place, and if this is not the case, we support local systems seeking to agree slow timelines for delivery. It is also vital that RCRP implementation is underpinned by strong partnership working across agencies – health, children's and adults' social care, VCFSE organisations, and the police. Importantly, it cannot be delivered without involving people with lived experience in co-producing changes to these services. This includes the involvement of people from racialised and ethnically diverse backgrounds, as set out in NHS England's Patient and Carer Race Equality Framework (PCREF).

1.1 Purpose and scope of this guidance

This guidance aims to support the implementation of the NPA:RCRP and covers guiding principles for implementation (section 2), multi-agency working (section 3), and the four phases of RCRP implementation (section 4). It is aimed at integrated care boards (ICBs) and providers of mental health services, ambulance services and acute services across England that deliver support to people of all ages with mental health needs. It will also support others involved in the local implementation of the NPA:RCRP, including commissioners and providers of primary care services, children's and adults' social care services, VCFSE organisations delivering mental health support and police forces.

This guidance should be read alongside the NPA:RCRP, which sets out the RCRP approach, including the threshold for a police response and what local cross-agency partnerships should seek to achieve for people with mental health needs through its implementation. The NPA:RCRP focused on mental health, and that is why the scope of this guidance is limited to mental health. Where the RCRP approach is being applied beyond mental health, local partners will need to agree their approach to deliver this.

This guidance should also be read with reference to separate, but jointly informed guidance from DHSC, which will be published shortly and is primarily aimed at social care

professionals, and the police toolkit produced by the NPCC and College of Policing, which is available via the College of Policing webpage. One of the modules of the toolkit, which was developed in consultation with the Association of Directors of Children's Services and the Local Government Association, covers principles for applying RCRP to children under 18. Across England, most police forces are including children and young people as part of their implementation of RCRP, which is why this NHS England guidance covers all age groups.

This guidance has been produced by NHS England's Mental Health team, working with an expert reference group that included people with lived experience, people working in health services (mental health – inpatient, crisis and community, acute hospitals, ambulance services, learning disability and autism services, primary care), police forces, Approved Mental Health Professional (AMHP) services, children's and adults' social care services and VCFSE organisations. This group also included people with expertise in relation to service provision for children, young people, adults and older adults (see Section 5 for acknowledgements).

Learning from each other is a critical part of implementing the NPA:RCRP. Alongside this guidance our FutureNHS space provides webinar recordings and resources from other systems, and we would encourage you to look at these. If you have any additional resources to share, please send them to england.adultmh@nhs.net.

1.2 Definitions of terminology used in this guidance

People and communities

- We refer to **a person** or to **people** with mental health needs, rather than to patients or service users, to focus on the person as an individual. Our references to 'a person' or to 'people' include children, young people, adults, and older adults.
- Where we refer to **people with mental health needs**, this includes people who require mental health support (including urgent mental health support) due to a suspected or diagnosed mental health condition. It includes people with a learning disability and autistic people, people with dementia, and people with drug or alcohol problems, where they also have a mental health need.
- We refer to **family and carers** to mean the family members, partners, friends, neighbours or other members of a person's social network who provide support to a person with mental health needs. This also includes those acting as a person's attorney or as a deputy appointed by the Court of Protection, as set out in the Mental Capacity Act and corresponding Code of Practice. For children and young people, the term family and carers should always include those with parental responsibility, which for most children and young people will be their parent or

guardian. Where the child or young person is looked after by the local authority, the local authority should be contacted to clarify who holds parental responsibility and to arrange their involvement in discussions about the care of the child or young person. Foster carers and residential staff will not hold parental responsibility, but they should be involved in discussions, unless there are exceptional reasons not to do so.

- We use the term **racialised and ethnically diverse communities** to refer to ethnic, racial and cultural communities who are minoritised populations in England and who experience marginalisation as a result of their heritage. Where relevant, more specific terminology, for example, 'Black communities', is used. This follows the approach in NHS England's PCREF.

Threshold for a police response

Where we refer to the **threshold for a police response**, this is the threshold for a police response to a mental health-related incident as set out in the NPA:RCRP. This is where there is a need:

- to investigate a crime that has occurred or is occurring; or
- to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm. (This person could be the person with mental health needs, a family member or carer, a mental health worker or other member of the public.)

Reference should be made to the full NPA:RCRP for the context to this threshold. Further information can also be found in the College of Policing Legal Overview for RCRP, which explains how the police have determined the threshold, based on Article 2 and Article 3 of the Human Rights Act.

Risk assessment

Where we refer to **risk assessment**, this means a health-based approach that involves weighing up the factors that protect a person or others from harm and those that increase the likelihood of harm (including the likely severity, imminence, frequency and duration of harm) to determine next steps that maximise therapeutic benefit and minimise any potential harm. This approach, rather than those based on stratifying risk into categories such as 'low', 'medium' and 'high' is in line with National Institute for Health and Care Excellence (NICE) guidance on self-harm.

Risk stratification can be harmful and misleading, particularly where it limits the access that people deemed as lower risk have to mental health support, or where it results in missed

opportunities to take steps to meet a person's needs and promote safety. However, we recognise that police forces may use different terminology for, and approaches to, assessing risk. Therefore, when communicating with the police, it may be necessary to state a risk level to demonstrate how the NPA:RCRP threshold (see section 1.2) of 'serious harm' is met, but this should always be done in conjunction with a clear articulation of the situation that is occurring and the reasons for contacting the police, including the potential harms that may occur.

We also recognise that risk factors are often dynamic, and it is therefore important that risk assessments are carried out as part of an ongoing process, to respond to any changes in risk factors in a timely and proactive manner.

2. Guiding principles for implementation

This guidance is underpinned by 5 principles, which should inform all aspects of how local areas implement the NPA:RCRP.

In addition to the principles that follow, local implementation, including any policies and protocols developed, must comply with legislation, along with relevant statutory guidance. This includes the:

- Mental Health Act 1983 (MHA) and its Code of Practice
- Mental Health Units (Use of Force) Act 2018
- Mental Capacity Act 2005 (MCA) and its Code of Practice
- Care Act 2014
- Health and Care Act 2022
- Equality Act 2010
- Human Rights Act 1998 (HRA)
- Data Protection Act 2018 (DPA)

It is also vital that policies and implementation comply with legal safeguarding obligations – these are not superseded by the NPA:RCRP. This includes statutory safeguarding partners (ICBs, the police, local authorities) complying with children's safeguarding duties set out in the Children Act 1989, the Children Act 2004, the Children and Social Work Act 2017, and the statutory guidance, Working Together to Safeguard Children and Care and Support. Further information is provided in the NHS Safeguarding Accountability and Assurance Framework and via the NHS Safeguarding App and FutureNHS Safeguarding workspace.

2.1 Working in partnership

Where RCRP has been implemented successfully, effective multi-agency partnership working has been key. The NPA:RCRP approach should be developed, implemented, monitored and adapted in the spirit of partnership and coproduction, with people who have lived experience and their family and carers, along with health services, the police, children's and adults' social care, and VCFSE organisations that offer support to people with mental health needs (including ethnic-led VCFSE organisations and those offering support with housing, homelessness and co-existing alcohol and substance use problems). It is vital that delivery is coordinated across agencies, with ICBs playing a key role, so that people with urgent mental health needs are not left without the support they need.

2.2 Personalisation

People with mental health needs should be treated with empathy, compassion, respect and understanding. All support should be delivered in a way that promotes positive experiences

of the urgent mental health pathway by enabling shared decision-making, supporting individual recovery outcomes, protecting each person from harm and taking into account people's individual needs, wishes and preferences. These may be expressed at the time by the person or their family and carers, or in crisis or advance care plans, and may require providing culturally appropriate care, care that is adapted to the needs of people who are LGBT+, and making reasonable adjustments, including for people with cognitive difficulties, dementia or a learning disability, and autistic people.

2.3 Least restriction

Implementation of the NPA:RCRP should focus on minimising the use of restrictive interventions, adhering to the requirements and guiding principles of the MHA Code of Practice in all relevant circumstances and of the Mental Health Units (Use of Force) Act in inpatient settings. Least restrictive alternatives should be explored and put into place when initially responding to someone with urgent mental health needs, during conveyance and throughout each person's care in a community or hospital setting. It is essential that use of restrictive interventions is documented, including the factors that contributed to their use, to inform positive changes to practice. This is especially important for communities that can experience higher levels of restrictive interventions, such as Black people, autistic people and people with a learning disability.

2.4 Addressing health inequalities

Implementation must be designed to meet the needs of the local population, including proactively recognising and tackling the differential experiences and outcomes of certain groups of people within the urgent mental health pathway. Action should be taken with people from groups who experience health inequalities and those with protected characteristics, with a focus on addressing the disproportionate levels of restriction and criminalisation experienced by certain groups, including autistic people and people from racialised and ethnically diverse communities, particularly Black people. Adopting the actions set out in NHS England's Advancing Mental Health Equalities Strategy and the PCREF, which include better use of data and workforce development, will help to achieve this.

2.5 Using local intelligence to monitor and adapt implementation

The approach to implementation should be informed by data – both operational data and feedback from people with lived experience, their family and carers, and people from across agencies involved in implementation. The collected data should cover access to care and treatment, the experiences and outcomes of people accessing support for an urgent mental health need, use of restrictive interventions, and information relating to serious incidents and escalations. Partners should work collaboratively to collate, analyse, share and review

relevant data – including any differential impact on any group of people – and use it to inform joint decisions about the ongoing approach to implementation. All data sharing must comply with data protection legislation and confidentiality duties (see section 3.7).

3. Effective multi-agency working to enable implementation

This section provides guidance on establishing effective multi-agency governance and delivery structures, and on the cross-cutting areas that partners will need to work together on for enable effective implementation of the NPA:RCRP.

3.1 Establishing multi-agency governance and delivery structures

The NPA:RCRP states that the services working together in each area to implement the RCRP approach should agree joint multi-agency governance structures for the planning, delivery and monitoring of the RCRP approach locally. Partners will need to consider what works for their locality; in some localities it will make sense to build on existing joint working arrangements, such as crisis care concordats, while in London a regional approach is appropriate given the geographical area of the Metropolitan Police. In general, we recommend that:

- ICBs hold overall accountability for leading and coordinating the implementation of the NPA:RCRP from a health perspective. A Senior Responsible Officer should be identified within the ICB, alongside leads in local police forces and local authorities. In some areas, the geographical boundaries for ICBs, local authorities and police forces may not overlap. In such cases, it may be possible to identify a lead ICB for a particular police force area, or it may be necessary for 2 or more ICBs to jointly lead implementation.
- Areas set up a multi-agency Implementation Board (or use appropriate existing local structures) to develop an agreed strategy and plan for delivering the NPA:RCRP locally (including setting out key milestones for each phase of RCRP implementation; see section 4); oversee delivery; and manage risks and escalations (see section 3.4). The Implementation Board should consist of senior leads from each agency, so that there is buy-in for the delivery approach and collective decisions can be made. Any local protocols/agreements should be jointly signed off by the Implementation Board.
- Areas should also set up working groups to focus on the delivery of the different phases of implementation and the actions set out in the NPA:RCRP (for example, data capture, impact assessments, multi-agency training). Each working group should have a clear workplan (including details of the protocols or other products they will develop) and report into the Implementation Board (or appropriate existing local structure).
- Stakeholder analysis is undertaken to identify who should be members of the Implementation Board and working groups. This needs to consider representation from the following:

- Health – including all-age mental health services (community, crisis and inpatient and NHS-employed AMHPs), ambulance services, acute providers and primary care.
- Police and probation services.
- Local authorities – including AMHP services, children's and adults' social care, drug and alcohol services, and homelessness and housing services.
- Organisations with responsibilities for safeguarding or with relevant statutory duties, including Safeguarding Adults Boards and Safeguarding Children's Partnerships.
- VCFSE organisations that support people with mental health needs – including ethnic-led VCFSE organisations and those that support people with housing, homelessness, and co-existing alcohol and substance use problems.
- People with lived experience of the urgent mental health pathway and of police involvement in mental health support, either directly or as a family member or carer, including people from racialised and ethnically diverse communities.
- Education services, including schools, colleges and universities and wider services for children and young people.
- Fire and rescue services.

- Both the Implementation Board and working groups meet regularly to promote partnership working, enable open communication between partners, review progress against agreed objectives, and discuss and resolve any challenges.

3.2 Building a shared understanding of the threshold for police response and multi-agency roles and responsibilities

The NPA:RCRP states that multi-agency partners should reach a shared understanding of the aims of implementing RCRP locally and the roles and responsibilities of each agency in responding to people with mental health needs. To support this, we recommend that multi-agency partners:

- Discuss their understanding of the RCRP approach, the outcomes that each agency is seeking to achieve through implementation, and any concerns about implementation.
- Share relevant information relating to mental health demand and the (anonymised or pseudonymised) experiences of people with mental health needs under current ways of working.
- Reach a shared understanding of the threshold for police response (see section 1.2), including how different agencies assess and view risk, and how certain legal

duties, for example in relation to the MHA, are distinct from the threshold (as set out in the NPA:RCRP).

- Review local examples of recent mental health-related cases, including complex cases and those where health and children's and adults' social care services requested police support, to determine which cases were suitable for a police response, and in which cases an alternative course of action would have been more appropriate.
- Reach a shared understanding of the local approach to applying the NPA:RCRP to children and young people, paying due regard to the need for statutory safeguarding partners (ICBs, the police, local authorities) to do this in a way that complies with legal safeguarding duties for children and young people (see section 2). For further information, see the NPCC and College of Policing's shared set of principles for applying RCRP to children aged under 18.
- Identify the lead agency for response in a range of situations and the role of other agencies (this may be developed within phase-specific working groups), including situations where it is not initially clear whether there is a health emergency or mental health concern at play. Based on this, we recommend developing a responsibility matrix that identifies who the agreed lead and supporting agencies for given situations, as well as those where further work is required to clarify who is expected to respond. An example responsibility matrix can be found on our FutureNHS space.

3.3 Undertaking an impact assessment, including of the equality and health inequality impacts of implementation

Based on the shared understanding of roles and responsibilities, areas should undertake an impact assessment to identify how different agencies and services will be impacted by the changes agreed, and how any negative impact will be mitigated. This should include an assessment of the resource impact to identify where any required additional resources (including funding) will come from, and any training or commissioning requirements. This assessment will likely need to be informed by and reviewed in light of the work undertaken by the phase-specific working groups.

Partners should ensure their impact assessment covers the equality and health inequality impacts of implementation, and that it is developed with people with lived experience and their family and carers. This will support the guiding principle of this guidance to address health inequalities (see section 2.4), and the need to implement with due regard to the public sector equality duty and NHS England's PCREF.

Areas should use their impact assessment to inform their approach to implementation, including what data to capture (see section 3.8), and development of policies and procedures. It should also be used as a dynamic tool to review progress with implementation, including to identify whether implementation has any differential impact on people from racialised and ethnically diverse communities, autistic people, or any other group, and to take action to address any negative impact.

3.4 Developing escalation processes

As set out in the NPA:RCRP, areas should develop robust escalation processes for when agreement cannot be reached on the appropriate agency to respond in certain situations, resulting in a possible delay or gap in service provision, and for when any other concerns are raised about implementation. Concerns may be flagged through data monitoring (see section 3.8) or raised by multi-agency partners, the wider workforce, or members of the public, including people with mental health needs and their family and carers.

An escalation protocol should be developed and agreed by the Implementation Board (or equivalent group), and shared with all relevant stakeholders, including those working in the VCFSE sector. The protocol should clearly set out how and to whom concerns should be escalated within each agency, and distinguish between:

- Real time escalation – escalation routes where there is uncertainty or disagreement between multi-agency partners about how to respond to a live situation. The protocol should set out that the overriding priority when handling real time escalations is that one agency agrees to respond (usually the agency initially contacted), so that there is no delay in a person receiving support, with retrospective escalation routes used for discussions and decision-making about who should respond to similar situations in the future.
- Retrospective escalation – used to regularly review situations that have occurred and been escalated to learn lessons and agree changes that are needed in terms of how similar situations will be handled in future. We recommend that escalations are reviewed at the Implementation Board to clarify roles and responsibilities, refine processes and practice, and inform updates to policies and procedures. All agreed changes should be communicated to the workforce and reinforced through leadership.

3.5 Stakeholder communications

Successful implementation of the NPA:RCRP requires good communication with stakeholders, both internally and externally. A stakeholder communications plan should be developed (based on a stakeholder analysis) that sets out which messages need to be

received by whom, by when, as well as which communications route will be most effective for sharing messages about implementation, including local protocols/arrangements.

Local areas should look to develop 2 specific aspects within their communications planning:

- A protocol (compliant with data protection legislation and confidentiality duties – see section 3.7) that assists healthcare staff to communicate definitively with the police about the situation that is occurring, the potential for harm, and the reasons police attendance is required (where applicable). This will support cross-agency communication and help police working in control rooms to make decisions about the deployment of officers. When developing this protocol, it should be noted that the threshold (see section 1.2) is for control room staff to use to determine whether to deploy officers; it is not for use by other agencies or members of the public to determine whether they should contact the police. Often contacting the police can be useful to make them aware of situations that may unfold, rather than because an immediate police response is needed.
- Local communications for people with mental health needs, family members and carers, and other members of the public to inform them who they should contact if they or someone they know requires support with their mental health, including urgent mental health needs. Consideration should also be given to providing police forces with information about when it is appropriate to refer callers to alternative sources of support, including NHS111. The NHS111 'select mental health option' soft launch communications toolkit can be found on this FutureNHS page.

3.6 Health-led multi-agency triage models

The NPA:RCRP sets out that areas should embed multi-agency ways of working that support decision-making about the most appropriate service or services to respond to a call to the emergency services (for example, whether it should be a police, ambulance or mental health response, or a joint agency response). Where there is joint working between agencies, information sharing agreements need to be in place between agencies, which protect confidentiality and comply with data protection legislation (see section 3.7).

An example of multi-agency working is Bristol, North Somerset and South Gloucestershire (BNSSG)'s Integrated Access Partnership model of joint working between the local ambulance service, integrated urgent care provider, mental health trust, police force, fire service and VCFSE organisations. The model has a police link worker embedded alongside ambulance and mental health staff in the ambulance emergency operations centre, to determine the right responder(s) to 999 calls. This has resulted in a 50% reduction in ambulance dispatch to 999 calls and a 32% reduction in police dispatch, with people with

mental health needs instead receiving timely access to more appropriate mental health care. Further information about the model, including a webinar, can be found on this FutureNHS page.

Other examples of joint working between mental health and ambulance services to improve the ambulance service response to people with urgent mental health needs have been shared in this webinar.

3.7 Information sharing

Partners should have agreements for cross-agency information sharing and ensure that all data sharing complies with the DPA and the Common Law Duty of Confidentiality. Information shared for the purpose of informing implementation planning and delivery should be anonymised or pseudonymised. Confidential information about a person should only be shared with family and carers or other agencies, including the police, where the person has consented to this, the disclosure is in the best interests of a person who lacks capacity to consent, or there is an overriding public interest to make the disclosure (for example, to protect others from serious harm).

Partners should establish clear thresholds and protocols for cases where information sharing without consent is lawful. Note that in cases where consent is not granted to share information, family and carers can be asked their views about the person's care and what might help them, provided confidential information is not shared with them.

Further information can be found on the NHS England Consent and Confidential Patient Information webpage, as well as the Caldicott principles from the National Data Guardian.

Capacity and consent in relation to children and young people under 18

A child or young person aged 12 or over is generally presumed to have the competence to give or withhold agreement to the sharing of their information. However, each case must be judged on its own merits.

Where a child or young person under the age of 16 lacks competence, those with parental responsibility can give or withhold agreement to the sharing of information on their behalf. For a young person aged 16 or 17 who lacks capacity under the MCA, information can be shared if this is determined to be in their best interests under the MCA.

The principles of capacity and consent also apply to decisions about healthcare treatment. For young people aged 16 or 17, as with adults, the MCA applies, and if they have capacity they can give or withhold consent to treatment. If they do not, they may be treated in their

best interests under the MCA (as long as this does not involve a deprivation of liberty, as this statutory scheme does not apply to under 18s).

For a child or young person under 16, the principle of Gillick competency applies. If they do not have Gillick competency (based on an individual assessment of their maturity, understanding and ability to appreciate the consequences of their decision), they cannot give or withhold consent to treatment, and those with parental responsibility need to make a decision on their behalf (unless it is an emergency situation). If they do have Gillick competency, then the child or young person can accept or refuse treatment, and those with parental responsibility cannot override this. However, it is good practice to encourage children and young people to involve those with parental responsibility in care decisions, unless it would not be in their interests to do so.

Further information can be found in the Care Quality Commission (CQC) guide on capacity and competency to consent in under 18s.

3.8 Data collection and use to inform implementation and delivery

As well as the guiding principle to use local intelligence to monitor and adapt implementation (see section 2.5), the NPA:RCRP includes an action for local systems to establish effective mechanisms to support data collection and sharing across agencies, to inform the planning and delivery of the RCRP approach locally. This should include measures of the impact of implementation on health, children's and adults' social care and police services, and on the experiences and outcomes of people requiring care, including those to capture impact on access to care and treatment, use of restrictive interventions, and any differential impact by protected characteristic.

Multi-agency partners, working with people with lived experience and their family and carers, should identify useful measures that can be captured locally. We suggest metrics for each of the phases of implementation in section 4. In addition, we recommend that data is captured on:

- The details of any escalations, for example, situations where healthcare staff feel the threshold for a police response is met (see section 1.2) but the police do not respond or provide a delayed response, and any impact of these escalations, including in terms of the safety and wellbeing of people with mental health needs, family and carers, staff, or other members of the public.
- The number of occasions where ambulance and NHS111 services signpost people to contact the police, and the police signpost people to contact health services, to understand shifting demand.

Partners should collaborate to identify mechanisms for the collection, storage and sharing of agreed data, using automated processes wherever possible. These should be underpinned by data sharing agreements and be legally compliant (see section 3.7). Areas will also need to set up processes for analysing data (including establishing accurate baselines of agreed metrics), regularly reviewing it and using the data to inform joint decisions about the ongoing approach to implementation. We expect that from a health perspective, ICBs will play a crucial role in facilitating processes for the collection and use of data.

3.9 Multi-agency training

The NPA:RCRP states that local areas should develop multi-agency training to support decision-making and understanding of roles and responsibilities in relation to RCRP, as well as the MHA. Areas should agree what training is required and how best to deliver it, ensuring that it is a rolling programme to onboard new starters. In some areas, training involves opportunities to shadow different disciplines (for example, mental health staff spending time in police controls rooms, or police shadowing intensive home treatment/crisis resolution home treatment teams; CRHTTs). Others have commissioned training such as Respond, which brings together multi-agency staff to discuss real-life scenarios relating to the urgent mental health pathway.

As well as supporting specific training needs in relation to RCRP, areas should ensure that staff supporting those with mental health needs understand how to apply relevant legislation (see section 2) and how to deliver care that is trauma-informed, promotes shared decision-making and is personalised to people's individual needs, including by providing care that is culturally competent, age-appropriate and meets the needs of people who are LGBT+, have a learning disability or are autistic.

Section navigation

This next section of the guidance sets out the different stages of implementation. Local areas are best placed to consider the sequencing of implementation please simply refer to the relevant stage below.

- Phase one: Responding to mental health related concerns for welfare - This section sets out that local areas should reach agreement on what is a MH related concern for welfare, which service is responsible for responding, what actions should be taken, and how progress should be monitored.
- Phase 2a: People with mental health needs who leave acute hospital before treatment is complete - This section covers the measures local areas should put in place in acute hospitals to improve experience and support people to remain in hospital, where appropriate.
- Phase 2b: People who absent themselves from inpatient mental health services - This section focuses on what mental health services need to put in place to locate and return people to hospital. Including when the person; is detained under the Mental Health Act, was admitted under the Mental Capacity Act, or in hospital voluntarily.
- Phase 3: Conveyance of people with mental health needs - This section suggests how partnerships can end the use of police vehicles for the conveyance of people with MH needs. It also suggests improvements to deliver the best possible experience for individuals in distress.
- Phase 4: Timely handovers to healthcare following the use of section 136 - This section provides information on reducing handover times and improving the experience for people who are held under Section 136. It also outlines how services and police can work together to reduce the use of Section 136.

4. Phases of Right Care, Right Person implementation

The 4 phases described in this section broadly match those used in Humberside to implement RCRP, where delivery took place over 3 years. Humber Teaching NHS Foundation Trust's implementation resources can be accessed on their website.

The phases are:

- Responding to mental health-related concerns for welfare (Phase 1).
- Responding to cases where people with mental health needs leave acute hospitals before assessment or treatment is complete (Phase 2a) and where people leave inpatient mental health services or do not return from leave when expected (including where people are detained under the MHA) (Phase 2b).
- Conveyance of people with mental health needs (Phase 3).
- Timely handovers to healthcare following use of Section 136 of the MHA (Phase 4).

Local areas will need to consider whether these phases suit their local context or they need to have different phases or require different sequencing.

4.1 Phase 1: Responding to mental health-related concerns for welfare

Concerns about the welfare of a person with mental health needs may be reported by a member of the public (such as a family member, carer or neighbour), or by health, children's or adults' social care or other services. When these concerns are about the person's safety or wellbeing, proportionate action needs to be taken to check on their wellbeing and that of any dependents, including children and young people. This will include attempts to contact the person and, if there is no response, may involve a visit to the person's home address or other place they are known to be or likely to be.

Although the police in some areas have previously responded to mental health-related concerns for welfare, including conducting in-person checks, it is generally best for mental health services to lead the response where there is good evidence that a concern relates to a person's mental health. This is because:

- Mental health staff have the appropriate training or expertise to undertake clinical assessments and establish an appropriate course of action if welfare concerns are identified. In some cases, they will already have a relationship with the individual.
- People generally have a right to a private life (under Article 8 of the HRA) and to choose not to accept treatment or support. Police-led responses to concerns for welfare risk implying that choosing to withdraw from treatment is unlawful.

- People who have had poor experiences with criminal justice services, particularly refugees, those who have experienced persecution or torture, people from Black and other racialised and ethnically diverse communities, people from the LGBT+ community (particularly trans people) and other people who are disproportionately affected by the use of police powers, are more likely to find the presence of police officers aversive and potentially re-traumatising. This can be harmful in itself, and may also further weaken trust and engagement with health services.

4.1.1 Aim of this section

The section will support multi-agency partners to implement a health-led approach to responding to mental health-related concerns for welfare. As a result of this section, local areas should reach agreement on:

- What is and is not a mental health-related concern for welfare.
- Which services/agencies are responsible for responding to mental health-related concerns for welfare in a range of scenarios, including those where police involvement is required.
- What actions should be taken in response to a mental health-related concern for welfare, including initial enquiries and in-person checks.
- How progress with implementation should be monitored and reviewed, including to ensure that there is no inequitable impact on those with any protected characteristic.

4.1.2 Defining mental health-related concerns for welfare

We use the term ‘mental health-related concerns for welfare’ to mean concerns for which there is good evidence that they relate to a person’s mental health (and not that there is concern about a person with mental health needs). Concerns for welfare that do not meet this definition (that is, are not mental health-related) are not covered in this section, but where local areas are applying RCRP more broadly than mental health, multi-agency partners will need to agree their approach to responding to these concerns.

Partners need to work through a range of scenarios to clarify what is and is not a mental health-related concern for welfare, and the resulting responsibilities. It is important to note that implementation of the NPA:RCRP does not supersede legal safeguarding duties (see section 2) and statutory safeguarding partners (ICBs, the police, local authorities) will need to continue to fulfil those duties. This includes in situations where a concern for welfare is raised about an adult and there is a child or young person with them, for example, in their household, which may require a safeguarding response.

4.1.3 Determining responsibility for responding to mental health-related concerns for welfare

Local partners will need to agree the right agency to respond to mental health-related concern for welfare in different scenarios. They will also need to agree how these concerns, which may be received through a number of routes (for example, 999, 101, crisis lines/NHS111 'select mental health option' or directly from healthcare professionals), will be communicated to the right agency or agencies in a timely way that complies with data protection legislation and confidentiality duties (see section 3.7), and with sufficient detail for the right response to be provided.

While responsibilities need to be determined locally, we anticipate that the following approach will be broadly followed for mental health-related concerns for welfare (as defined above):

- For emergency situations: the ambulance service will lead the response if there is an emergency health concern (including an emergency physical health concern alongside a mental health need). The police may also provide an emergency response, where the threshold for their involvement is met (see section 1.2) and/or there is a legal or statutory duty for the police to act.
- For non-emergency situations where a person is currently receiving support from a community mental health service: their usual mental health care service will normally lead the response. However, if the person's usual care team is unable to respond with sufficient urgency (including out of hours), then the CRHTT/intensive home treatment team will lead.
- For non-emergency situations where a person is not known to services or they are receiving support from a talking therapies service (that is, are not on the caseload of a secondary mental health service), but there is good evidence that the concern relates to the person's mental health: intensive home treatment/CRHTT will lead.

The lead agency may be supported in its response by other services; for example, primary care (which can be a useful source of information and advice), children's or adults' social care, housing or VCFSE organisations, or mental health and ambulance services where they are not already the lead agency. This will depend on the person's individual needs and the nature of the situation, including the urgency of the concern. Where the threshold for a police response is met (see section 1.2) and/or the police have a legal or statutory duty to act, a joint approach with police services will be appropriate. As with other elements of RCRP the threshold for a police response (see section 1.2) needs to be considered both in terms of the concerns raised about the individual and the potential risks to staff, for example in

undertaking a check at the person's home address, or to others, for example children present in the home.

Mental health services are likely to already have protocols in place to respond to mental health-related concerns for welfare, and these should be reviewed (or, if required, created) with multi-agency partners and people with lived experience in light of the NPA:RCRP. The local protocol should identify the lead and supporting agencies for a range of scenarios, ensuring clarity on which service should respond across the local system's geography. It should also align with existing local response standards, for example the mental health clinically-led review of standards.

As set out above, during local working hours and in non-emergency situations, it will usually be appropriate for the response to a welfare concern involving a person currently receiving support from community mental health services to be from their usual mental health service. This service has an existing relationship with the person, knows the person's history and care plan and will therefore be able to make the most informed decisions about the right next steps following the check. Additionally, it will be able to provide age-appropriate care and be aware of any reasonable adjustments required to respond to the concern (such as communication adaptations for people with dementia, a learning disability, or who are autistic). In situations where the service responding to the concern for welfare does not have ongoing responsibility for the person's care, there should be a clear protocol in place for the handover of information to the service that does, including information on the action needed to support the person. Where a person is located outside their usual care pathway and an in-person check is required, mental health services within the area that the person is located are expected to take reasonable steps to support this check.

Some mental health staff may think that they cannot conduct an in-person check without the person's consent. Although staff cannot enter a property without the occupant's permission, they can still attend and request to speak to an individual, to check on their wellbeing. If there are significant concerns about a person and staff cannot gain entry on arrival, then further action should be considered, for example whether it would be appropriate to apply for a warrant under Section 135 of the MHA. Alternatively, in an emergency situation, the police or fire and rescue service may need to be contacted (as set out in locally agreed protocols), as they have powers of entry in certain situations. For example, under Section 17 of the Police and Criminal Evidence Act, the police can force entry for the purpose of 'saving life or limb'.

ICBs should work with health providers (including ambulance and mental health providers) to assess whether additional staffing or resource is required to respond to concerns for welfare,

and how these requirements will be met. Agreement should also be reached with partners about the timeline for implementing the agreed response to mental health-related concerns for welfare. If there is any potential gap in the availability of suitably skilled mental health staff members to respond to such concerns, in any part of a system's geography and at any time, this should be reflected in system risk registers, with suitable mitigation in place. If a gap has arisen because of incomplete implementation of systemwide 24/7 age-appropriate mental health crisis services, or the Community Mental Health Framework for adults and older adults, expediting expansion of these services should form part of the system's plan to address the risk.

4.1.4 When police assistance is required to respond to mental health-related concerns for welfare

The police may support the response to a mental health-related concern for welfare where the threshold for a police response is met (see section 1.2) and/or when they have a legal or statutory duty to act. The decision about whether health services involve them should generally be made after initial enquiries to better understand the welfare concern.

There will be circumstances where it is hard to judge whether police involvement is warranted in the response to a concern for welfare, and partners should work together to test different scenarios and ensure joint understanding, which should be reflected in local policies and protocols. Protocols should also be clear about how healthcare staff request police support with concerns for welfare.

As referenced above, some people will find it distressing or traumatic to interact with the police, and if the police assist with in-person checks, the person may respond both to the police and other services involved with distrust. This could lead to misinterpretation of risk and unwarranted use of force. Where there may occur, it is important to consider whether additional trusted support can be provided, for example by drawing on the person's family and carers or the support of VCFSE organisations that serve a particular community.

4.1.5 Actions in response to a mental health-related concern for welfare

Local protocols should set out the responsibilities of and expected steps that services will take in response to a mental health-related concern for welfare, depending on the level of urgency (where it is an emergency situation, existing emergency service protocols should be followed).

Initial enquiries

For non-emergency concerns, the following steps should usually be taken first (where a more urgent response is required, the above steps and an in-person check may be carried out in parallel):

- Review the person's Summary Care Record and electronic record (including recent engagement, care plans, crisis/safety plans and any known welfare or safeguarding concerns).
- Make attempts to contact the person and the family and carers via text, phone or email.
- Check with other people involved in the individual's care about recent contact – these may include representatives from other health services (including GPs), children's or adults' social care, housing, education, and VCFSE organisations. The extent of this engagement will depend on the urgency of the situation.

Before gathering information, staff should consider their confidentiality duties (see section 3.7) and any potential harm from making enquiries.

If it is possible to contact the person or their family and carers via phone or email and assure their wellbeing, this should be recorded in their electronic record. Consideration should still be given to whether the person requires any additional support, building on their care plan.

If it is not possible to contact the person and/or assure their wellbeing, this should be recorded in their electronic record, and consideration given to conducting an in-person check at the person's home address and/or other location where they are likely to be.

In-person checks

There should always be a clear purpose or reason for carrying out an in-person check, and the decision to do one should be informed by legal frameworks. These include risk to life under Article 2 of the HRA and risk of serious harm or abuse under Article 3, as well as a person's right to a private life under Article 8 and the principles of the MCA, which state that people over the age of 16 can make their own decisions, even if unwise, unless they are assessed as lacking capacity to make these decisions. For children and young people under 16, the principle of Gillick competency should be considered, alongside the duty to safeguard children from harm, which may mean sharing information with the adult with parental responsibility for the child or young person, if this is in their best interests.

It is important that in-person checks meet the needs of the individual concerned. Local areas should work with people with lived experience, including people from racialised and

ethnically diverse communities, to agree the best approach to carrying out in-person checks. Suggestions include:

- Ensuring that before carrying out an in-person check, initial enquiries have provided a sufficient understanding of the person's circumstances and needs. For example, it will be important to understand if a person with dementia or a learning disability, or who is autistic, has any communication or sensory needs, so that reasonable adjustments can be made.
- Carefully considering who should attend in-person checks. This may include multi-agency staff (health, children's social care, adults' social care, housing, police, or education for children and young people), family and carers, or other individuals who the person trusts, for example peer support workers or people working in VCFSE organisations. Particular consideration should be given to planning how to undertake in-person checks in a culturally appropriate and trauma-informed way for people from Black and other racialised and ethnically diverse communities and those who have experienced persecution or trauma.
- Ensuring that those undertaking the check understand its purpose before it is conducted, including that the police (where they are assisting) understand their role and the joint approach being taken.
- Informing the person of the in-person check in advance wherever possible, using the method of communication that the person is most likely to access (text, phone call, email).
- Explaining clearly to the person at the start of the check why it is being undertaken, and by who, and seeking to understand how to make the person feel safe and comfortable during the check. For example, this could include offering to meet outside the person's home address or property they are in, where this is practicable.
- Discussing the person's holistic needs with them during the check and working collaboratively to agree immediate next steps. Follow-up discussions may be needed to update the person's ongoing care plan, and to agree the steps that should be taken if the person withdraws from the support of services in the future, or if there is a concern for their welfare. These discussions should include the person, relevant multi-agency services, and the family and carers that the person has consented to involve in their care (see section 3.7).
- Ensuring that there is no implication during the check that if the person does not adhere to certain conditions, then they will be sanctioned, for example detained under the MHA, or that the police will carry out a follow up check.
- Ensuring all mental health staff involved in welfare checks are suitably trained and competent. This includes having skills in providing personalised, collaborative,

trauma-informed, culturally appropriate care; carrying out personalised risk management and safety planning (based on the risk assessment principles outlined in section 1.2); and an understanding of how to apply the MHA and MCA in the context of welfare checks.

- Uploading a record of the in-person check to the electronic record system of the lead agency, including details of the actions agreed during the check.
- Following lone working policies in all instances. This is to ensure not only the safety of the person whose welfare is a matter of concern but also that of the staff undertaking the check.
- Ensuring that where mental health services have not located a person through in-person checks and critical concerns remain about their safety, this is referred to the police, who can assess against local missing persons policies.

Services should also seek to understand the reasons that mental health-related concerns for welfare are reported and identify if any changes are needed to service delivery. For example, ensuring everyone on mental health services' caseloads has a crisis/safety plan in place, or working with people with lived experience to identify how best to support people to stay engaged with services.

4.1.6 Reviewing progress with implementation

We recommend that the following measures are collected, analysed and used to inform implementation:

- Number of mental-health related concerns for welfare reported, who reported the concern, which service/agency the concern was reported to, and brief details of the concern.
- Number of mental health-related concerns for welfare responded to, number involving an in-person check, which services/agencies were involved in in-person checks, and brief details of the outcome of the response.
- Number of mental health-related concerns for welfare where police assistance was requested and by who, the percentage of requests accepted and police were deployed, the reasons why the police attended or declined to attend, and brief details of the outcome of the response (both where the police were and were not part of the response).

Each agreed metric should be broken down by protected characteristics, including race, age and whether someone has a co-existing physical health problem or disability, a learning disability or autism. Where there is unwarranted variation, particularly in relation to police

involvement in undertaking in-person checks, actions should be taken to address this, working in partnership with people with lived experience from relevant groups.

Where data monitoring indicates any issues with the approach to implementation or other concerns arise in relation to mental health-related concerns for welfare, the working group should discuss these and if they cannot be resolve an issue, it should be escalated, following locally agreed escalation processes (see section 3.4).

4.2 Phase 2a: People with mental health needs who leave acute hospitals before assessment or treatment is complete

Acute hospitals, particularly emergency departments (EDs), are not always the best place for people presenting for support with a mental health need. EDs can be busy and pressured environments, and staff in acute hospitals are generally not mental health specialists (apart from those working in psychiatric liaison teams). This is why the NHS Long Term Plan has helped systems to establish a range of community-based mental health support options for people with urgent mental health needs. However, some people will continue to seek support for a mental health need by presenting at ED (including those who also have an urgent physical health condition that requires assessment or treatment), and some people admitted to acute hospitals for physical health treatment will have a significant mental health need.

While the proportion of people presenting at EDs with a mental health need is small (internal NHS data indicates around 3%), wait times are a key reason why people may decide to leave an ED before they have been formally assessed, received an intervention or completed treatment. People may also decide to leave acute hospitals because they are not clearly told about next steps in their care, because of being subject to ongoing supervision by police or hospital security, and because they are experiencing symptoms such as paranoia, delusions or suicidal thoughts, or withdrawal from nicotine or other substances.

The NPA:RCRP sets the objective that the police should only be involved when a person with mental health needs leaves an acute hospital if the threshold for a police response is met (see section 1.2) and/or legal or statutory duties apply. Alongside continued work to develop and promote community-based services where people can access support for urgent mental health needs, achieving this objective will involve ensuring that acute settings have effective provision in place to support people to remain in treatment. It will also involve strong partnership working between agencies to agree and put in place clear response protocols for when a person leaves hospital.

4.2.1 Aim and scope of this section

The guidance for this phase focuses on people whose primary reason (or a significant reason) for attendance at ED is a mental health need (who may also require assessment or treatment of a physical health need, for example, due to self-harm); and people with a significant mental health need who are admitted to an acute hospital for assessment or treatment of a physical health problem (including people transferred to an acute hospital from a mental health inpatient service). These people may have attended hospital voluntarily, have been assessed as lacking capacity under the MCA if over 16 years old or be detained or held under the MHA.

The section covers:

- Measures that should be in place in acute hospitals to improve experience and support people to remain in hospital, where appropriate.
- Procedures that should be in place to respond where a person indicates that they intend to leave, or have left, an acute hospital, including an ED.

It should be read alongside the following documents, to inform local approaches to delivery:

- 'The Patient Who Absconds', produced by the Royal College of Emergency Medicine. This provides detail on legal powers and practical considerations in relation to people leaving EDs.
- The multi-agency response for adults missing from health and care settings: A national framework for England – produced by the NPCC, Home Office and the charity Missing People, supported by health, social care and other partners.
- Statutory guidance on children who run away or go missing from home or care – produced by the Department for Education, and the accompanying flowchart showing roles and responsibilities when a child goes missing from care.

Note that cases where a person leaves a hospital or other health setting are separate to missing persons cases. Health services should first take reasonable steps to try and locate a person (in relation to acute hospitals, see section 4.2.5). Where services are unable to locate a person and critical concerns remain about the person's safety or wellbeing and/or the person is detained under the MHA, this should be referred to the police, who will assess against local missing persons policies (which are not impacted by the NPA:RCRP). Health services should also continue to follow best practice for missing persons, including the creation and use of Herbert Protocols.

4.2.2 Measures to support people to remain in acute hospital settings for assessment or treatment

While the NPA:RCRP does not directly introduce changes around the quality of care that people presenting with mental health needs receive in acute hospitals, by improving people's experience, it is more likely that they will stay in hospital for the assessment or treatment they require. Improving quality and experience of care for people with mental health needs presenting in acute hospitals is also the right thing to do.

Local implementation should therefore involve acute hospitals coming together with all-age mental health services (psychiatric liaison, community, crisis, inpatient), AMHP services and people with lived experience from diverse backgrounds to understand current challenges, including the reasons that people leave hospital before assessment or treatment is complete, and to identify how to strengthen the care pathway. This should be informed by existing standards and guidelines, including:

- NHS England, the National Collaborating Centre for Mental Health, and NICE guidance on mental health liaison services for adults and older adults.
- The Royal College of Psychiatry Psychiatric Liaison Accreditation Network standards, which cover children, young people and adults.
- The Royal College of Emergency Medicine Mental Health in Emergency Departments toolkit.
- NHS England guidance on supporting children and young people with mental health needs in acute paediatric settings.
- The Royal College of Paediatrics and Child Health Facing the Future - standards for children and young people in emergency care settings, which include standards for mental health.

Suggestions in relation to the care of individuals include:

- Supporting the person to contact their family or carers, if they have not already done so, to see if they can come to hospital to contribute to decisions about the person's care and provide support (for example bringing a phone charger, change of clothes or other items that help the person feel more comfortable while in hospital). For children and young people under 18, it is vital that their family and carers are contacted, as well as their social worker, if they have one.
- Ensuring there is clear and frequent communication with the person and their family and carers (where consent for this has been given – see section 3.7) about the next steps in the person's care and when the person is likely to be seen by a clinician for

assessment or treatment. If an interpreter is required, this should be promptly arranged.

- Reviewing a person's existing mental health care plan (where applicable) and speaking to the person and their family and carers (where consent has been given – see section 3.7), to identify any reasonable adjustments that need to be met and to tailor support to meet the person's needs and preferences, for example in terms of age, cultural background or whether a person is LGBT+. This will depend on what is feasible in an acute hospital or ED environment.
- Making sure the hospital environment is as safe and quiet as possible. Outside spaces should be accessible, dependent on local policies and an individual assessment of the benefits and risks to the person of going outside.
- Asking at the initial assessment whether the person smokes or uses e-cigarettes and, wherever possible, offer nicotine replacement therapy. Similarly, there should be active management of any alcohol or drug withdrawal symptoms to support continued engagement with hospital care.
- Ensuring people's physical and mental health needs are met in parallel and kept under regular review. For example, while someone receives mental health assessment or treatment, their wound dressings should be regularly changed, and they should be provided with any medication they need for physical and mental health needs.

Suggestions to consider at a service or system level include:

- Working to improve access to and the quality of the community-based mental health crisis pathway, including crisis alternatives such as crisis cafes, sanctuaries and crisis houses, which enable people to access care in settings other than the ED. Some EDs employ community navigators to help people attending the ED to access these alternatives. Other areas have set up crisis assessment centres, which offer an alternative to the ED for urgent same-day crisis care; further information is available on this FutureNHS page.
- Putting processes in place to enable timely triage, initial assessment, and referral of people requiring mental health support to psychiatric liaison teams. The mental health clinically-led review of standards indicates that for people in EDs with mental health needs, the psychiatric liaison team should aim to start a face-to-face assessment within one hour of referral. To achieve this, psychiatric liaison teams will need sufficient capacity to respond to local patterns of demand.

- Putting additional support in place from peer support workers, a VCFSE service or healthcare assistants, to give people someone to talk to, who will respond with empathy and compassion while they are in hospital.
- Working towards ending the use of security staff to undertake observations. Every hospital should have provision, or develop plans for, in-house observation by appropriately skilled and trained staff (in conjunction with security staff where there is risk of violence). All staff who undertake observations (including security staff), and where possible wider staff in acute hospitals, should be trained in providing supportive care to people presenting with mental health needs, least restrictive practice and de-escalation techniques. The NHS England South West regional team has compiled these mental health training resources for ED staff. Training for acute hospital staff working with children and young people with mental health needs, can be accessed via NHS England's e-learning platform.
- Working with local police forces to agree the types of situations in which it is warranted for the police to remain in attendance to support the management of a person presenting with mental health needs, and when it is appropriate for them to handover care (in line with the MHA and threshold for police response, see section 1.2).
- Reviewing all-age pathways for onward care from an acute setting (for example, for MHA assessments, community-based mental health crisis care, mental health inpatient care, and drug and alcohol support), identifying the causes of any delays and actions to address these, as well as ensuring effective escalation processes are in place.
- Ensuring there are urgent action and escalation protocols for when transition delays occur (for example, waits of more than 12 hours in the ED), and that these are followed. Protocols should cover both the action to secure onward care as quickly as possible, and how the person can be supported and made as comfortable as possible while they wait. For example, they will need regular meals and any required medication prescribed; support could also include arranging for the person's named key worker or other trusted professional to visit the person in hospital. The protocol used in London, the East of England and the South East is the Mental Health Compact.

Where identified service or system level changes have resource implications, changes should be planned with the relevant ICB and the funding implications assessed. Any staffing requirements (for example, to undertake observations) should be considered as part of bi-annual establishment reviews, with any new roles having a quality impact assessment, including to set out the scope of the roles and the training and supervision requirements.

It is also vital that NPA:RCRP implementation does not increase the use of restrictive interventions to prevent people from leaving hospital (monitoring should take place as set out in section 4.2.7). There must be a legal justification for use of restrictive interventions, and any use must be proportionate, for the minimum time necessary, as a last resort after de-escalation techniques have been attempted, and documented in clinical records. There should also be written agreement with hospital security services regarding the training they require to apply restrictive interventions (for example, training in least restriction and de-escalation), the circumstances in which they can be applied (including the importance of doing so under the guidance of clinical staff), how to apply them in different circumstances, and when police support may need to be requested (with reference to the threshold for police response, see section 1.2).

4.2.3 Procedures when a person indicates that they intend to leave, or have left, an acute hospital before assessment or treatment is complete

With NPA:RCRP implementation, it is expected that healthcare staff will take reasonable steps to locate people for whom a mental health need is a significant part of their presentation and seek to return them to hospital (if required) before contacting the police, apart from where the threshold for a police response is met (see section 1.2), and/or legal or statutory duties apply. This will be a change in practice from immediately calling the police for some services.

To support this change, acute hospital providers and mental health services, working with other relevant partners such as ambulance providers, should develop or review their existing protocols for how to respond when a person leaves an acute hospital before assessment or treatment is complete. Section 4.2.4 onwards sets out guidance on how local areas may decide to approach this. To inform these protocols, health partners should review examples of recent cases with police colleagues, including complex and all-age examples, to reach clarity and agreement among partners about when the response should be health-led and when the threshold for a police response is met (see section 1.2) and/or the police have a legal or statutory duty to act. The protocol should document the agreed actions that the police are expected to take, recognising that where the police are involved in responding, health services are still expected to work with the police to locate the person, as part of their ongoing duty of care. Note that the police generally only have the power to return someone to an acute hospital against their wishes if they are under arrest, detained or subject to police holding powers under the MHA.

Protocols will need to take account of a person's age, legal status (for example, voluntary attendance, assessed as lacking mental capacity under the MCA, detained under MHA, awaiting MHA assessment, recommended for detention, or liable for detention but awaiting admission), whether they are known to mental health services or not, whether they have a

physical health need that needs to be addressed in parallel, and their stage of care, for example, whether they have already been seen by the psychiatric liaison team. Where a hospital is located on the boundary of different police force areas, elements of the protocol relating to the police response will also need to be agreed with neighbouring forces.

Below are suggestions for what should be covered in these protocols, though roles and responsibilities should be agreed locally, dependent on local service models. For the protocols to be effective, acute staff need to have been trained in the application of legal frameworks (particularly how to assess mental capacity to make a specific decision under the MCA, and how to weigh up the hospital's duty to protect life under Article 2 of the HRA against the duty under Article 5 to not restrict liberty disproportionately).

4.2.4 Actions before a person leaves or attempts to leave hospital

Acute staff should ensure at the initial assessment in the ED or on admission to an acute hospital:

- The contact details of the person and one of their family members or carers are documented (where the person is willing and able to provide them). For a child or young person under 18, the contact details of those with parental responsibility should be recorded.
- A physical description of the person is recorded to assist if there is a future need to locate the individual.
- The person is advised about the plan for assessing and/or treating them and when they are likely to be seen by a clinician, with regular updates provided. Their family and carers should also be informed (where the person has consented to this – see section 3.7).
- The risks of leaving hospital before assessment or treatment is complete are explained to the person, and they, and their family and carers (provided consent has been given – see section 3.7) are given details of who to contact if certain side effects or symptoms occur.
- The person's mental capacity under the MCA is considered (for those aged 16 and older), and if there is any reason to doubt capacity, a formal assessment is made and documented in relation to the plan for their assessment and/or treatment. For children and young people under 16, Gillick competency should be considered, and involvement of those with parental responsibility, where required.

Acute staff should also assess the factors that might contribute to the person leaving hospital before assessment or treatment is complete (such as likely waiting time, types of symptoms), and what concerns would arise for the person's safety (or that of others) and wellbeing if

they were to do so. This assessment should follow the principles set out in NICE guidance on self-harm; that is, it should focus on how to support the person's immediate and longer-term psychological and physical safety, and should not involve using risk assessment tools or risk stratification to predict future suicide or self-harm. See also the risk assessment definition in section 1.2.

Where assessment indicates substantial concerns for a person's safety or wellbeing (or that of others) were they to leave hospital before assessment or treatment is complete, acute staff should ensure that the person is:

- Prioritised for a mental health assessment by the psychiatric liaison team and the person is supported to stay in hospital – see section 4.2.2.
- Observed (this may be enhanced observation if the person is at very high risk of leaving), either with the person's consent or within an appropriate legal framework (this should be documented in clinical record systems).

If a person expresses the wish to leave hospital, a senior decision-maker, ideally from the psychiatric liaison team (especially where the person is due to be admitted to an inpatient mental health service) or jointly with acute care staff (particularly where the person also has a significant physical health need), should assess if leaving is in the person's best interests. If from weighing up the likelihood of harm and protective factors it is judged that:

- The person does not need to be in an acute hospital, then this should be documented in the person's clinical record and they can be discharged.
- It is in the person's best interests to remain in hospital:
    - The reasons for this should be explained to the person, and attempts made to understand why they want to leave and address their concerns. At the same time, a clinician trained in assessing mental capacity under the MCA (or Gillick competency for under 16s) should assess their capacity to make the decision to leave hospital.
    - If the person cannot be persuaded to remain in hospital and there is no legal justification for preventing them from leaving, they must be allowed to leave.
    - If the assessing clinician believes there is a legal justification to prevent the person from leaving, then steps must be taken to prevent them from leaving, ensuring compliance with the identified legal framework. Where the position is unclear, legal advice should be sought.
    - Where a restrictive intervention is used to prevent a person from leaving, this should be proportionate, used for the minimum time necessary and as a last

resort after de-escalation techniques have been attempted. It should also be recorded as an incident in clinical record systems, with the legal justification. Any restraint applied by hospital security should be under the direction of clinical staff, and carried out by hospital security who have been trained in least restrictive practice and de-escalation.

4.2.5 Actions when a person has left hospital without notifying or agreeing this with the inpatient team

- Acute staff should attempt to contact the person, using the contact details given during the initial assessment, or held in clinical record systems.
- If it is not possible to speak to the person or ascertain their safety, acute staff should make rapid contact with the psychiatric liaison team to determine next steps, based on an assessment of the person's physical health, mental health and any known risks to self or others (based on the risk assessment principles outlined in section 1.2). The mental health assessment should draw on information from the psychiatric liaison assessment (if completed) and relevant information in a person's clinical record (if known to mental health services). If the psychiatric liaison team had not yet assessed the person before they left hospital, acute hospital staff will need to share as much information as possible about the person's presentation from triage and the initial assessment to inform the decision.
- The different outcomes of this process are:
  a) No further action is required (based on the assessment of protective factors and likelihood of harm) and because the person is not subject to detention under the MHA. Note that if the person is a child or young person under 18, a safeguarding referral should be made.
  b) A non-urgent follow-up (i.e. beyond 24 hours) is required by the community mental health service already overseeing the person's care. If a person is not already on the caseload of a community mental health service, the psychiatric liaison team should refer for assessment by the most appropriate service locally. For children and young people under 18, a safeguarding referral should also be made.
  c) A follow-up, either urgent (within 24 hours) or very urgent (within 4 hours), is required by the local intensive home treatment/CRHTT. The psychiatric liaison team should make this referral to the intensive home treatment/CRHTT that operates in the person's most likely location. A referral may also need to be made to local AMHP service for an MHA assessment, where this is required.
  d) The threshold for a police response is met see (see section 1.2) and emergency action by the police is needed to locate the person, liaising closely

with the acute hospital or crisis mental health services, as required. Ambulance services may also be involved in the response once the person's location is known and they are identified as having an emergency health need that the ambulance service can support with. If there are any differences in opinion between agencies about how to respond to a particular situation, local escalation processes (see section 3.4) should be followed.

- If the person's situation is judged to be urgent, very urgent or an emergency, in parallel with contacting the relevant services:
    - Hospital security staff should rapidly search the hospital and grounds, making use of CCTV footage.
    - Acute staff should continue to try and contact the person, as well as their family and carers, using contact details supplied at the initial assessment or held in clinical record systems (where consent for sharing information with family and carers has been given – see section 3.7).
    - A safeguarding referral should be made if the person is under 18, or there are concerns an adult is at risk of abuse or neglect.
- If the police are contacted for emergency support to locate a person, the acute hospital should have a proforma outlining the information staff should share with the police. This should include the person's name and a description of them, when and which department they left from, the actions that the hospital has already taken to locate them, a clear articulation of the potential for harm to self or others (that is, why police involvement is needed), and the recommended actions if the person is located. Where confidential information about a person is disclosed to the police, this must be in line with data protection legislation and confidentiality duties (see section 3.7).
- If the ambulance service is involved in the response (once a person's location is known), then the acute hospital should similarly communicate information about the person's presentation and the intended plan, for example what assessments will be needed and whether or not it is likely that the person will need to return to hospital.

4.2.6 Actions when a person is followed-up or located

The response may be led by mental health services (in non-urgent, urgent or very urgent cases), the police (emergency action to locate the person, where the threshold for a police response is met, see section 1.2), or the ambulance service (once the person's location is known and there is an emergency health need that the ambulance can support with). Regardless of the responder, it is important that the person is treated with compassion and understanding when they are located or followed up, and not made to feel judged or that they will be punished.

When the response is led by mental health services:

- The person's mental health needs should be assessed:
  - If this assessment indicates that the person requires urgent mental health support, then this should be arranged. This could involve support from an intensive support team/CRHTT, other community-based crisis support or – after sufficient consideration of less restrictive alternatives – an inpatient admission (with an MHA assessment arranged where required).
  - Where urgent mental health support is not required, mental health staff should still ask the person why they went to hospital, and discuss any support they would find helpful at this time (for example, through talking therapies, community mental health or VCFSE services).
- Their physical health needs should be assessed, as required:
  - If they have physical health needs that require emergency attention, for example due to serious self-harm or a suicide attempt, an ambulance should be called. Paramedics may be able to treat the person at the scene or need to convey the person to hospital.
  - If they have non-emergency physical health needs, the person should be encouraged to seek appropriate medical attention from an urgent treatment centre (for example, to treat cuts), through their GP, pharmacy or NHS111.
- Following any immediate action required, the person's crisis/safety plan should be reviewed (or developed if they do not have a plan), to identify the specific support they can access if in crisis again; for example, through contacting local crisis lines/NHS111 'select mental health option', and crisis alternatives like crisis cafes, sanctuaries and/or crisis houses. It is also important that the person's clinical record is updated so that information on relapse signs and what action can help is easily accessible in any future crisis.

If mental health services are unsuccessful in contacting or locating the person after multiple attempts, and critical concerns remain about their safety or wellbeing and/or they are detained under the MHA, the person's case should be referred to the police. The police can then assess against local missing persons policies.

Where the response is led by police and/or ambulance services in emergency situations:

- There should be ongoing communication with the acute hospital and/or mental health services to share relevant information and inform next steps.
- Health services should assess the person's physical and mental health needs, as appropriate, once the person is located. Based on this assessment and information

shared, health services should decide whether return to an acute hospital is required.

- If it is required, an assessment should be made of how to carry this out, including who should lead and whether there are any legal powers that could be used to return the person if they will not return voluntarily. Note that if the person is not subject to powers under the MHA and they have mental capacity under the MCA, generally there is no power under which they can be made to return. If it is deemed that an MHA assessment is required, then this should be arranged.
- If the person is returned to hospital, hospital staff should clarify their legal status, (for example, detained under the MHA, subject to Section 135 or 136 police holding powers, brought in under the MCA, or voluntary attendance), and agree handover processes.
- The person should be considered higher risk for leaving hospital again, and hospital staff should review their management plan to reflect this.

4.2.7 Reviewing progress with implementation

To understand what leads people to leave hospital, as well as the impact of changes introduced by the NPA:RCRP where people leave acute hospitals before assessment or treatment is complete, we suggest that ICBs facilitate the collection and analysis of the following measures:

- Number and proportion of mental health attendances where the person spends over 12 hours in the ED. This information can be accessed via the Urgent and Emergency Mental Health Dashboard. Where possible, this data should also be broken down by protected characteristics including race, age, and whether someone has a co-existing physical health problem or disability, including a learning disability or autism to determine if there is unwarranted variation.
- Number and proportion of mental health attendances in the ED where the person requires 1:1 observation, and whether this is undertaken by healthcare assistants, nurses, hospital security or police officers.
- Number and proportion of people for whom a mental health need is the primary (or a significant) reason for their presentation who have left an acute hospital. This data should be broken down by protected characteristics and legal status – for example, whether the person was in hospital voluntarily, under the MCA, recommended or liable for detention under the MHA, detained under the MHA (including which section they were detained under) or subject to police holding powers (for example, Section 136).
- Number and proportion of cases where a person has left an acute hospital and a) did not require follow-up, b) required follow-up and referral to mental health

services, c) required follow-up and a call to the ambulance service, d) required follow-up and a call to the police.

  - Where a report is made to the police, brief details of why a report was made should be recorded and the number and proportion of these cases that were accepted for police response. This should inform joint learning about when it is warranted for the police to respond.

- Number of people brought to the ED by the police voluntarily or under the MCA for whom a mental health need is the primary (or a significant) reason for attendance, and the proportion of these cases in which restraints (such as handcuffs or leg cuffs) are used. This needs to be monitored to ensure that an increase in inappropriate use of restraint or legal powers is not an unintended consequence of NPA:RCRP implementation.
- Number of uses of restrictive interventions in acute hospitals (including the ED) on people for whom a mental health need is the primary (or a significant) part of their presentation. This should be recorded as an incident on clinical record systems, analysed by protected characteristic and monitored during implementation to ensure that the use of restrictive interventions does not increase with NPA:RCRP implementation.

Where data monitoring indicates any issues with the approach to implementation or other concerns arise in relation to how cases where people leave an acute hospital are managed, the phase-specific working groups should discuss these, and if they cannot resolve a concern, then this should be escalated following locally agreed escalation processes (see section 3.4).

4.3 Phase 2b: People who absent themselves from inpatient mental health services or do not return from leave when expected

A person may choose to leave an inpatient mental health service without informing or agreeing this with the inpatient team, or may not return to hospital following a period of agreed leave because, for example, they are very unwell, feel their needs are not being supported in hospital, or dislike the restrictions to everyday freedoms in inpatient settings, such as how frequently they can see loved ones. Some people with lived experience have also reported that feeling unsafe and experiencing racism, homophobia, transphobia and assault in inpatient settings contributed to their decision.

That a person chooses to leave or not return to hospital when expected may be a real concern for their family and carers, and hospital staff, who may fear for the person's health

and wellbeing when they are no longer receiving support and treatment from an inpatient service.

4.3.1 Aim and scope of this section

With implementation of the NPA:RCRP, the police may only respond to situations where a person leaves an inpatient mental health service, or does not return from a period of leave when expected, if the threshold for a police response is met (see section 1.2), and/or the police have a legal or statutory duty to act. This aligns with the MHA Code of Practice, which states that the police should only be asked to assist in returning a person who is detained to hospital if necessary, and that where a person's location is known, the police's role should, wherever possible, only be to assist a mental health professional to return a person to hospital (28.14).

This section focuses on what mental health services, including NHS inpatient mental health providers and NHS commissioned independent providers, need to put in place to enable health-led responses to locate and return people to hospital.

We cover situations where the absent person:

- Is detained under the MHA.
- Was admitted under the MCA (if aged over 16) as the person was assessed as lacking capacity to consent to admission and assessment or treatment and does not fall within the scope of the MHA.
- Was receiving assessment or treatment in hospital voluntarily.

It is important that with regards to people detained under the MHA, this section is read alongside Section 18 of the MHA and Chapter 28 of the MHA Code of Practice.

While the MHA refers to people who are 'Absent Without Leave (AWOL)', we generally avoid both the terms 'Absent Without Leave/AWOL' and 'absconded' because they assign a label or judgement and because this guidance also covers people who are not detained under the MHA. Instead, we refer to a person having 'absented themselves'.

The term 'Absent Without Leave' refers to a number of situations involving people who are detained under the MHA (for example, people placed on a community treatment order under Section 17A of the MHA not returning to hospital when recalled). In this section, we focus on 2 situations where someone may be classified as 'Absent Without Leave': people leaving hospital without informing or agreeing this with the inpatient team, and people not returning from a period of leave at the expected time. These are the situations that the police report most frequent contact about. However, the principles in this section may inform local

approaches to responding to other situations involving people classified as 'Absent Without Leave'.

Note that cases where a person leaves a hospital or other health setting are separate to missing persons cases (see section 4.2.1).

4.3.2 Addressing the reasons why people absent themselves from inpatient mental health services or do not return from leave when expected

Mental health providers should carry out a multi-disciplinary review of the care received for each person who has absented themselves to understand how and why they chose to do so, including discussing the reasons with the person. Using this information, organisations should work with people with lived experience to identify steps that could prevent people absenting themselves. These will likely focus on improving the quality of inpatient care, for example by: making sure that people have supportive and collaborative relationships with staff in inpatient services; care is therapeutic, trauma-informed, culturally and developmentally appropriate, and adjusted to individual needs; and that shared decision-making is promoted. It is also crucial that as a response to NPA:RCRP implementation, inpatient services do not increase the use of restrictive interventions – inpatient services should continue to work towards minimising the use of restraint in line with the Mental Health Units (Use of Force) Act.

Further information on good practice is provided in the NHS England guidance on acute inpatient mental health care for adults and older adults and through guidance on the Quality Transformation programme webpage.

Inpatient providers should also ensure that the steps that will be taken if a person leaves hospital or has not returned from leave are individually planned, particularly for people detained under Part III of the MHA. Individual planning may be informed by learning from any previous occasions where a person has absented themselves, for example, the location they went to.

4.3.3 Determining when and how to report cases to the police where people absent themselves from inpatient mental health services or do not return from leave when expected

Currently, if a person absents themselves, it is common for inpatient mental health services to report this to the police. Following the NPA:RCRP, it is expected that mental health services will take reasonable steps to locate and return a person, before contacting the police, apart from where the threshold for a police response is met (see section 1.2), recognising that risk factors may change as the situation unfolds, and/or the police have a legal or statutory duty to act.

Multi-agency partners should work through scenarios to reach a shared understanding about when the threshold for a police response is met (see section 1.2) in relation to people who absent themselves, including how the threshold applies to children and young people, ensuring there is compliance with legal safeguarding duties (see section 2). They should also take into account that the MHA Code of Practice states that where a detained person is particularly vulnerable, dangerous and/or subject to restrictions under Part III of the MHA, the police should be immediately informed (28.15). If a multi-agency public protection arrangement (MAPPA) is in place, then the MAPPA coordinator should be informed.

Based on these discussions, partners should develop a written protocol outlining the circumstances in which the police should be informed, by whom and at what point, and ensure it complies with data protection legislation and confidentiality duties (see section 3.7). As part of the MHA Code of Practice (28.11), hospitals should already have written policies in place, agreed with multi-agency partners, including the police and ambulance, about the actions that should be taken when a detained person absents themselves, which all relevant staff should be familiar with. 28.12 of the MHA Code of Practice sets out what should be included in these policies. Multi-agency partners should review and update these policies in light of the changes introduced under the NPA:RCRP – including with information on when the police should be informed. Where these policies do not cover people who are not detained under the MHA, this information should be added or a separate policy developed for this group.

When reports are made to the police, the situation should be explained in a way that is specific and unambiguous, and with explicit reference to why police assistance is required, so that the right decisions are made about next steps. To support communication, we recommend that inpatient mental health services and the police jointly develop a proforma outlining the information that should be shared (compliant with data protection legislation and confidentiality duties, see section 3.7). This should include sharing information on what has occurred, the potential for harm to self or others, actions that the health provider has already taken and what support the health service is seeking from the police. If police involvement has distressed the person in the past, this should also be conveyed to the police to inform their response, with the aim of reducing distress.

4.3.4 Actions to locate a person who has absented themselves or not returned from leave

People may absent themselves by leaving hospital buildings or grounds, leaving an escort while on escorted leave, or not returning from unescorted leave at the agreed time. The actions that health services take to locate them will depend on the situation and whether the person is detained under the MHA, and will need to be informed by a risk assessment,

(based on the risk assessment principles outlined in section 1.2). Even where a report has been made to the police, mental health services will be expected to try and locate the person as part of their ongoing duty of care, working with the police to do so.

Depending on the circumstances, mental health services may try and locate a person who has absented themselves by:

- Conducting a search of the hospital grounds and places in the vicinity, if appropriate, and the person is believed to be nearby. When doing this there should be an ongoing risk assessment (based on the risk assessment principles outlined in section 1.2), adequate staff deployed to the search to ensure staff safety and wellbeing, and clear communication with the inpatient team about the unfolding situation, including if further assistance is required. Wherever possible, staff looking for the person should know the person and have formed a trusted relationship with them, to support their return to hospital.
- Phoning or texting the person.
- Contacting other services and agencies that support the person, as well as the person's family and carers to find out if they have seen or heard from the person (where consent to share information with these agencies and family and carers has been given – see section 3.7).
- Visiting the person's home address and other locations in the local area where there is a reasonable likelihood they may be, for example, where a person has been found when they have previously absented themselves. This will need to be informed by a risk assessment (based on the risk assessment principles outlined in section 1.2), and undertaken in line with lone working policies. As above, staff known to the person and with whom they have a positive relationship with should do these visits.

Hospitals should ensure that their written policies concerning people who absent themselves are updated in relation to the actions that mental health services will take to locate them. Policies should cover people who were in hospital voluntarily, people who were detained under the MHA, and people aged over 16 who were admitted under the MCA, as they lacked capacity to consent to admission and assessment or treatment and fall outside the scope of the MHA. These policies should set out the role of the police in assisting with locating people where the threshold for a police response is met (see section 1.2) and/or there is a legal or statutory duty for the police to act, ensuring there is clarity between partners about the actions that the police will take to help locate people in a range of circumstances. Where a hospital is located on the boundary of different police force areas, the policy will need to be agreed with neighbouring forces.

Staff should be trained in the locally agreed policy, including how to respond when someone leaves an inpatient mental health service unexpectedly. Training, guidance and support should be provided on:

- How to conduct a risk assessment, in line with the risk assessment principles outlined in section 1.2, to inform decision-making about appropriate and proportionate next steps when someone has absented themselves. For example, a person may be slightly late to return from unescorted leave because of transport difficulties, and this situation will likely require a different response from when a person has left a hospital building.
- Who should be informed and how urgently when a person has absented themselves, and what information needs to be communicated. The person in charge of the inpatient service and the staff member in charge of the person's care (the responsible clinician for people detained under the MHA) should be informed and other agencies, such as the local authority and the person's family and carers may also be informed (where the person has consented to the sharing of information with these agencies and family and carers, see section 3.7). Guidance should also be provided on what action to take if there is good reason to think someone could be harmed as a result of the person absenting themselves.
- The situations in which the police should be informed, in a way that complies with data protection legislation and confidentiality duties (see section 3.7), and the actions that the police can be expected to take.
- The circumstances in which the hospital grounds and local vicinity should be searched, and how mental health staff should undertake this search (including the role of hospital security, where applicable).
- The circumstances in which the person's home address and any other locations should be visited, and how to arrange this (see paragraph below on local arrangements in relation to this).
- How to apply relevant parts of the MHA in relation to people who are detained, namely Section 18 and Chapter 28 of the Code of Practice.

Services will need to consider the availability of inpatient staff to support with locating people who are absent. Agreement will also need to be reached locally about who is responsible for conducting visits to the person's home address and any other locations in the local area. For example, it may be agreed locally that this is the responsibility of community or crisis mental health services. Services should review data on the number of people who absent themselves to determine what additional resource may be needed, with the funding implications of this assessed by ICBs, and plans put in place about how any additional resource requirements will be met. Where someone has been admitted to a hospital outside

their home address area, we expect that mental health services operating locally to the person's home address will help in undertaking visits.

4.3.5 Actions when a person is located

Under the NPA:RCRP, mental health services will be expected to play a role in responding when a person is located, including returning them to hospital, where required. For people who are detained, this is in line with the MHA Code of Practice (28.14), which states that the police should only be asked to assist in returning a person who is detained to hospital if necessary, and that where a person's location is known, the police's role should, wherever possible, only be to assist a mental health professional to return a person to hospital.

Hospitals should work with partners to review and update their written policies on the actions that mental health services will take when a person who has absented themselves is located and when they are not found. The policies should also set out the role of the police in assisting with returning people to hospital, where the threshold for a police response is met (see section 1.2), and/or where there is a legal or statutory duty for the police to act, ensuring there is clarity between partners about the actions that the police will take to support a person's return. Where a hospital is located on the boundary of different police force areas, the policy will need to be agreed with neighbouring forces.

Policies will need to set out the actions where people are willing and unwilling to return to hospital, for people who are detained under the MHA, people admitted under the MCA (those aged over 16) as they lacked capacity to consent to admission and assessment or treatment and fell outside the scope of the MHA and people who were in hospital voluntarily.

In all cases, when a person is found they need to be treated with compassion and understanding, and not made to feel judged or that they will be punished. It is also important that, as soon as practicable, there is a collaborative conversation with the person to understand why they left hospital or did not return as agreed, to inform next steps in their care, including any changes to improve their inpatient experience, and to identify any wider learning. This conversation should involve the person's family and carers, where consent for involving them is given (see section 3.7).

For people who were in hospital voluntarily and are unwilling to return, healthcare staff should listen to and understand why they do not want to return. Consideration should be given to whether they need to return, or whether a community service, such as an intensive home treatment/CRHTT could support them. If it is judged that the person needs to return, then healthcare staff should seek to explain to the person why it would be beneficial to do so, and to discuss what changes could be made to their care in hospital to better support their

needs. This could include consideration of admission to an alternative inpatient service or hospital. Where possible, this conversation should involve the community mental health service with ongoing responsibility for the person's care, any other key services that support the person, and the person's family and carers (where consent has been given to involve them – see section 3.7). If the person remains unwilling to return to hospital, their decision should be respected unless there are concerns about potential harm to self or others; if there are, consideration should be given to contacting the local AMHP service to determine whether an MHA assessment is needed.

Healthcare staff should also listen to people detained under the MHA who are unwilling to return to understand why, and seek to encourage a voluntary return by explaining the benefits and any changes that could be made to their care in hospital to better support their needs. In many cases, this is successful. Where the person remains unwilling to return to hospital, returning the person without their consent, under Section 18 of the MHA will need to be considered. This section states that a person can be returned to hospital by an AMHP, hospital staff member, a police officer or any other person authorised in writing by the responsible clinician or hospital managers. If healthcare staff believe that they cannot safely return the person to hospital without police involvement, then the police should be contacted for assistance, with a clear explanation as to why their help is required. If a person is in a private dwelling and will not grant entry, an application may need to be made to court for a warrant under Section 135(2) to gain entry. Local processes should be in place for staff to make these applications; where they are not, advice may be sought from AMHP services, who may support using their knowledge of the Section 135(1) process.

Hospital providers should ensure that relevant staff have received training, guidance and support on the actions they should take when they locate someone who has absented themselves, in line with the locally agreed policy. This should cover:

- Roles and responsibilities of different services when a person who has absented themselves is located, including how to apply relevant parts of the MHA to people who are detained, namely Section 18, and Chapter 28 of the Code of Practice.
- Steps to return people who are and are not detained under the MHA.
- How to respond to people when they are located with compassion and understanding, in a way that meets their individual needs and seeks to understand why they absented themselves.
- How to use verbal persuasion to encourage people to return to hospital.
- Techniques to prevent and manage aggression, with a clear focus on ensuring that practice is least restrictive. Restrictive interventions should only be used to protect the person's or someone else's safety and wellbeing and use the least restrictive

means available, for the minimum time possible, as per inpatient service guidelines.
- When the police should be contacted to support the return of people to hospital.

Systems will need to consider the availability of mental health staff to support when people are located and with returning them to hospital, informed by data about the frequency of these situations. Local agreement should be reached on the circumstances in which it is the responsibility of inpatient services to respond, and when it is the responsibility of community or crisis mental health services. Where it is determined that additional staffing resource is required, ICBs should assess the funding implications and put plans in place to meet any additional resource requirements.

4.3.6 Actions when a person cannot be located

Where mental health services have exhausted all reasonable efforts to locate a person (see section 4.3.4), and critical concerns remain about the person's safety or wellbeing, or the person is detained under the MHA, the case should be referred to the police who can assess against local missing persons policies (which are not impacted by the NPA:RCRP).

Further information on missing persons procedures can be found in following guidance:

- The multi-agency response for adults missing from health and care settings: A national framework for England – produced by the NPCC, Home Office and the charity Missing People, supported by health, adults' social care and other partners.
- Statutory guidance on children who run away or go missing from home or care – produced by the Department for Education, and the accompanying flowchart showing roles and responsibilities when a child goes missing from care.

4.3.7 Reviewing progress with implementation

We recommend that the following measures are collected, analysed and used to inform the approach to NPA:RCRP implementation:

- Number of people who have absented themselves from inpatient mental health services – broken down by whether the person was or was not detained under the MHA and whether they a) left from hospital buildings or grounds b) left while on escorted leave c) did not return from unescorted leave at the agreed time. This data should also be analysed by protected characteristics, including race, age, and whether someone has a co-existing physical health problem or disability, including a learning disability or autism.

- Details of how a person absented themselves (for example, how a person was able to leave hospital buildings or grounds), the reasons that people give for having left or not returned to hospital as agreed, and the suggestions they make for improving their inpatient mental health experience. This information should also be reviewed by multi-disciplinary members of the inpatient mental health provider, who should have a debrief after each case of a person absenting themselves.
- Number and proportion of people who have absented themselves who are reported to the police (broken down by protected characteristics), brief details of why each case was reported to the police, and the number and proportion of these cases that are accepted by the police - to inform joint learning about where it is warranted for the police to respond.
- How people are returned to hospital (via police or others), broken down by protected characteristics. If there is unwarranted variation in police involvement in returning people with particular protected characteristics, action should be taken to address this, working in partnership with people with lived experience from relevant groups.
- Use of restrictive interventions in inpatient mental health services, broken down by protected characteristics – to ensure that use does not increase to prevent people absenting themselves. Further information on recording restrictive interventions can be found in Section 6 of the statutory guidance on the Mental Health Units (Use of Force) Act.

Where data monitoring indicates any issues with the approach to implementation or other concerns arise in relation to people who absent themselves are managed, the working group should discuss these and if they cannot resolve an issue, then it should be escalated following locally agreed escalation processes (see section 3.4).

4.4 Phase 3: Conveyance of people with mental health needs

People with mental health needs are regularly conveyed or transported between different settings, for example, from private addresses and public places to a health-based place of safety (HBPoS), from mental health hospitals to acute hospitals, and between mental health hospitals. We know that experiences of conveyance can be confusing, distressing and potentially traumatic, especially where restraint is used, as illustrated by these quotes from people with lived experience and staff (taken from the Ambulance Mental Health Commissioning Guide):

> “Need to remember that conveyance in itself is an extremely scary and anxiety-inducing experience.”

> "Sometimes patients are driven around for hours on end without being informed what was going on and with no toilet breaks, drinks or food provided."

> "Being cuffed in an ambulance is a painful and uncomfortable experience."

Use of police vehicles can further escalate people's distress and fear of what is going to happen to them, increasing the potential for harm and likelihood restriction or force will be used. We also know that there are inequalities in the use of police vehicles for conveyance that need to be addressed. For example, internal NHS England data indicates that in some regions Black people are more likely to be transported to an HBPoS in a police car.

The NPA:RCRP sets an expectation that all local areas will work towards ending the use of police vehicles for conveyance, aligning with Chapter 17 of the MHA Code of Practice, which states that when someone is transported to hospital, ambulance vehicles or similar should be used wherever practicable, with police officers supporting where required (17.14), and that transporting people in police vehicles should only happen in exceptional circumstances (17.15). A commitment was also made in the NHS Long Term Plan to introduce new mental health response vehicles (MHRVs) to improve the timeliness, quality, and experience of conveyance and reduce the use of police vehicles for conveyance. Up to 90 MHRVs will be in use by the end of 2024/25.

4.4.1 Aim of this section

This section suggests how local partnerships can work towards ending the use of police vehicles for the conveyance of people with mental health needs, recognising that Home Office data indicates that in 2021/22 nearly 50% of people held under a Section 136 were transported to a first place of safety in a police vehicle. It also suggests how conveyancing arrangements can be improved to deliver the best possible experience for individuals in distress, including through acting on inequalities.

4.4.2 Developing the right local model of health-based conveyance

Vehicle provision

A major part of delivering Phase 3 will be identifying the right model of vehicle model provision to meet people's needs and putting in place the required provision locally to enable timely access to health-based transport. To plan and deliver this provision, local areas will need to involve people with lived experience; AMHPs - given their central role in arranging and coordinating transport in relation to the MHA; commissioned ambulance providers (including local ambulance mental health leads); mental health providers; acute hospital providers; ICBs and the police.

Areas should begin by gaining a thorough understanding of the current vehicle provision used to convey people with mental health needs, including the reasons why police vehicles are used, and conduct demand and capacity modelling. Suggested areas to consider as part of demand and capacity modelling include:

- Types of health-based transport that are available locally to support conveyance of people with mental health needs (including ambulances, MHRVs and privately commissioned secure transport), their capacity to transport people, and whether this varies by time of day, day of week, or other factors.
- How frequently people with mental health needs require transport, and whether demand varies according to the time of day, day of the week or other factors.
- Frequency with which transport is required for individuals with additional needs, such as a physical disability, frailty, a learning disability or autism, or for those who have urgent physical health needs requiring medical attention.
- Circumstances in which transport is required and which vehicles are used in different circumstances, including:
    - Transporting people to hospital who have been assessed as requiring detention under the MHA; are going to hospital voluntarily for assessment and treatment; or will be admitted under the MCA (for those aged over 16) because they lack capacity to consent to admission and assessment or treatment and fall outside the scope of the MHA.
    - Transferring of people between hospitals – those detained under the MHA admitted under the MCA, or receiving assessment or treatment voluntarily. Transfers include situations where someone requires transport from an out of area hospital to a hospital closer to their normal residence.
    - Returning people to hospital who have absented themselves or not returned from leave when expected.
    - Taking people on a community treatment order or who have been conditionally discharged to hospital on recall.
    - Returning people who are subject to guardianship to the place their guardian requires them to live.
    - Taking people to and between HBPoS.
    - Taking people to and from court.
- The frequency with which, and the reasons why, police vehicles are used for conveyance, and the frequency and reasons for requiring police assistance where people are conveyed in health-based vehicles.
- Vehicle response times, including whether these vary by time of day, day of week or other factors, and whether they differ according to circumstances, such as providing transport to or from an out of area location.

Based on this modelling, local agreement should be reached about the right model of health-based vehicle provision needed locally to meet demand and offer good experiences to people requiring conveyance, drawing on the expertise of people with lived experience. This should include agreement on which health-based transport option is most appropriate in different circumstances (noting the concerns discussed below about some secure transport providers). It will also involve consideration of the response times in different circumstances.

For example, where a person is subject to police powers under Section 136 of the MHA ambulances aim to achieve an average response time of 30 minutes.

Any gaps identified between the current provision of health-based transport and the agreed model should inform commissioning decisions (for example, whether more MHRVs need to be commissioned) and any other actions required. ICBs should assess the funding implications and, if additional resource is required, plans put in place to meet these requirements.

Using privately commissioned secure transport services

In some areas of England, the commissioning of secure transport services has improved the timeliness of conveyance and reduced police involvement in the provision of transport. The CQC has however raised concerns about secure transport services, including that some lack knowledge about people's rights when detained, inappropriately use restraint and routinely transport people in safe spaces ('vehicle cages') without conducting a risk assessment of whether this is required. Further information can be found in the Ambulance Mental Health Commissioning Guide (Annex A).

If ICBs or mental health providers commission secure transport, due diligence is vital in managing the contract. In line with the NHS Standard Contract, all NHS commissioned services must be quality assured to ensure that subcontracting arrangements adhere to all national and any locally agreed standards. This includes ensuring that all uses of restrictive interventions are recorded and monitored. It is also good practice to involve local AMHP services, health providers (mental health, ambulance and acute) and people with lived experience in the tendering and contracting process and reviews of provision.

Secure transport providers that operate vehicles with safe spaces ('vehicle cages') need to register with the CQC, whereas those that do not have safe spaces are not necessarily required to be registered. Therefore, it should not be assumed that it is best to commission a registered provider, as safe spaces are highly restrictive and better alternatives are available, such as vehicles that separate the driver and other staff from a person who is highly distressed.

NHS England's Reducing Restrictive Practice Oversight Group (part of the Quality Transformation Programme) has recently commissioned the Restraint Reduction Network (RRN) to raise awareness of the experiences of people in inpatient settings who have been conveyed using secure transport, and how providers and commissioners can build on examples of good practice to improve care.

Workforce

Based on local demand and capacity modelling, areas will need to consider the staffing levels and mix (including in terms of male-to-female staff ratio) required to put in place the agreed conveyance model, with ICBs assessing the funding implications. Any gaps in the staffing required for the model to work effectively should be recorded, and actions identified to address them.

It is also crucial that all staff involved in the conveyance of people with mental health needs, whether working for an NHS service or a commissioned service, have the right skills to support people who may be experiencing significant distress. Without such skills, situations can escalate, resulting in avoidable restraint or police involvement. Services should work to ensure that staff have received training and are competent in the following areas, as well as those outlined in section 3.9:

- Understanding what drives mental distress and underlies mental health presentations, including where people are reluctant to be conveyed and appear distrustful, violent or aggressive.
- How to engage with people experiencing mental distress, quickly establish therapeutic rapport, offer choice and provide person-centred care, including where individuals have a learning disability, cognitive difficulties or are autistic.
- De-escalation and restraint reduction techniques to manage situations without use of restraint. This training should adhere to RRN standards, which include specific guidelines for the conveyance of people with mental health needs who may also have a learning disability or be autistic (see Appendix 24 of the standards).
- Appropriate use of restraint to manage violence and aggression, proportionate to the situation, as a last resort and for the minimum time necessary, in line with RRN standards. In particular, staff should understand that handcuffs (including 'soft cuffs') should not be used unless there is a legal justification for doing so, and their use needs to be reasonable, necessary and proportionate to the circumstances, including for the shortest time possible.
- Conducting live risk assessments (based on the risk assessment principles outlined in section 1.2), and putting in place contingency plans for the management of an escalation or incident during conveyance.
- Understanding roles and responsibilities under the MHA in relation to conveyance.
- Providing basic life support (at a minimum), but ideally intermediate life support, as this is recommended where staff may be involved in delivering rapid tranquilisation or using restraint.

The requirements for staff working for a commissioned secure transport service should be set out in the service contract and reviewed as part of quality assurance processes.

The NHS Learning Hub Mental Health Ambulance Service Education is an online repository of mental health training resources relevant to supporting people with urgent mental health needs.

4.4.3 Ensuring clarity about roles and responsibilities

Clarity is needed around the roles and responsibilities of different agencies for the locally agreed model to work. This is in line with the MHA Code of Practice (17.26), which states that local multi-agency agreements should be in place in relation to transporting people and these should set out the roles of each agency in relation to conveyance.

In implementing the NPA:RCRP, local agreements will need to be reviewed, with reference to Chapter 17 of the MHA Code of Practice and agreement reached on the limited circumstances in which the police should assist conveyance in ambulances or other health-based transport, and the exceptional circumstances in which police vehicles will be used to transport people; that is, where there is no viable alternative that is in the best interests of the person. For example, situations where remaining in the same location, such as by a motorway or bridge, could result in harm to them or others. The agreement on situations where police involvement in conveyance is warranted should be reached following a review of recent local cases where the police were involved.

When reviewing and updating local agreements, note that:

- The police have a legal power to take people held under Section 135 and 136 of the MHA to an HBPoS. As set out above, however, in most cases an ambulance or other health-based transport service should be used.
- For Section 136, the police officer who has exercised the holding power should arrange the health-based transport and escort the person to the HBPoS to facilitate the handover to healthcare staff (MHA Code of Practice, 16.41).
- For Section 135, the police may need to remain in attendance and support conveyance to an HBPoS, where it is agreed that police assistance is required, for example, to manage potential harm to the person or others

It is also important that the local agreement sets out:

- Communication channels between services involved in conveyance, including for requesting police assistance.
- Who is responsible for arranging and ordering transport across the range of circumstances in which transport can be needed, including who holds the budget and cost code for ordering privately commissioned secure transport, where this is used.
- How all staff, including frontline staff, can escalate concerns around how local arrangements are working, following locally agreed escalation processes (see section 3.4).

The updated local agreement should be communicated to all staff across agencies that have a role in the conveyance of people with mental health needs and reinforced by service leads and those in senior leadership roles.

4.4.4 Improving experience of conveyance

A person's needs for transportation will often be at a time when they are experiencing substantial distress. While the NPA:RCRP does not change the way conveyance is undertaken, beyond the aim of working towards ending the use of police vehicles, it presents an opportunity to improve the quality and experience of conveyance by making sure it is least restrictive, meets people's individual needs, and makes people feel safe, supported and treated with kindness and empathy. It also involves identifying any inequalities in the way that people are conveyed, including the potential role of discrimination and racism, and taking steps to address these inequalities.

Local areas should work with people with lived experience, including people from racialised and ethnically diverse communities, to determine what actions can be taken locally to improve experiences of conveyance. Information to support this process can be found in Chapter 17 of the MHA Code of Practice and NHS England's Ambulance Mental Health Commissioning Guide; and the suggestions here:

- Identify what could help the person to feel more comfortable during conveyance, through reviewing their electronic record (including any advance choices recorded) and speaking to them and their family and carers (where the person has consented to involving them in their care, see section 3.7). The person's individual mental and physical health, sensory, cultural and communication needs (such as whether someone is a non-English speaker or non-verbal) and any needs related to the person's age should be considered, as well as understanding what worked well and less well during any previous conveyance.
- Enable a person's family member or carer to travel with them to provide reassurance and support and to help communicate the person's needs and preferences. In addition, it can be helpful to have a family member or carer meet the person at the destination. Where there is a specific reason why a person's family member or carer cannot travel with the person (for example, a safeguarding concern, individual preference), a mental health staff member, who is not the driver, should travel with the person to provide support and reassurance.
- Explain to the person in a way they can understand, where they are going, why and what will happen on arrival, and continue to communicate with them about how the journey is going and how long it will take to reach the destination. It may help some people to track the journey themselves on an electronic device (for example, a mobile with GPS).
- Plan what to do if the person needs to use the toilet or requires a comfort break during the journey, particularly on longer journeys and/or if the person has a physical health need or disability.
- Ensure that adequate water or other refreshments are available, particularly for longer journeys.
- Give the person the option to play sound during the journey (for example, music, a podcast or an audiobook), or to have a quiet environment. Autistic people or those who have other sensory needs may want to wear ear defenders to block out sound, including vehicle sirens.

- Allow people to bring possessions with them that they find calming and help to meet sensory needs, and anything else they would find useful or need in hospital, including glasses or hearing aids.
- Ensure that where a person has been sedated or received rapid tranquilisation before conveyance, they are accompanied by a healthcare professional who can identify and respond to any physical distress or complications and has access to the necessary emergency equipment to do so (usually requiring conveyance in an ambulance). If a person has other physical health needs, steps should be taken to provide the appropriate physical health support.
- Ensure that healthcare staff meet the person on arrival at their destination and that there is a process in place for the prompt handover of information about their care, so that the person can move from the vehicle into the onward care setting without delay. The information handed over should include the reasons for/circumstances around conveyance, information from the person's care plan (including any immediate potential harms), information about dose and timing of any medication, and information on any restrictive intervention used as part of conveyance, which may affect the person's care needs.

4.4.5 Reviewing progress with implementation

We recommend that the following measures are collected, analysed and used to inform the approach to NPA:RCRP implementation:

- People's experience of health-based conveyance, by vehicle type – to understand whether people feel that conveyance is done in a therapeutic, supportive, least restrictive and safe way, and what could improve the experience. These measures should be collected after people have had a chance to settle and can reflect on their experience (that is, not when they are highly distressed or unwell) and there should be a particular focus on collecting information from groups who face inequalities in the urgent mental health pathway. Data should also be collected on people's experience of conveyance in commissioned secure transport, and this should be reviewed as part of contract management.
- Number of times people with mental health needs are conveyed, where conveyance is to and from, the vehicle type used (including police vehicle) and vehicle response time. This should be broken down by protected characteristics, such as race, age, and whether someone has a co-existing physical health problem disability, such as a learning disability or autism, and any other relevant inequalities.
- Reasons why police vehicles were used for conveyance, the proportion of such conveyances where the ambulance service was contacted before the police undertook the conveyance, and if not, the reasons for this.
- Use of restraint during conveyance, broken down by type of restraint (including mechanical restraint using handcuffs or 'soft cuffs') and by protected characteristics. The reporting of this data should be a requirement of the contract of commissioned secure transport services, and it should be reviewed as part of contract management.

In particular, cases where police vehicles are used for conveyance should be regularly reviewed to inform ongoing work to reduce its frequency. Action should also be taken to

identify and address any unwarranted variation in the use of police vehicles in relation to any protected characteristic, working in partnership with people with lived experience from relevant groups.

Where data monitoring indicates any issues with the approach to implementation or other concerns arise in relation to conveyance, the working group should discuss these and if they cannot resolve an issue, then it should be escalated following locally agreed escalation processes (see section 3.4).

4.5 Phase 4: Timely handovers to healthcare following use of Section 136

Section 136 of the MHA gives police the power to remove a person from a public place to a place of safety (or to keep them in a place of safety if they are already at one) for up to 24 hours, or 36 hours with an extension, for the purpose of completing an MHA assessment and making any necessary arrangements for the person's treatment or care. This power, which does not require a warrant, can be used if the person is in any place other than the house, flat or room where they live, appears to have a "mental disorder" and be "in need of immediate care or control", and the police think it necessary to exercise the power in the interests of that person or for the protection of others. Before using this power, where practical to do so, police officers are required to consult a registered medical practitioner, a registered nurse, an AMHP, occupational therapist or paramedic. Chapter 16 of the MHA Code of Practice provides further details on police powers and places of safety.

Although the NPA:RCRP sets the threshold for the police response to mental health cases (see section 1.2), this does not affect the threshold for decision-making in the application of Section 136. Police officers in control rooms use the NPA:RCRP threshold to decide whether the police are the right agency to respond at the point the public or other professionals contact them, while it is for police officers at the scene to decide whether to use Section 136.

The NPA:RCRP sets an ambition for health systems to work towards enabling the police to complete handovers of care within 1 hour of arrival at a place of safety, unless mutually agreed otherwise on a case-by-case basis. Currently police officers can spend significant time waiting to handover care – The Policing Productivity Review estimated this to be around 800,000 hours annually – and often during this time people with mental health needs will not be receiving specialist care. In most circumstances, police should seek to handover care at a HBPoS; a definition of which is provided in section 4.5.2 rather than at an ED or other place of safety.

While it is best for a person in mental distress to start receiving care from a health professional as soon as possible, achieving prompt handovers should not be put ahead of

providing compassionate treatment and ensuring the safety and wellbeing of the person, staff, or other members of the public.

4.5.1 Aim of this section

This section provides information on what health systems can do to reduce handover times and improve the experience of handover for people who are held under Section 136.

While we use the term 'handover', people with lived experience and their carers can find it dehumanising. It is important that the transfer of care and support between agencies is done in a caring and humane way, with the needs of the person given priority over the completion of paperwork. Wherever possible, handovers should be done in an environment that is designed for people in crisis, and not one that is busy or noisy. This is particularly important for people with sensory needs, including autistic people and people with dementia.

This section also outlines how healthcare services can support the police in reducing the use of Section 136, including by supporting officers' decision-making about when to use Section 136 powers and providing advice on alternative care pathways. Reducing the use of Section 136 will likely improve handover times due to creating increased capacity within the system, as well as improving people's experiences of care.

Section 136 is the MHA power that the police use most frequently and one that can result in long handover times between the police and health services, and as such is the focus of this section. However, many of the recommendations are also applicable to Section 135. Section 135 allows the police, once they have obtained a warrant, to enter a person's home and take them to a place of safety (or keep them at a place of safety if they are already in one) so that an MHA application can be made, or other arrangements made for their treatment.

4.5.2 Health-Based Places of Safety (HBPoS)

MHA legislation sets out the locations that can be used as a place of safety. This allows for local flexibility to respond to different situations and to identify the place of safety that best meets the needs of the person in crisis. However, DHSC and Home Office guidance is clear that, with limited exceptions, the most appropriate place to take the person to is a dedicated, mental health-based HBPoS. Where available, HBPoS generally provide a more therapeutic environment for people in crisis, better access to suitably trained mental health professionals and handover times from the police to healthcare services are typically quicker. One important exception is that people with an urgent physical health need should be brought to an ED.

Increasing numbers of people held under Section 136 are being brought to EDs, even when they do not have an urgent physical health need; increasing to almost 40% over the past 5

years according to Home Office data (with HBPoS used in 58% of cases). This is often because HBPoS are at capacity. Adequate HBPoS capacity is vital in all areas as this makes a crucial difference to how long police officers spend with a person before their care and support is handed over to health services, and reduces pressure on EDs. Good access to community-based crisis care and inpatient mental health services is equally important, so that following assessment at the HBPoS, the person can be swiftly transferred to onward care. ICBs should assess the funding implications and if additional resource is required, determine how this will be met.

4.5.3 Development of local handover protocol

Local areas should develop or review their Section 136 handover protocol in light of the NPA:RCRP, in partnership with local health services, police forces and social care partners. Consideration should be given to:

- Compliance with the ruling on Webley v St George's Hospital NHS Trust (2014). This sets out good practice principles for safe and effective handovers from the police to health services. This includes that police officers have a duty to:
  - Take reasonable steps to ensure that the person does not come to physical harm while in their custody.
  - Take reasonable care only to release the person into a safe environment.
  - Provide relevant information to those into whose care the person is transferred, including the circumstances for holding someone under Section 136.
- How HBPoS and ED staff should confirm to the police that they are willing and capable of accepting the person. The police should remain with the person until HBPoS or ED staff have accepted responsibility for their care. The protocol should set out the actions that should be taken where the police would like to handover care, but HBPoS or ED staff do not feel this is safe, including using local escalation processes (see section 3.4) to swiftly resolve any differences of opinion.
- The types of circumstances in which the police may be required to remain in attendance beyond 1 hour. In an HBPoS, unless staff request this due to the individual circumstances of a case, the police are not expected to remain once the handover is completed. In EDs, which are generally less secure environments, the ED should determine if it is safe for the person and healthcare staff to accept legal responsibility for the individual or if police officers may be required to continue to provide support.
- Escalation where there is an unwarranted or exceptional delay in handovers from the police to health services. Processes should be in place to review handover times and address any challenges to timely handovers.
- Steps to ensure timely handovers from other providers involved in the transportation of people held under Section 136. For example, the NHS Standard Contract (Annex A – National Quality Requirements Ref E.B.S.7) sets out quality standards for handovers between ambulance and ED. The aim is for handovers to be completed within 15 minutes (100% within 60 minutes, 95% within 30 minutes and 65% within 15 minutes).

4.5.4 Supporting a reduction in use of Section 136, where appropriate

There will continue to be cases where it is appropriate for police officers to use Section 136 powers and their use should not be avoided altogether. However, apart from 2022/23 when there was a 3% decrease, Home Office data shows that there has been a sustained year-on-year increase in use of Section 136 powers. It is important that there is continued growth in community-based crisis support, which can support people in crisis without police involvement, therefore helping to reduce the number of Section 136s. In turn, with fewer Section 136s issued, this can help to improve handover times.

Considerations for enabling an appropriate reduction in the use of Section 136 include:

- Embedding joint working models that reduce unwarranted use of police powers and enable timely access to appropriate support when powers are used. Review existing models of partnership working between the police, health and social care services in relation to responding to people with urgent mental health needs and consider how they can be strengthened. For example, the Bristol, North Somerset and South Gloucestershire (BNSSG), Mental Health Integrated Access Partnership has helped reduce police deployments and use of Section 136 as well as ensure that people only need to tell their story once when accessing physical and mental health services.
- Supporting police access to specialist mental health advice about use of Section 136. As set out in Section 136, where practical to do so, police officers are required to consult with a registered doctor, nurse, AMHP, occupational therapist or paramedic, before keeping someone in, or taking someone to, a place of safety. This function is often achieved through professional advice lines, which police officers call for information about alternative sources of mental health support, such as crisis cafes, sanctuaries and crisis houses, and, for people known to services, guidance about how best to support the person, based on their care record, including information from their crisis/safety plan. The partnerships set up to implement the NPA:RCRP should review data on uptake of this advice before holding people under Section 136, and address any issues with police accessing this support or using the information in their decision-making.
- Reviewing cases of people held under Section 136 to improve crisis pathways. For people already known to mental health services, who experience a crisis that leads to police involvement, systems should seek to understand whether they should have received earlier intervention, and whether any additional provision is needed within the local care pathway to support people to stay well and not reach the point of crisis. For example, all areas should ensure that their community-based mental health care and crisis care is accessible via the NHS111 ‘select mental health option’ and sufficiently responsive.
- Understanding variation in the use of Section 136 by analysing data by protected characteristics, and taking steps to address any unwarranted variation. For example, at a national level, we know Black people are disproportionately likely to be held under Section 136 (see Home Office data). The cultural appropriateness of the community mental health may need to be improved through working with VCFSE organisations that are ethnic-led and/or support ethnic minority

communities. This is in line with the PCREF, implementation of which is mandatory for all mental health trusts by the end of 2024/25.

4.5.5 Managing demand for and capacity of HBPoS

Effectively managing the demand for, capacity of and onward flow from HBPoS will enable timely police handovers. Demand may depend on time of day, day of week and other factors.

Some suggested actions in relation to this include:

- Analysing data to understand the HBPoS capacity required to meet demand, requirements for 24/7 staffing, and the reasons why HBPoS reach full capacity (for example, waits for inpatient admissions). Data should also be analysed to identify how frequently people require urgent assessment or treatment of physical health needs alongside mental health support – these people will need to go to the ED as an HBPoS would not be appropriate. Additionally, an assessment should be made of how often children and young people require an HBPoS. Any gaps identified between the current provision of HBPoS and the agreed model should inform commissioning decisions and any other actions required. ICBs should assess the funding implications and if additional resource is required, consider how this can be met.
- Developing arrangements to coordinate the use of HBPoS. Local areas should have systems in place to advise police officers of the closest HBPoS that has capacity to receive someone. This could be achieved through police contacting the HBPoS duty nursing officers or professional advice lines (described above). To work effectively, HBPoS coordinators will need access to real-time HBPoS capacity. Systems may also wish to explore local agreements for neighbouring HBPoS to share capacity, particularly at times of peak demand, noting that where such agreement exists, the police should only take a person to a HBPoS in a different locality if a healthcare professional agrees this is in the person's best interests.
- Improving the timeliness of MHA assessments to reduce the time an individual spends in an HBPoS by:
    - Analysing data to understand frequency and patterns of demand for MHA assessments across the ICB and using this to plan Section 12 doctor and AMHPs staffing. Good practice suggestions in relation to Section 12 doctor availability can be found via this FutureNHS link.
    - Ensuring HBPoS staff notify the local AMHP service of the need for an MHA assessment as soon as clerking and an initial check of the person's needs (which may show there are reasons to delay the assessment, for example, the person being intoxicated or having urgent physical health needs) is completed. The HBPoS should also give the AMHP service a named contact who can provide further information, if required.
    - Developing cross-border agreements to clarify responsibilities between neighbouring areas, to avoid situations where there can be a difference of opinion about who should conduct an MHA assessment when a person is taken to an HBPoS outside the area they live.
- Using data to identify how often and in what types of cases handovers from the police to health services cannot be completed within 1 hour (ensuring data is

pseudonymised/anonymised). This can pinpoint the challenges in staffing and demand that need to be addressed and inform discussions with the police about the types of situations in which it is appropriate for them to remain in attendance.

- Commissioning services to support the running of HBPoS. For example, Hampshire and the Isle of Wight ICB delegates the coordination of their HBPoS to its commissioned secure transport provider, which works in partnership with the mental health trust to manage HBPoS occupancy and provide support within it. Police officers contact the secure transport provider directly to arrange conveyance and handover of the person to the HBPoS. In other areas, VCFSE or peer support services provide a dedicated support worker who can sit with the person while they wait for assessment or onward care.

4.5.6 Improving experiences of HBPoS and EDs for people held under Section 136

Implementation of the NPA:RCRP presents an opportunity to consider what improvements can be made to improve the experiences of people when they are held under Section 136. We recommend that services work with people with lived experience to do this. Below are suggested areas to consider; see also the CQC A Safer Place to Be report:

- Reviewing the environment to identify improvements that can be made to help people feel as safe and comfortable as possible within it, including providing facilities that are age appropriate (for example, chairs that are not too low for an older person) and meeting the needs of people with a range of mental health, physical health, sensory and communication needs.
- Ensuring staff working with people held under Section 136 have the right skills and access to relevant support and training – with training ideally co-delivered by people with lived experience. People working in HBPoS should be trained and competent in:
  - Supporting people who are in acute mental health crisis, in a way that is trauma-informed, compassionate and person-centred.
  - Using de-escalation and restraint reduction techniques to manage situations without the use of restrictive interventions. This training should adhere to RRN standards, which include specific guidelines for people with mental health needs who may also have a learning disability or be autistic (see Appendix 24 of the standards).
  - Providing age-appropriate care to children, adults and older adults. HBPoS staff are often adult mental health practitioners and it is particularly important that they are able to apply contextual safeguarding principles and understand the role of the network around a child or young person. MHA assessments should also be conducted by clinicians who specialise in working with children and young people.
  - Providing culturally appropriate care to people from racialised and ethnically diverse communities who are in crisis, for example, understanding different cultural descriptions or interpretations of symptoms and enabling access to interpreters.
  - Recognising the needs of people with a learning disability and autistic people and how to adjust care to meet these needs. At a minimum, mandatory Oliver McGowan training must be completed.

    - Providing appropriate care to people from the LGBT+ community, including using inclusive language.
    - Supporting people who are intoxicated with drugs or alcohol, and recognising when people have acute physical health needs that require medical attention. To support this, staff should have completed basic life support training and have access to emergency first aid equipment.
- Ensuring HBPoS staff have access to health records to understand the needs of people brought to the service and to record information about the diagnosis, treatment and care of individuals. Where possible this should include access to both primary and secondary care records. Having this information will help staff to put the right support in place as quickly as possible to minimise a person's distress and can also facilitate faster handover of care from the police.
- Ensuring the person's needs and preferences shape decisions about their care. Staff should discuss care needs and preferences with the person and the family and carers that they have consented to involve in their care (see section 3.7). Care notes should also be reviewed, including the content of any crisis/safety plans and advanced directives, which should be followed as far as possible.

4.5.7 Additional considerations when EDs are used as a place of safety

Many of the above points are as applicable to EDs as to HBPoS. However, EDs are generally a less therapeutic environment in which to receive people, and when used as a place of safety, there are additional considerations to ensure people receive the best possible care. Good practice suggestions include:

- Ensuring a senior ED doctor, the nurse in charge and, if possible, a member of the psychiatric liaison team meets with the police to obtain information about the circumstances of the individual's detention, presenting risks and any physical health needs. The handover from police to health services should be completed in line with the local handover protocol (see section 4.5.3) and all legal duties. Should a member of the psychiatric liaison team not be present at the initial handover (and this team are part of the local Section 136 pathway), ED staff should facilitate the subsequent handover to this team by giving them the information obtained from the police along with that from the initial ED assessment.
- Ensuring that as soon as the person arrives in the ED, a referral is made to the local AMHP service for an MHA assessment (unless there are factors such as urgent physical health needs or intoxication, which means that it is best to delay assessment). The ED should provide a named contact, who the AMHP service can liaise with for further formation, if required, and communicate the information provided by the police officer to this service.
- Ensuring that an urgent joint review takes place between emergency medicine and the psychiatric liaison team if police officers have applied mechanical restraint (such as handcuffs or leg restraints), to determine whether the mechanical restraint can be ended immediately. If it is not safe to do so, procedures set out in Chapter 26 of the MHA Code of Practice should be followed.
- Using de-escalation strategies if a person's agitation or aggression is such that the police cannot safely handover and leave, with restrictive intervention (including rapid tranquilisation) only used as a last resort to protect a person's safety or wellbeing,

after other strategies have not worked. If restrictive intervention is used, the person will need to be monitored, and its use documented.
- Ensuring the psychiatric liaison team liaise with ED staff to decide whether it is in the person's best interests to be transferred to an HBPoS once capacity becomes available and/or after physical health treatment has been provided.
- Minimising the use of hospital security for undertaking observations. As set out in section 4.2.2, every hospital should have provision or develop plans for in-house observation by appropriately skilled and trained staff (in conjunction with hospital security where there is risk of violence), with systems working towards ending the use of hospital security for observations.

Services can use the Royal College of Emergency Medicine guide to Section 136 for EDs to develop and improve their processes for handling Section 136 cases in the ED. See also section 4.2.2 of this guidance for information on providing good care to people with mental health needs in EDs.

An initiative being trialled in West Sussex is to situate AMHPs in the ED to conduct MHA assessments following referral, working in partnership with the psychiatric liaison team. This is reducing waiting times and enabling earlier handovers from the police.

4.5.8 Reviewing progress with implementation and responding to escalations

We recommend that the following measures are collected, analysed and used to inform NPA:RCRP implementation, with each broken down by protected characteristics (such as race, age and whether someone has a co-existing physical health problem disability, a learning disability, or is autistic), and any other relevant inequalities:

- Number of uses of Section 136 and the proportion involving people already receiving support from mental health services.
- Number and percentage of cases where police sought advice from a mental health professional before holding a person under Section 136.
  - If advice was sought, the number and percentage of cases where the outcome was and was not use of Section 136.
  - If advice was not sought, the reasons it was not practical to do so.
- Length of time that a person is held under Section 136, handover time from police to health services, and the reasons for any handover times being longer than 1 hour.
- Utilisation levels of each HBPoS, including whether the people taken to an ED required treatment for an urgent physical health need or not.
- Number and percentage of people held under a Section 136 who following an MHA assessment go on to:
  - Be detained in hospital, and where they are not, the reasons for this.
  - Receive community-based crisis care.
- Time to allocate a mental health inpatient bed, where an MHA assessment following Section 136 indicates that this is required.

Agreement will need to be reached between the police, AMHP and health services on who is best placed to collect which metrics and how data will be shared across agencies in a way that complies with data protection legislation and confidentiality duties (see section 3.7).

Multi-agency partners should monitor these measures and review any escalated cases, with a view to informing continuous learning and improvement on the use of police powers, including reducing any unwarranted variation by any protected characteristic; improving people's experience of handovers; and reducing handover times.

5. Acknowledgements

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- NHS Providers

Right Care Right Person

Sefton Council

Right Care Right Person

Right Care Right Person (RCRP) is an operating model for Police and Partners to ensure that calls for service are responded to by those with the right skills and expertise to provide the best possible service.

An approach designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs.

At the centre of the RCRP approach is a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents

The new threshold for a police response to a mental health-related incident is:

- *to investigate a crime that has occurred or is occurring; or*
- *to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm*

Right Care Right Person

***"*Whilst it remains imperative that the police continue to identify risk (THRIVE) the focus will now be on the most appropriate agency to respond to the risk. Even though a risk is identified it does not necessarily mean it is a police risk"**

- Initially developed in Humberside
- Specific areas of practice addressed gradually in a phased way over a period of years.
- Planning via local Crisis Care Concordat with key partners (building on existing networks).
- Reporting high levels of success for the police in relation to hours saved and arrest records.
- Implementation varies across the country – Merseyside Police have worked collaboratively. Other areas less so….

Legal Considerations

<u>European Convention on Human Rights / Human Rights Act (1998)</u>

- **<u>Article 2</u> – "**Right to Life" - The duty on the state not to take life and protect against specific threats to life.
- **<u>Article 3</u> -** "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

<u>The police assume a 'Duty of Care' by agreeing to undertake a positive act.</u> *<u>Sherratt v Chief Constable of Greater Manchester Police –</u>* <u>A well intentioned call handler assumed responsibility for the incident on behalf of the police and therefore, a duty of care</u>

- **Do the police have a legal power of entry?**
- **What are we asking the police to do?**

Decision-Making Guide

- **<u>Decision-Making Toolkit Considerations</u>**

  - Is there an immediate risk to life / serious harm?
  - Is there a ‘present and continuing’ risk to any other person, other than the subject?
  - Is a crime suspected of being committed?
  - Are the police required to provide a physical restraint to save life?
  - Is the location of the individual known? – Have reasonable enquiries been made to establish the whereabouts?
  - Who is reporting the concern? Member of the Public/Partner Agency
  - Is the subject under 18-years. Is there an immediate safeguarding risk to prevent significant harm?

RCRP Impact on Children

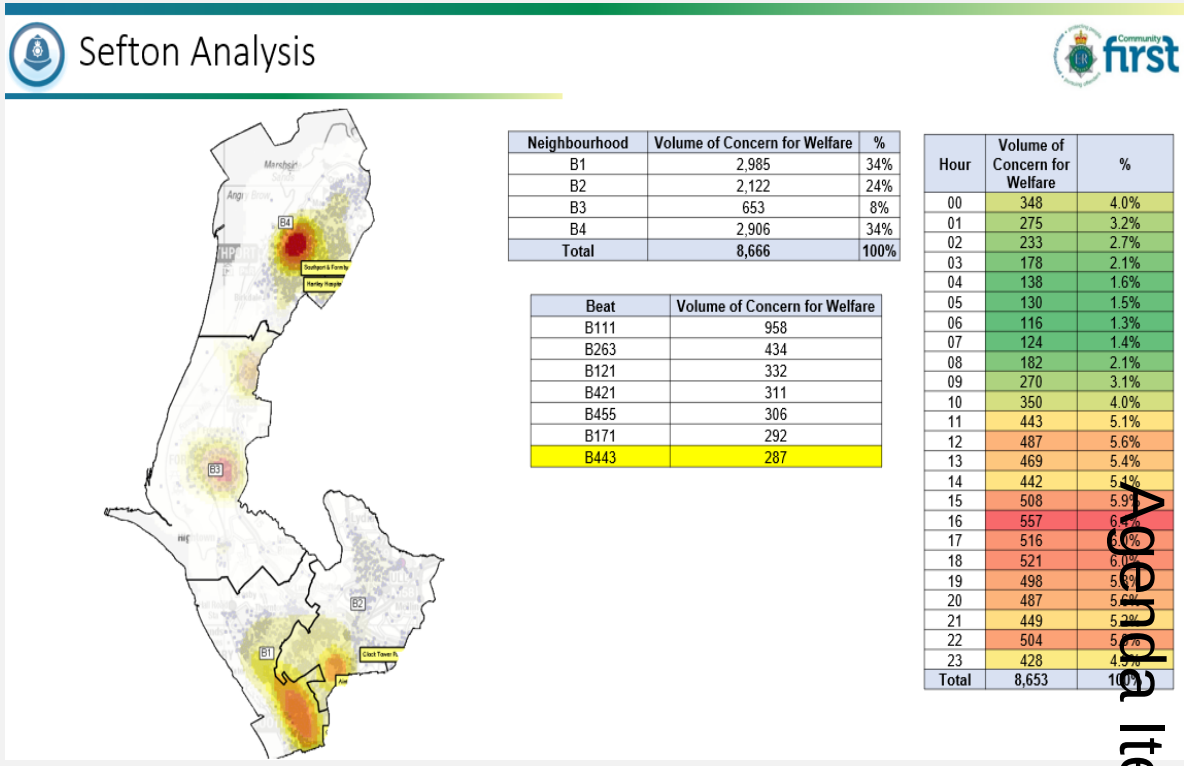
- NPA – " Consideration should also be given to ensuring that the way each incident is risk assessed against the RCRP threshold is appropriate for individual needs, for example, in relation to children and young people"

- Local Authority Child Safeguarding Boards and Alder Hey Hospital received bespoke briefings to provide reassurance.

- The paradox of involving children in RCRP provides greater opportunities for immediate safeguarding to be addressed, considering the PPO available to police, using the lower threshold of 'Significant Harm' as opposed to 'immediate risk to life'

The picture in Sefton

- Merseyside Police had a total of 47,168 concern for welfare incidents in 2022/23.
- For 2022/23 there were 8,666 concerns for welfare raised with Merseyside Police within Sefton.
- 46% of welfare concerns were recorded as directly related to mental health concerns.
- Merseyside Police deployed to 67% of welfare checks requested across Merseyside, equating to 5806 deployments within Sefton.



Neighbourhood	Volume of Concern for Welfare	%
B1	2,985	34%
B2	2,122	24%
B3	653	8%
B4	2,906	34%
Total	8,666	100%

Beat	Volume of Concern for Welfare
B111	958
B263	434
B121	332
B421	311
B455	306
B171	292
B443	287

Hour	Volume of Concern for Welfare	%
00	348	4.0%
01	275	3.2%
02	233	2.7%
03	178	2.1%
04	138	1.6%
05	130	1.5%
06	116	1.3%
07	124	1.4%
08	182	2.1%
09	270	3.1%
10	350	4.0%
11	443	5.1%
12	487	5.6%
13	469	5.4%
14	442	5.1%
15	508	5.9%
16	557	6.4%
17	516	6.0%
18	521	6.0%
19	498	5.8%
20	487	5.6%
21	449	5.2%
22	504	5.8%
23	428	4.9%
Total	8,653	100%

North West Ambulance Service

The role of an emergency ambulance service is to triage, treat and, where appropriate, convey patients to a healthcare facility, so that they can receive care for a health need. This means that NWAS can provide the following services and support to patients with an urgent mental health need, or other concern for welfare:

- Facilitate access to mental health support via 111, either by telephone or online, by directing callers to the appropriate local mental health crisis team.

- Callers dialling 999 are triaged using the NHS Pathways tool. If an ambulance is required, this will be dispatched, for example if there is an immediate physical and mental health need that requires an emergency response. This can include a confirmed physical health issue, or mental health need with a co-associated physical need, such as an overdose or attempted hanging, that requires an emergency response.

- 7 mental health response vehicles (MHRVs). They will be used to assess patients who have had a mental health telephone triage that suggests that they require a face-to-face assessment from a mental health practitioner, during the operational hours to be agreed with local commissioners.

Communication

- **Guidance for staff re responses to welfare concerns**
- **External messages circulated to ensure that members of the public know what to expect from the police.**
- **Information sent to commissioned providers**
- **Regular meetings with partners with a forum to raise issues**
- **Local Authority leads meet regularly**

- **Merseycare crisis support: Help in a crisis (merseycare.nhs.uk)**

Phase 2 & Phase 3

- **Phase 2 - AWOL (October 2024)**
- **Phase 3 - S135/136 MHA and conveyance (March 2025)**

- **Considerations around the observational support provision in line with the National Partnership Agreement (Police to handover observational support after 1-hour).**

- **Observational Support to be provided even where there may be RAVE Factors present.**

- **Considerations regarding to the training that staff are provided (control and restraint), suitability of location and resource management.**

- **Common sense approach will be applied to individuals who are extremely violent.**

Scenario 1

Police receive a call that Derek has left his nursing home in the last 10-minutes.

Derek is 83-years of age and in good physical health but has suffered with dementia in recent years.

Derek has walked out of the home last month and was found at Liverpool South Parkway, wanting to purchase a train ticket to Manchester to see his brother (who sadly died 15-years ago).

Derek is described as 6 feet tall, medium build, short grey hair and glasses. Derek does have a mobile phone with him, cash and credit cards and is dressed in white shirt, blue tie and grey trousers.

Derek does not have any local family and the NOK lives in Aberdeen.

Scenario 2

A postman calls saying that he has not seen the 88-year-old male that lives in an address on his round for several days. The mail is piling up, the curtains are closed and his car is parked on the driveway.

The Postman would ordinarily speak to him as he is a very chatty man. The Postman knows that the 88-year-old male lives on his own and appeared in good physical health the last time he saw him.

Scenario 3

A social worker reports that a service user they support called earlier this morning, saying he was having a mental health breakdown. He has cancelled a planned appointment today.

The social worker states that they are busy and do not have any staff available to conduct a welfare check.

The informant believes the male is still at his home address as the landline is being answered and immediately put down.

Scenario 4

A Social Worker has attended a female's address as it was reported that she was hoarding large amounts of rubbish inside bin bags at the address.

The Social Worker enters the property with the permission of the occupier and as she is about to start the hoarding assessment when the female discloses that she has taken all 12 of her pregabalin tablets (1000mg), as she would "rather die than have to live elsewhere".

The female is not known to the social worker who cannot assess if her presentation is out of the ordinary or not.

The ambulance service have been contacted and have graded this as a Category 2, with an ETA of 90-mins.

The Social Worker believes this requires a faster response.

Scenario 5

Paul who is 55-years has been living on his own for the last 6 years since his wife has passed away.

Recently, he has recontacted his bereavement counsellor, Sandy, confessing his undying love for her. Paul has e-mailed over the weekend, requesting Sandy goes on a date with him.

Paul has delusional thoughts and now believes that Sandy killed his wife so they could be together. Paul's children believe their dad is suffering with his mental health as he has stopped all communication with them, which is completely out of character and is living as a recluse. They are concerned that he may harm himself if he believes Sandy is rejecting him.

Social Services have also been contacted by Paul's children with the concerns. Social Services request that the police attend and speak to Paul to assess what is happening.

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Report Title: Here

Date of meeting:	Tuesday 7 January 2025		
Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)		
Report of:	Director of Public Health		
Portfolio:	Health and Wellbeing		
Wards affected:	All wards		
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 12 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 2024 through August 2024.

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.

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

Recommendation(s):

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 November briefing of the Cabinet Member for Health and Wellbeing.

Reasons for the Recommendation:

Committee Members have asked to receive this report routinely.

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

None

1. The Rationale and Evidence for the Recommendations

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 enduring impacts of the Coronavirus pandemic and high cost of living,
- Make recommendations as required.

The complete Public Health Performance Framework – August 2024 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

- pregnancy (conceptions in under 18s and smoking rates at the end of pregnancy)
- health behaviours (excess weight in adults, physical activity and inactivity in the adult population, and admissions to hospital related to alcohol)
- public health services (successful drug treatment rates and NHS Health Checks)
- preventable causes of death (mortality rate from suicide and undetermined injury)

Updated indicators discussed in this report mostly reflect data collected during the so-called 'post-pandemic' phase, dating from 2022 up to spring 2024 in the case of NHS Health Checks**.** This period also spans a period of high cost of living and falling living standards. Subsequent updates may reveal population health consequences associated adverse climate events as well.

As Sefton's large gap in life expectancy at birth shows (updated previously - see full report 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.

3. Overview

3.1 Strengths and improvements

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

- **Smoking in pregnancy:** prevalence in the north of the borough has continued to fall slightly faster than the national average and in the south of the borough rates are falling approximately in line with the national average. Overall, Sefton (8.5%, n=202) has remained in line with the national average rate (8.8%) for a fourth successive year. As noted in previous reports, progress on this outcome 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.
- **Successful Completion of drug treatment:** the Office for Health Improvement and Disparities (OHID), which is responsible for PHOF will soon switch to using a new national measure of "showing substantial progress" - looking at how much people have reduced their substance use in drug treatment. Under this measure Sefton is in line with national averages. **The Latest Sefton data showing substantial progress (July 2023 - June 2024)**
    - Opiates and/or Crack – Sefton 45%, England 45%.
    - Opiates only – Sefton 65%, England 58%.
    - Non-opiates only – Sefton 54%, England 49%.

- **Alcohol-related hospital admissions rate (narrow):** in the financial year 2022/23 were 514 per 100 000 as a directly standardised rate. The term directly standardised means that differences in the age profile of Sefton's population have been adjusted for. This represents **quite a large drop from 598.0 per 100 000 DSR in the later pandemic period of 2021/22, which is reflected in the 6-point rank improvement**.

3.2 Points to note

- **Overweight and obesity in adults:** Overweight and obesity in adults has improved by 2 percentage points. **Prevalence is 69.2% for 2022/23** compared to 71.2% in 2021/22. Sefton continues to **have a statistically significantly higher rate than England (64.0%)**.
- **Physical inactivity:** The latest data show that **Sefton has a statistically significantly higher rate of physical inactivity (26.3%) compared to England (22.6%, stable trend),**

and this was also the case in the two years prior to the start of the Coronavirus pandemic. National data shows 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.

- **NHS Health Checks:** 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. **The PHOF provides cumulative outcomes on a rolling five-year cycle (2020/21 to 2024/25).** During these years, the proportion of the national eligible population which was offered a health check was 57.9%. In the North West the average was significantly higher – 82.1%. In **Sefton** the proportion was **3.9%.**
- **Mortality from suicide:** Incidence of suicide and injury of undetermined intent in Sefton **remains in line with the national picture and North West rate, with an expected level of variation** year to year. This similarity with England rates extends to the wider range of indicators available in the OHID suicide profile. Sefton's suicide rate has not been statistically significantly higher than England's since 2015-17 and has not been statistically significantly lower since 2007-09.

3.3 Health inequality

- **None of the indicators discussed in this report include data on socio-economic inequalities in population health that are drawn directly from Sefton level data**. This is because the numbers of health events being counted year to year is mostly too small to perform this type of analysis in a valid way. However, appropriate interpretation of breakdowns from national data, e.g. according to indices of multiple deprivation is discussed in context for Sefton.
- **Sefton's alcohol-related admission** rate for males is significantly higher than the England average for males and is almost 2.5 times the admission rate for females (which is in line with the England rate). The **gap between Sefton and England remains significant** but has **closed to an 8.0% difference from a recent peak, 45.0%** higher than England rates in 2019/20.

3.4 COVID-19 and cost of living

- Updated indicators discussed in **this report mostly reflect data collected during the so-called 'post-pandemic' phase, dating from 2022 up to spring 2024 in the case of NHS Health Checks**
- 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. Noting these socio-economic factors, it is likely that longer-term effects of the pandemic and increased cost of living have **at least maintained if not widened health inequalities in this important health behaviour**.
- The **unequal health and social impacts of the pandemic** continue to be well documented. **Negative effects of high cost of living** on health fundamentals such as adequate diet, social connection, and protection from cold risk further tipping the scales towards greater health inequality in Sefton. A third strand of health risk and inequality comes from the growing likelihood of **serious climate events**, e.g. flooding and drought.

3.5 Response

- **Public Health services have an important part to play in responding to and preventing higher 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,
    - Plans for improved outreach support to the most vulnerable in the community to access sexual health care, including young people with care experience.
    - Updates to the obesity action plan to reflect the even more challenging behaviour change context created by the cost-of-living crisis, and additional training to develop skills and capacity in tiers one and two of the draft adult weight management pathway.
    - A range of improvement actions to substance use support that reflects the impact of additional physical and mental health, and social needs on recovery and wellbeing.
    - More primary, secondary and tertiary prevention activities focused on alcohol use across the life-course.
    - Sefton suicide prevention board is refreshing its action plan and has started to hold spotlight sessions to forge stronger links with relevant partners working on areas such as substance use, domestic abuse and gambling.

2. Financial Implications

Not applicable

3. Legal Implications

Not applicable

4. Risk Implications

Not applicable

5 Staffing HR Implications

Not applicable

6 Conclusion

Alternative Options Considered and Rejected:

None

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

What consultations have taken place on the proposals and when?

(A) Internal Consultations

Executive Director of Corporate Services and Commercial (FD7893/24) and the Chief Legal and Democratic Officer (LD5993/24) 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
Telephone Number:	
Email Address:	helen.armitage@sefton.gov.uk

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 November 2024 briefing.

Copy of Public Heath Performance Framework indicators August 2023

Background Papers:

There are no background papers available for inspection.

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Cabinet Member / OSC (ASCH) Update Report Agenda Item		
Councillor	**Portfolio**	**Period of Report**
Mhairi Doyle	Health and Wellbeing	March – August 2024
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 enduring impacts of 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 2023 to February 2024. This report concentrates on 12 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 to August 2024. Most of the indicators under discussion relate to the years 2022 and 2023 but can relate to data collected as early as April 2021, e.g. deaths from suicide and undetermined injury, and as late as June 2024 for NHS Health Checks.

These indicators, and this accompanying report serve to describe the scale and distribution of population health priorities, their underlying causes, and associated health inequalities. This overview lends context by discussing trends over time, and relevant comparisons with the national picture, other local authorities in the North West and Liverpool City Region (LCR), and areas with similar characteristics to Sefton (Statistical Neighbour Group, SNG). Information is also provided about Public Health led improvement actions that target these high-level indicators. Where relevant, the report highlights impacts from the pandemic and high costs of living.

The complete Public Health Performance Framework – August 2024 is provided in Appendix A, and separately with this report. 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

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

comparison to its previous value; summary bar charts to enable comparison with local authorities in LCR; 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).

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.

To a greater or lesser extent, all indicators are subject to a range of social and economic influences that are outside the scope or control of individual services or programmes. This fact should not diminish the value or population health impact of preventative public health interventions.

2. Summary

Updates in this report include indicators associated with

- pregnancy (conceptions in under 18s and smoking rates at the end of pregnancy)
- health behaviours (excess weight in adults, physical activity and inactivity in the adult population, and admissions to hospital related to alcohol)
- public health services (successful drug treatment rates and NHS Health Checks)
- preventable causes of death (mortality rate from suicide and undetermined injury)

- **Strengths and improvements**: This review of updated population health indicators includes some notable areas of continuing good performance and improvement.

    - **Smoking in pregnancy:** prevalence in the north of the borough has continued to fall slightly faster than the national average and in the south of the borough rates are falling approximately in line with the national average. Overall, Sefton (8.5%, n=202) has remained in line with the national average rate (8.8%) for a fourth successive year. As noted in previous reports, progress on this outcome 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.
    - **Successful Completion of drug treatment:** the Office for Health Improvement and Disparities (OHID), which is responsible for PHOF will soon switch to using a new national measure of "showing substantial progress" - looking at how much people have reduced their substance use in drug treatment. Under this measure Sefton is in line with national

averages. **The Latest Sefton data showing substantial progress (July 2023 - June 2024)**

- Opiates and/or Crack – Sefton 45%, England 45%.
- Opiates only – Sefton 65%, England 58%.
- Non-opiates only – Sefton 54%, England 49%.

- **Alcohol-related hospital admissions rate (narrow):** in the financial year 2022/23 were 514 per 100 000 as a directly standardised rate. The term directly standardised means that differences in the age profile of Sefton's population have been adjusted for. This represents **quite a large drop from 598.0 per 100 000 DSR in the later pandemic period of 2021/22, which is reflected in the 6-point rank improvement**.

- **Health inequality**
  - **None of the indicators discussed in this report include data on socio-economic inequalities in population health that are drawn directly from Sefton level data**. This is because the numbers of health events being counted year to year is mostly too small to perform this type of analysis in a valid way. However, appropriate interpretation of breakdowns from national data, e.g. according to indices of multiple deprivation is discussed in context for Sefton.
  - **Sefton's alcohol-related admission** rate for males is significantly higher than the England average for males and is almost 2.5 times the admission rate for females (which is in line with the England rate). The **gap between Sefton and England remains significant** but has **closed to an 8.0% difference from a recent peak, 45.0%** higher than England rates in 2019/20.

- **Points to note.**
  - **Overweight and obesity in adults:** Overweight and obesity in adults has improved by 2 percentage points. **Prevalence is 69.2% for 2022/23** compared to 71.2% in 2021/22. Sefton continues to **have a statistically significantly higher rate than England (64.0%)**.
  - **Physical inactivity:** The latest data show that **Sefton has a statistically significantly higher rate of physical inactivity (26.8%) compared to England (22.6%, stable trend),** and this was also the case in the two years prior to the start of the Coronavirus pandemic. National data shows 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.
  - **NHS Health Checks:** 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. **The PHOF provides cumulative outcomes on a rolling five-year cycle (2020/21 to 2024/25).**

During these years, the proportion of the national eligible population which was offered a health check was 57.9%. In the North West the average was significantly higher – 82.1%. In **Sefton** the proportion was **3.9%.**

- **Mortality from suicide:** Incidence of suicide and injury of undetermined intent in Sefton **remains in line with the national picture and North West rate, with an expected level of variation** year to year. This similarity with England rates extends to the wider range of indicators available in the OHID suicide profile. Sefton's suicide rate has not been statistically significantly higher than England's since 2015-17 and has not been statistically significantly lower since 2007-09.

- **COVID-19 and cost of living effects**
  - Updated indicators discussed in **this report mostly reflect data collected during the so-called 'post-pandemic' phase, dating from 2022 up to spring 2024 in the case of NHS Health Checks**
  - 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. Noting these socio-economic factors, it is likely that longer-term effects of the pandemic and increased cost of living have **at least maintained if not widened health inequalities in this important health behaviour**.
  - The **unequal health and social impacts of the pandemic** continue to be well documented. **Negative effects of high cost of living** on health fundamentals such as adequate diet, social connection, and protection from cold risk further tipping the scales towards greater health inequality in Sefton. A third strand of health risk and inequality comes from the growing likelihood of **serious climate events**, e.g. flooding and drought.

- **Response**
  - **Public Health services have an important part to play in responding to and preventing higher 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,
    - Plans for improved outreach support to the most vulnerable in the community to access sexual health care, including young people with care experience.
    - Updates to the obesity action plan to reflect the even more challenging behaviour change context created by the cost-of-living crisis, and additional training to develop skills and capacity in tiers one and two of the draft adult weight management pathway.

- A range of improvement actions to substance use support that reflects the impact of additional physical and mental health, and social needs on recovery and wellbeing.
- More primary, secondary and tertiary prevention activities focused on alcohol use across the life-course.
- Sefton suicide prevention board is refreshing its action plan and has started to hold spotlight sessions to forge stronger links with relevant partners working on areas such as substance use, domestic abuse and gambling.

Recommendation

The Committee is recommended to,

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

3. Overview

Appendix A contains the Public Health Performance Framework dashboard at August 2024.

Six of the 12 updated indicators have a green direction of travel arrow, showing the current figure has improved when compared to the previous figure (smoking in pregnancy rates in the north and south of Sefton, excess weight in adults, successful drug treatment outcomes, prevalence of excess weight in adults, and alcohol-related admissions to hospital). This symbol does not connote a change that is necessarily part of a meaningful improvement in trend.

The remaining six updated indicators have red arrows, showing that the latest data is less favourable compared to the previous value (under-18 conceptions, physical activity and inactivity in adults, NHS Health Check invitation and completion rates, and mortality from suicide/injury of undetermined intent).

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.

The North West RAG-rated rankings show **two green indicators, showing relative improvement** – excess weight in adults and alcohol-related hospital admissions; and **five indicators** are colour-coded red, showing **a relative deterioration** – smoking at the time of delivery (SATOD) in South Sefton, under-18 conception rate, physical activity and inactivity in adults, and successful completion

of treatment for opiate use. SATOD in South Sefton is an example of where the trend continued downwards, i.e. smoking in pregnancy rates improved, but South Sefton's ranking amongst comparator areas in the North West worsened (from seventh best to fifteenth). This shows that several areas managed to drop their rates faster during this period and illustrates the usefulness of the rankings information presented in the framework. The other **five indicators coded yellow** saw no change in their ranked position relative to other local authorities in the North West region - smoking at the time of delivery in North Sefton, NHS Health Checks invitation and completion, alcohol-related hospital admissions, and mortality from suicide/injury of undetermined intent. **Note** that the suicide and undetermined injury rate shows a small increase in the latest data, but there is no change in Sefton's position in relation to other local authorities in the North West. This is suggestive of fluctuation occurring in parallel, probably reflecting a degree of universality from pandemic and cost of living influences.

In comparison to **Sefton's five closest statistical neighbours**, Sefton has maintained its position in the rankings (yellow) for smoking in pregnancy, physical activity in adults, successful drug treatment for non-opiate use, alcohol-related admissions, NHS Health Checks invitation and completion, and mortality from suicide/injury of undetermined intent. **Ranked position improved (green)** in three indicators – excess weight in adults, physical inactivity, and drug treatment for opiate use. obesity in reception, and premature mortality from respiratory disease. Only one indicator saw a fall in **ranked position worsened (red)** – under 18 conceptions. **However,** only the two SATOD indicators fall in the top/best ranked half of the distribution. The other ten updated indicators are in positions fourth, fifth or sixth out of six.

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**

[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)

changes post-Covid. This breakdown is likely to reflect cost of living pressures in future updates.

- 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 new Stop Smoking Service Mobilised on the 1st April 2024 following completion of a tendering process.
- An application for Sefton to take part in the Swap to Stop pilot has been successful and aims to encourage current smokers to swap cigarettes for a free trial of e-cigarettes (the scheme does not permit disposable vapes).
- Sefton has received funding from the national Smokefree Generation programme to support access to support local stop smoking services, plans are currently being developed around the use of this funding.
  Phase 4 of the C&M Targeted Lung Health Check pilot has started with Southport and Formby anticipated to go live in early 2026. This programme is due to be rolled out nationally following successful pilots across the UK.

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 Government has 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 tobacco treatment services in hospitals.

Key points

- In 2022/23 **8.5% (n=202) of pregnant women in Sefton were identified as continuing to smoke at time of delivery.** This compares to 9.0% in 2020/21; 10.3% in the North West (Sefton's rate rank's 6th lowest), and 8.8% in England. Sefton has remained in line with the national average rate for a fourth successive year and continues to improve at a slightly faster rate.
- The latest updated data for the former CCG areas of South Sefton and Southport and Formby is from the 12-month period beginning April 2023 show further reductions compared to the preceding year. In **South Sefton** 8.1% of deliveries were to a mother who continued to smoke. This is down 1-percentage point but has moved from rank 7 to 15 in the North West, suggesting other previous CCG geographies improved at a faster rate. However, South Sefton retained its second-place ranking in its statistical neighbour group.
- **Southport and Formby 5.4%.** Following a 2-percentage point drop, smoking in pregnancy prevalence in Southport and Formby is now statistically significantly lower than the national rate and the North West rate and remains lowest among statistical neighbours.
- The dark blue trendline in the framework (Appendix A) illustrates the impressive and ongoing decrease in smoking through pregnancy that is being achieved in Sefton, with prevalence in the north of the borough falling slightly faster than the national average and the south of the borough now falling approximately in line with the national average. This **internal inequality** has narrowed from baseline, but the gap has not yet been closed completely.
- Although Sefton did not quite achieve the target reduction to 6% in 2022 the **external inequality in smoking in pregnancy has been closed**.

Action and progress update

- Mersey and West Lancashire Teaching 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 Mersey and West Lancashire Teaching Hospital sites 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:
    - Carbon monoxide (CO) monitoring is in place. This ensures an objective measure of women's smoking status, rather than self-report.
    - Guidelines have been 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 Mersey and West Lancashire Teaching Hospital.

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 parents 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 June 2022, the crude rate of conceptions in women under the age of 18 **increased slightly to 17.5/1000** from 15.7/1000 at the end of 2021. This latest rate is similar to pre-pandemic levels in the period 2017 through 2019. This apparent rebound from a nadir of 12.6/1000 in 2020/21 likely reflects factors associated with the pandemic, which temporarily suppressed the conception rate. It is also important to remember that **numbers are small** from a statistical point of view (60-100 conceptions per year) and large year to year variation is expected, as seen in the trendline.
- Nevertheless, **Sefton's rate remains in line with England and the North West,** but smaller rate increases in some other areas means that Sefton now **ranks in the middle of the range** in the North West and among similar local authority areas.

Action and progress update

- Pharmacy emergency hormonal contraception provision has been recommissioned by the Sexual Health Service.

- The national pharmacy contraception service where young people can initiate and continue oral contraception through community pharmacists is now available in Sefton.
- 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 have completed the teenage pregnancy prevention self-assessment (short version) to confirm current situation and identify any gaps.
- Service is implementing ChatHealth and online booking to provide increased number of access routes to the service in a means more in line with needs of young people.
- The Sexual Health Service has agreed a 2-year trial of a digital C-Card scheme, where young people can collect condoms from registered sites free of charge.
- Through the newly appointed Health Improvement Manager, the Sexual Health Service is developing plans for outreach to support those most vulnerable in the community to access sexual health care, including young people with care experience.

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 practically unheard of 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.

In 2017, the Government 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 that requires largescale restaurants, cafes and takeaways to use energy labelling on their menus and prevents retailers from offering promotional deals on the unhealthiest foods.

Nationally, the proportion of children who are **obese in reception class is twice as high in the most compared to the least deprived tenth of the population (12.4% vs 5.8%)**. The social gradient **in year 6 is steeper still (30.2% vs 13.1%).** Looking back to 2016/17, when these ten- and eleven- year-olds were measured in reception, around three children in a class of 30 were classified as obese. In 2022/23 around 7 children in the same class of 30 have a weight for height in the obese range. **This data shows that obesity in England doubled during the primary school years for the reception year of 2016/17.**

The rate of obesity is matched in boys and girls in reception but is a quarter higher in year 6 boys compared to girls. Over the last ten years, **health inequality in childhood excess weight has increased over time because of rising prevalence of obesity and particularly severe obesity in children experiencing the highest levels of disadvantage**.

In reception, obesity is most prevalent in children of Black African ethnicity and lowest in children of Chinese ethnicity (these groups are separated by a three-fold difference). White British children fall in the middle of this range. In year 6, this gap is smaller because the rate of obesity increased 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 therefore the importance of not depending on individualistic interventions to deliver high impact change**.

Key points

- The prevalence of obesity in **reception age** children is **10.3% in 2022/23 – slightly lower than the baseline measure of 11.4% in 2007/08**. The trend over this time is stable.
- In 2022/23 **Sefton is slightly, but statistically significantly higher than England (9.2%)** and has dropped by one percentage point, in line with national figures compared to 2021/22.
- Sefton ranks approximately in the middle of North West local authorities but **continues to have a higher prevalence than all but one statistical neighbour.**

3.5 Obesity in year 6

Key points

- Trend from 2007/8 to 2022/23 shows that nationally, the percentage of children in year 6 who are obese has risen from 18.3% to 22.7%. **During this period, year 6 obesity rates in Sefton have closely tracked the national trend, rising from 17.3% to 23.9% in 2022/23.**
- Approximately half of local authorities in the North West have year 6 obesity rates that are above Sefton's. However, Sefton ranks lowest compared to our five closest statistical neighbours.
- **Over their primary school years, the prevalence of obesity in the most recent current year 6 cohort increased from around one in ten (10.4%, 2016/17) at reception stage to close to one in four (23.9%) in 2022/23.** Faster rates of increase are seen in areas of higher deprivation.

Action and progress update

- The Integrated Wellness Service for children and young people, 'Happy 'n' Healthy' Sefton is now operational as an integrated partnership after being launched in July 2023. Available for children aged 0-19 (up to 25 with SEND) and their families, it brings together all public health commissioned services, including the 0-19 Healthy Child Programme, 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. Signposting across services should also mean that children, young people, and families can reach appropriate support for healthy weight.
- In late 2023, Public Health was successful in securing **'Why Weight to Talk' training (delivered by Food Active)**. This training, which has been offered across all services working with children and young people, upskills front line staff to have meaningful and positive conversations with families around healthy weight, using language that decreases weight stigma. The training also explores the link between weight and adverse childhood experiences and increases the awareness of Sefton's children's weight management pathway.
- A children and young peoples' **weight management snapshot** has been produced and disseminated across all services, which outlines the weight management offer in Sefton, ranging from brief advice to clinical support services.
- The children and family weight management service '**Move It' continues to be delivered to children aged 5-18 year** and their families. Due to increased demand, **additional capacity has also been added to the team to focus on younger children, aged 0-5 years**.

- As part of a **12-month pilot programme, 10 front line practitioners across the 0-19 Service, Active Sefton and Early Help have been trained in HENRY**, a healthy lifestyle programme for families with **0–5-year-olds**. HENRY Programmes and workshops have been delivered across Sefton as part of the pilot, which has now been extended to September 2024.
- The **universal programme for schools 'Active Schools'**, which delivers healthy lifestyle support, continues to be delivered, with a range of options for schools that includes individual workshops or sessions (such as healthy lunchboxes) through to a 6-week healthy habits programme. 74% of Sefton primary schools access the Active School's offer (Qu. 3, 2023-24).
- 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.
- After being piloted in 2022-23, the **School Health Team are continuing to carry out follow up phone calls to parents and carers of children who received National Child Measurement letters**, which classify their children as being very overweight (according to BMI centile). The follow up phone calls allow for personalised advice and support and ensure families are supported to access services that may be of benefit to them, such as the MOVE IT Programme. This has led to a significant increase in referrals to MOVE IT (22.2% increase).
- Under the Obesity Action Plan and its life course approach, the 'Start Well' Obesity sub-group continues to meet frequently. With representatives across the children's partnership, the group continue to push forward the obesity agenda and actions that will improve healthy weight locally.
- Active Sefton continue to deliver all physical activity support services for children and young people through its facilities and programmes. In addition to those outlined earlier, this also includes the 121 Programme, Be Active school holiday programme and Park Nights.
- Linked to healthy weight, Public Health continue to support the **breast-feeding** offer delivered through Mersey Care. Additionally, **an infant feeding pathway for families facing food insecurity with infants under 1 has also been developed,** which will provide a voucher to families who find themselves in an emergency and unable to access infant formula.
- A **cost-of-living support group** has also been set up to support frontline practitioners by raising awareness of help and support available to families facing financial hardship. An objective of this group is to also increase uptake of the national Healthy Start Programme.
- Sefton Council's **breast-feeding policy to ensure breast feeding mothers can continue after returning to work** has been approved and is now available to support staff. A series of focus groups exploring infant feeding choices and preferences will take place shortly.

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 in this part of the population. The group with the highest rate of excess weight is found in the population living in the most deprived 10% of areas, in which around 7 out of ten adults are overweight or obese. **This high prevalence of overweight and obesity across a shallow socio-economic gradient shows the influence of pervasive changes to our food environment and way of life** that impact virtually everyone – widely available, high-energy foods, more sedentary lifestyle, and more eating away from home.

Interestingly, the extensive national dataset collected from children at reception and year 6 ages shows that the **size and trend of inequalities varies considerably depending on the degree of overweight**. In the **overweight but not obese group** trend has been **stable** for nearly two decades with a growing but **still relatively small socio-economic gap of just 2.4 percentage points**.

In the **obese group,** there is now a **greater than two-fold difference** in rates between the most and least disadvantaged groups, and this **gap has widened** over the past two decades or so because of a **much faster rate of increase in the most disadvantaged 10%** of the population.

Looking at trends in **severe obesity in childhood**, in 2007/08, 1.5% of 10–11-year-olds from the most affluent neighbourhoods were found to have this level of body fatness, and 5.1% of children from the most deprived neighbourhoods. With the onset of the pandemic all socio-economic groups showed an increase prevalence of severe obesity. And in the latest data from 2022/23 the least disadvantaged prevalence of severe obesity had increased to 2.1% - a 40% increase from baseline.

However, in children from the most disadvantaged rates of severe obesity stood at 9.2% - an 80% increase from baseline. **This means rates of severe obesity are now over four times higher in children from the most compared to the least deprived areas.**

This breakdown of national figures suggests that **development of obesity and severe obesity in childhood are more sensitive to socio-economic disadvantage compared to development of overweight.** This is likely to reflect a combination of risk and protective factors broadly related to income. Body composition established in childhood tends to be maintained into adulthood. So, this data has **important implications for the health and wellbeing of the next generation of adults.**

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

- Overweight and obesity in adults has improved by 2 percentage points. **Prevalence is 69.2% for 2022/23** compared to 71.2% in 2021/22. Rank position has improved slightly, dropping from 27th to 24th in the North west and from 6th to 4th amongst SNGs. But this still means that most comparator areas outside of LCR have slightly lower rates of excess weight in their adult populations than Sefton. Sefton continues to **have a statistically significantly higher rate than England (64.0%)**.
- The national trend shows a gradual increase (0.5 -1.0% per year) in the prevalence of excess weight. However, Sefton's trend tends more towards a variable but **essentially stable** picture in recent years.

Action and progress update

- The **six-week weight management programme 'Weigh Forward',** delivered by Active Sefton, continues in a group format, virtually and face to face, in addition to courses being delivered through the Living Well Sefton offer. For those residents who are above their ideal weight and suffering with health conditions, the Active Lifestyles Exercise Referral Programme continues to be available to support with physical activity.
  - Weigh Forward has expanded its reach through training more staff across Living Well Sefton. And there are now more delivery dates across community venues with online and evening offers. There is continued work alongside Active Workforce to offer programmes to partner organisations alongside their current offers.
  - For practitioners there is a regular programme of Making Every Contact Count (MECC) training provided through Living Well Sefton, with new

information added around the impact of alcohol on weight. A MECC champions programme has been set up to help encourage employers recognise the importance of every contact in relation to wellbeing and to designate leads within their organisations to support and encourage this messaging. The introduction of MECC Moments is now being captured on the Integrated Wellness System (IWS) to monitor for trends linked to weight.

  - Active Sefton have received training from a clinical lead to help support staff working with transgender clients to be equipped when addressing matters such as calorie intake and BMI.
  - Following an increase in referrals of individuals with high BMIs (35+), Active Sefton Development Officers have attended an Obesity and Diabetes Level 4 Wright Foundation training course. This will better equip staff to support those with a higher BMI and / or Diabetes.

- The **Living Well Sefton (LWS)** recommission included increased community delivery and support around a healthy weight, within venues such as warm spaces, community pantries and foodbanks, recognising the importance of cost of living and the impact on mental health.
  - Staff have attended 'why weight to talk' training to help increase confidence, learn useful hints and tips and recognise inappropriate terminology, when working with individuals around weight management.
  - Food and nutrition sessions are being delivered in the community through Living Well Sefton, which follows the successful cook and eat programme, with a focus on more affordable healthy meals and clear linkages with the Weigh Forward programme.
  - In line with Sefton's whole systems obesity work, Living Well Sefton have continued to roll out regular healthy weight community resilience grant opportunities, for the delivery of healthy weight activities.
  - Increased social media campaigns continue to be posted through Living Well and Active Sefton's social media channels to reach communities covering how to eat well, cook on a budget, and increase physical activity.
- **Active Sefton's community offer** continues to be available to residents, including access to the Couch 2 5K Programme and partnership with Parkrun, in addition to the offer across Active Sefton Facilities and the voluntary, community and faith sector. Lake District walks, 5km and 10km events have seen a positive uptake from organisations.
- Under the **Sefton Obesity Action Plan** and its life course approach, 'Live Well' and 'Age Well' obesity sub-groups have been developed. The Live Well group are focusing on implementation of the Healthy Weight Declaration and the Age Well group is 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

services and support locally, whilst also strengthening collaboration across tier 1-4 support services (from brief intervention to clinical support).

- The Age Well sub-group has developed improved linkages and communication between services that form the (draft) adult healthy weight pathway, ensuring that service users are receiving the most appropriate and timely support to best meet their needs. This is particularly important for colleagues working within clinical services, who are better able to signpost residents into local, community support around healthy weight following any specialist treatment.
- The impact of the cost-of-living crisis on people's health, wellbeing and finances means that work on the healthy weight agenda is particularly challenging. The obesity action plan is in the process of being updated to reflect this.
- Work has progressed with Sefton Partnership regarding the weight management offer from universal through to clinical / specialist. Discussion has taken place in relation to potential gaps in provision and appropriate BMI thresholds per support level to ensure residents are accessing services best suited to meet their needs.
- Ongoing review of specialist tier three weight management services, which are the responsibility of NHS commissioners, as well as possible changes to be set out in the new NHS Ten Year plan are likely to have further implications for the adult weight management pathway.

- **Cheshire and Merseyside ICB** is currently undertaking an assessment of options to deliver specialist weight management services as a single Cheshire and Merseyside NHS system. Current actions in progress are:
  - Written options appraisal by the end of October 2024
  - Implementation of any approved recommendations from April 2025.

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

- Latest annual rates show that the proportion of physically active adults aged 19 and over has decreased slightly from 65.9% in 2021/22 to **63.3% 2022/23.** This marks a return to near pre-pandemic levels and continues the **broadly stable trend** seen over the past decade in Sefton and England.
- Sefton is now towards the bottom of the North West rankings for physical activity, i.e. in most local authorities in the North West the percentage of adults meeting activity guideline levels is higher than 63.3%. However, this **difference is not large enough to reach statistical significance** compared to England or North West average.
- Noting the socio-economic factors associated with being more physical active, it is likely that longer-term effects of the pandemic and increased cost of living have **at least maintained if not widened health inequalities in this important health behaviour**.

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

- The proportion of physically inactive adults aged 19 and over in Sefton has **increased slightly from 24.5% 2021/22 to 26.8% 2022/23**. Breakdowns of national data show that this uptick in physical inactivity is most pronounced among the unemployed.
- The latest data show that **Sefton has a statistically significantly higher rate of physical inactivity compared to England** (22.6%, stable trend), and this was also the case in the two years prior to the start of the Coronovirus pandemic.
- Aside from physical inactivity, high rates of obesity extending to children (one quarter) and working age adults (e.g. one third of 55-64 year-olds), in addition

to food poverty and poor 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

- Sefton have procured a consultancy agency to develop a physical activity strategy
  - Sefton is part of Sport England's place expansion work which aims to increase activity, decrease inactivity, tackle inequality whilst providing positive experiences. Nine in neighbourhoods in South Sefton have been selected to receive funding to help achieve this.
  - Public Health staff have shared key learning and presented on new initiatives linked to healthy weight at OHID's North West Physical Activity and Health and Wellbeing forums.
  - Sefton public health continues to play a leading role within the 'All Together Active' partnership, addressing the whole system approach to embedding physical activity opportunity.

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 currently 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.

OHID will soon replace this indicator with a new drug treatment progress measure. This is discussed, alongside the latest service data for Sefton using the new indicator in the 'action and progress' section below.

Key points

- The latest data (appendix A) is for the for the year to December 2023 and shows **3.2% of service users in Sefton achieved this outcome** – significantly lower than the most recent **England average (5.0%)**. This is under half the success rate for Sefton at baseline (8.6% in 2010/11).
- By this measure, Sefton remains significantly lower than the North West average (4.6%). Sefton ranks fifth lowest amongst the group of six statistical neighbours and has the **lowest opiate treatment success rate in LCR.**
- It is important to note that in most areas **the number 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. There are **neither clear signs of improvement nor deterioration in this measure over the last several years.** After a steady drop-off in successful treatment outcomes in England since 2011, there has been a stabilisation in the trend since 2020.

- National data shows a relationship between higher socio-economic deprivation and lower treatment success rate – populations from more affluent areas are around 50% more likely to achieve a 'successful' treatment outcome by this measure than those from more deprived areas. Even then, successful outcomes are only achieved by around 1 in 15.

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

- Despite an improvement from 17.6% (January through December 2022) to **22.3% (January through December 2023), Sefton is ranked bottom for this outcome among its statistical neighbours and continues towards the lowest end of rankings for areas in LCR and in the North West** – a statistically significant difference compared to the regional average (z-score -1.28).
- The England average (30.2%) for this measure is approaching twice that in Sefton, which is a **statistically significant difference**.
- The current success rate for non-opiate drug treatment is **under half what it was at baseline in 2010 (23.3% vs 52.2%)**. The national picture achieved its best outcome in 2014 – 39.2% but has gradually decreased in the years since.
- National data shows a **small social gradient in treatment success rates for non-opiate use**, which favours those from more affluent backgrounds. Efforts to minimise this inequality by minimising socio-economic barriers to successful treatment appear to have attenuated this gap.

Action and progress update

- The PHOF data (Jan22 - Dec23) here **predates the new national measure being used within the National Drug Treatment Monitoring System** local outcomes framework and in the Joint Combating Drugs Unit which services

are using. Progress against the new measure has been good (see below). Given the aging opiate profile and complexity of physical and mental health of service users in Sefton, the new measure better reflects performance.

- **The new indicator broadens the focus of successful completion to include progress made by people still in treatment.** Service users are considered to have made **substantial progress if** they:
  - have successfully completed treatment.
  - are still in treatment and are not using their problem substances.
  - are still in treatment and have substantially reduced use of their problem substances.
- **The Latest Sefton data showing substantial progress figures (Jul 2023 - Jun 2024)**
  - Opiates and/or Crack – Sefton 45%, England 45%.
  - Opiates only – Sefton 65%, England 58%.
  - Non-opiates only – Sefton 54%, England 49%.
- **Actions:**
  - Open access clinical sessions for rapid prescribing when appointments are missed.
  - Titration groups for those new to medically assisted treatment to get the right medication quickly and optimalisation of dosage.
  - Development of a Respiratory Pathway for COPD with Mersey Care
  - Expansion of mental health support with psychologist, assistants and counselling within the service.
  - LERO and service user forum now in place to facilitate people with lived experience to make improvement suggestions.
  - Improved recovery support offer and improved handover from structured care to recovery support.
  - Introduction of Recovery Housing.

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

- Alcohol-related admissions to hospital for Sefton residents in the financial year 2022/23 were **514 per 100 000** (n=1,499), which is a **directly standardised rate** (DSR). (The term 'directly standardised' means that differences in the age profiles of local authority populations have been adjusted for). This represents **quite a large drop from 598.0 per 100 000 DSR (n=1,704) in the later pandemic period of 2021/22**, which is reflected in the 6-point improvement in Sefton's North West ranking.
- **Sefton's rate ranks seventh highest in the North West** but closer to the middle of admission rates among statistical neighbours.
- The **gap between Sefton and England remains significant** but has **closed to an 8.0% difference from a recent peak of 45.0%** higher than England rates in 2019/20. This is encouraging if it predominantly represents a true reduction in need or increased use of appropriate out of hospital provision, rather than an increase in barriers, for example higher admission thresholds.
- It is important to remember that **in 2020/21 the validity of this indicator as a fair reflection of alcohol-related need in the population was undermined by changes to hospital admissions linked to the pandemic.** So, whilst hospital admissions due to alcohol fell in 2020 there was an increase in premature mortality from liver disease. (Most mortality from liver disease originates from preventable risk factors – 60% of all the risk for death from liver disease is attributable to high alcohol use in Sefton[7]).
- As expected, national data shows that **admission rates are 50.1% higher in the most disadvantaged tenth** of the population compared to the least disadvantaged tenth. The health inequality in alcohol-related admissions is less steep than for many other health outcomes. This likely reflects the **universality of risk to health posed by alcohol**. Also, it may be that people with more resources are more likely to attend hospital – this group has better survival for alcohol-related conditions compared to people living in more deprived circumstances.
- **Sefton's alcohol-related admission rate for males is significantly higher than the England average for males and is almost 2.5 times the admission rate for females**, which is in line with the England rate.

Action and progress update

- Strong links made with Aintree hospital to work together to try and avoid repeated admissions.

[7] VizHub - GBD Compare

- Alcohol outreach worker to engage with street drinkers to support and encourage into treatment pathways.
- Electronic Referral form on the GP system to simplify referrals.
- Fibro scanner purchased and nurse recruited to complete fibro scanning to identify liver disease earlier and improve access to the treatment pathways.
- Community van available to carry out promotion and provide information on safer drinking.
- Lower My Drinking App Campaign across the Borough to encourage individual behaviour change.
- Regular weekly attendance in the strand shopping centre to raise awareness and provide education.
- LERO and service user forum in place to facilitate people with lived experience to make improvement suggestions.
- Attendance at complex lives in North and South Sefton to access people identified at risk to prevent deterioration.
- Education of partner agencies to raise awareness and encourage alcohol referrals.
- Appointment of YP workers to work with young adults in appropriate settings and a community engagement worker to deliver education.
- Hidden Harm and MPACT programmes to work with children and families where alcohol and drug use are a factor.

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, and 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.'

Key points

- The percentage of the eligible population **invited for an NHS Health Check in quarter 1 of 2024/25 is 0.3%**, which compares to 0.5% for quarter 1 of 2023/24.
- The percentage of the eligible population who **received an NHS Health Check in quarter 1 2024/25 is 0.2%**, which compares to 0.4% for quarter 1 2023/24.
- **The PHOF provides cumulative outcomes on a rolling five-year cycle (2020/21 to 2024/25).** During these years, the proportion of the national eligible population which was offered a health check was 57.9%. In the North West the average was significantly higher – 82.1%. In Sefton the proportion was **3.9%.**
- In the same period, the proportion of the national eligible population which received a health check was 22.7%. In the North West, the average was 26.1%. In Sefton, the proportion was **2.9%.**
- In Sefton, the proportion of people offered a check who went on to receive it was **74.0%,** the second highest in the North West and almost twice as high as the England average, albeit the total number of health checks was by far the lowest.

Action and progress update

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 ongoing with key stakeholders with a view to commissioning a GP based delivery route.
- New equipment has been purchased to help support the current offer - **Active Sefton's community-based health check programme**, which has made the process of performing checks more efficient.
- Active Sefton are developing their offer by encouraging schools who are signed up to the Active Schools programme to offer health checks to eligible staff.
- Blood pressure champion training has been further extended to Living Well Sefton partners.
- Sefton was successful in achieving workplace cardiovascular disease funding from OHID and implementation of a programme to increase checks in workplaces is currently underway. The NHS Health Check will be offered on-site at workplaces as part of a holistic lifestyle and wellbeing offer. Employers of manual/shift workers, people in lower paid roles, ethnic minority staff members, and male dominated workforces will be prioritised, along with unpaid carers,

3.14 Mental health and wellbeing

Issue description.

Mental health surveillance reports by the Office of National Statistics during the pandemic measured changes in mental health during the pandemic and showed that population wellbeing fluctuated, as new waves of infection were followed by 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.[8]

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. In 2018-20, the rate of premature (under 75 years) mortality in Sefton residents with a referral to secondary care mental health services in the five years before their death, was over four times higher than in 18–74-year-olds who died with no evidence of this in their records. This is in line with the England average. The impact of unidentified and under- or untreated mental health disorders can cause significant health impacts across the life course; primary prevention and early intervention helps problems of reduced wellbeing from developing and escalating and brings major societal benefits.

The socio-economic context of people's lives is an increasingly 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 using a national **self-report survey** (the integrated household survey) from a sample of Sefton's population aged 16 and over. Wellbeing data are derived from answers to four questions,

Overall, how satisfied are you with your life nowadays?
Overall, how happy did you feel yesterday?
Overall, how anxious did you feel yesterday?
Overall, to what extent do you feel the things you do in your life are worthwhile?

[8] COVID-19 mental health and wellbeing surveillance: report - GOV.UK (www.gov.uk)

Responses are given on a ten-point scale and the number of people who score themselves in the four worst scores, i.e. lower evaluation of life being satisfying, happy, worthwhile, and higher evaluation of anxiety, is expressed as a percentage of all respondents. The latest data is from the so-called 'post-pandemic' period, 2022-23.

Key points

- The latest data from 2022/23 shows that **Sefton is not statistically significantly different to England across all four indicators of low wellbeing**, and rates are also in line with the North West average and with other LCR local authority populations.
- When interpreting these percentages, it is **important to consider the number of adult residents estimated to experience subjective low wellbeing, which is in the thousands**. Some people in this population will have diagnosed or diagnosable mental health conditions, many others would not.
- **In Sefton, low life satisfaction has reached a new peak of 7.7%**, higher than during the pandemic (7.2% 2020/21), and similar to rates around ten years ago in 2013/14. The one percentage point reduction in the previous year, 2021/22 was not maintained. Sefton's recent trend is similar to England's – rising noticeably from around 2018.
- **The percentage of adults who feel life is not worthwhile has increased slightly from 4.8% in 2021/22 to 5.0% in 2022/23**. Values in the years just before were around 4.0%. Nationally, there is a continuing rising trend, and Sefton figures appear to be following in line.
- **Around one in ten (10.3%) adults in Sefton reported low happiness in 2022/23,** a small increase from the previous year (9.5%). After a relatively large increase to 10.4% in the first year of the pandemic, 2020/21, low happiness rates have fluctuated around this same level. Peak low happiness in this data series was 13.1% in 2016/17.
- The survey estimates that nearly a quarter of Sefton's over 16 population (**24.3%) reported higher anxiety**. As noted above, this is typical of comparator areas. The trend shows a continuing, slow rate of increase.

- **Statistics for England can be used to understand some wellbeing inequalities.** Of note,
  - **Females have 25% higher rates of self-reported anxiety** compared to males.
  - People in their late 40s through to early 60s have higher rates of low life satisfaction than younger adults. **16–19-year-olds show a large increase in anxiety from 18.7% in 2021/22 to 24.2% in 2022/23** – akin to adults in their 20s, 30s and 40s. The 65+ age group has the lowest reported rate of higher anxiety.

- There is a notable **three-fold higher prevalence of low life satisfaction and low worthwhile scores amongst unemployed compared to employed survey respondents**. Recent increases in these two indicators could reflect rises in cost of living. Prevalence of anxiety and low happiness did not increase in line with low life satisfaction and not feeling that life is worthwhile in the unemployed group.
- **Part-time workers were slightly more likely to report low wellbeing**, perhaps because of hidden effects of differences in health, income, and caring responsibilities.
- **Low life satisfaction and low worthwhile scores are five times more prevalent in disabled compared to not disabled respondents** (13.4% and 10.4% respectively); **low happiness is three times higher** (15.4% vs 5.5%), and **higher anxiety is twice as prevalent** (35.8% vs 18.2%). Inequalities have widened slightly for each indicator since 2017/18. The size of these differences and the size of the disabled population represented mean this effect has an appreciable effect on the headline averages for each wellbeing indicator.
- The **Asian/Asian British ethnic group, followed by the White group have the lowest rates of low wellbeing**. Differences are not as large compared with those seen for employment and disability status.

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 2023/24, there were 226 children and young people who accessed the service, with 80% showing an improvement in mental well-being as measured through the WEMWBS and SCWBS tools.

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 has received national praise as best practice for public health mental health promotion via the Faculty of Public Health. It will be the featured project on an upcoming blog on the Faculty of Public Health’s website. Plans are underway for the next phase of the campaign.

3.15 Mortality from suicide and injury of undetermined intent

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. Reduced access to means of suicide is associated with reduced numbers of deaths.

National data shows that **lower deprivation is associated with lower rates of suicide**. Difference in rates according to sex shows a stronger relationship - **the rate is three times higher in males compared to females. In the present population, suicide risk is higher amongst people of working age compared to 10–24-year-olds or seniors aged 65 and over.** This pattern of mortality from suicide and injury of undetermined intent contributes to inequalities in life expectancy, particularly in males. **Data about risk groups helps to underpin a well-developed evidence-base, covering a wide range of interventions that can effectively reduce the risk of suicide at a population level**.

Key points

- Because annual numbers are small, **suicide rate is calculated as a rolling three-yearly average per 100 000 people aged 10 years and over**, which is adjusted ('directly standardised') to take account of age differences across local authority populations. This is necessary because of the variation in suicide rates in different age groups.
- There has been a small increase in the three-year rolling rate for this indicator from 11.6 per 100 000 people aged 10+ in 2020-22, to **13.1 per 100,000 (n=96) in 2021-23**.
- Incidence of suicide and injury of undetermined intent in Sefton **remains in line with the national picture and North West rate, with an expected level of variation** year to year. This similarity with England rates extends to the wider range of indicators available in the OHID suicide profile.[9]
- As described in the national data, the **suicide rate in males is around three times higher than that for females**, and trendlines continue to move in parallel.
- There are clearest signs of a possible gradual but continuing downward trend in suicide in the youngest 10-24 age group in Sefton.
- The national rate (10.7 per 100, 000, 2021-23) has varied very little over the past 20 years. Periods of rise and fall in Sefton's data reflect chance variation

[9] Suicide Prevention | Fingertips | Department of Health and Social Care

as well as systematic changes in risk factors. Sefton's suicide rate has not been statistically significantly higher than England's since 2015-17 and has not been statistically significantly lower since 2007-09. **Therefore, it is important to interpret changes in trend with caution.**

Action and progress update

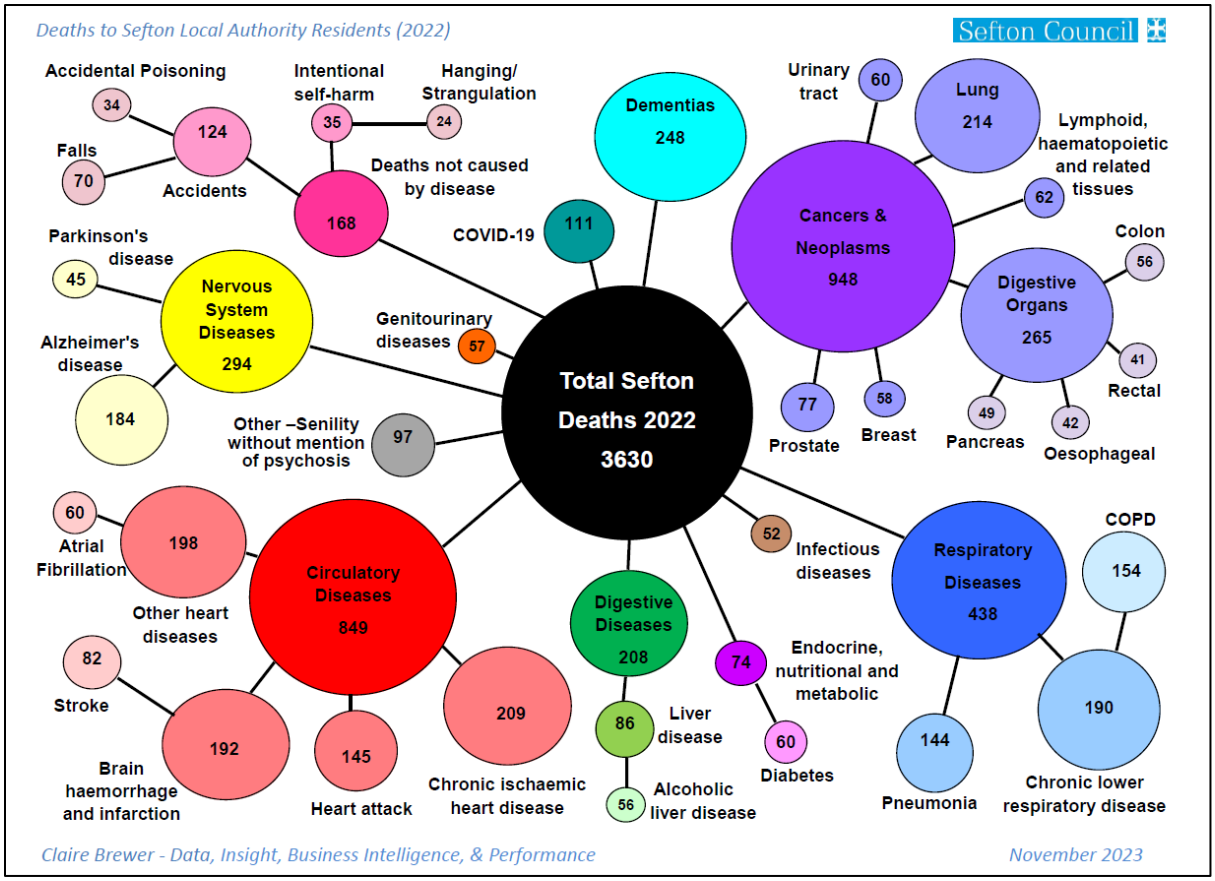
- Sefton continues to engage with regional and national data collection, and surveillance through the annual suicide audit.
- An evidence and intelligence-led approach to suicide prevention has led to greater cross-working around the domestic abuse agenda.
- The suicide prevention signage has been updated at Fisherman's Path in Formby near the railway station in collaboration with the national Samaritans team.
- A pilot project on safer prescribing of antidepressants by clinicians is underway via Mersey Care, with support from Sean's Place.
- The Sefton suicide prevention board has started a spotlight format to highlight topic areas related to suicide prevention and to help forge connections across different partnerships. Sessions have been run on harmful gambling and drug and alcohol services.
- The Sefton suicide prevention board is refreshing the board's terms of reference to ensure up to date membership and function. The board is also updating the local suicide action plan in line with the regional timescale.
- Consultant in Public Health representing Sefton on regional task and finish group exploring suicide epidemiology.

3.15 Mortality from causes considered preventable.

Issue description.

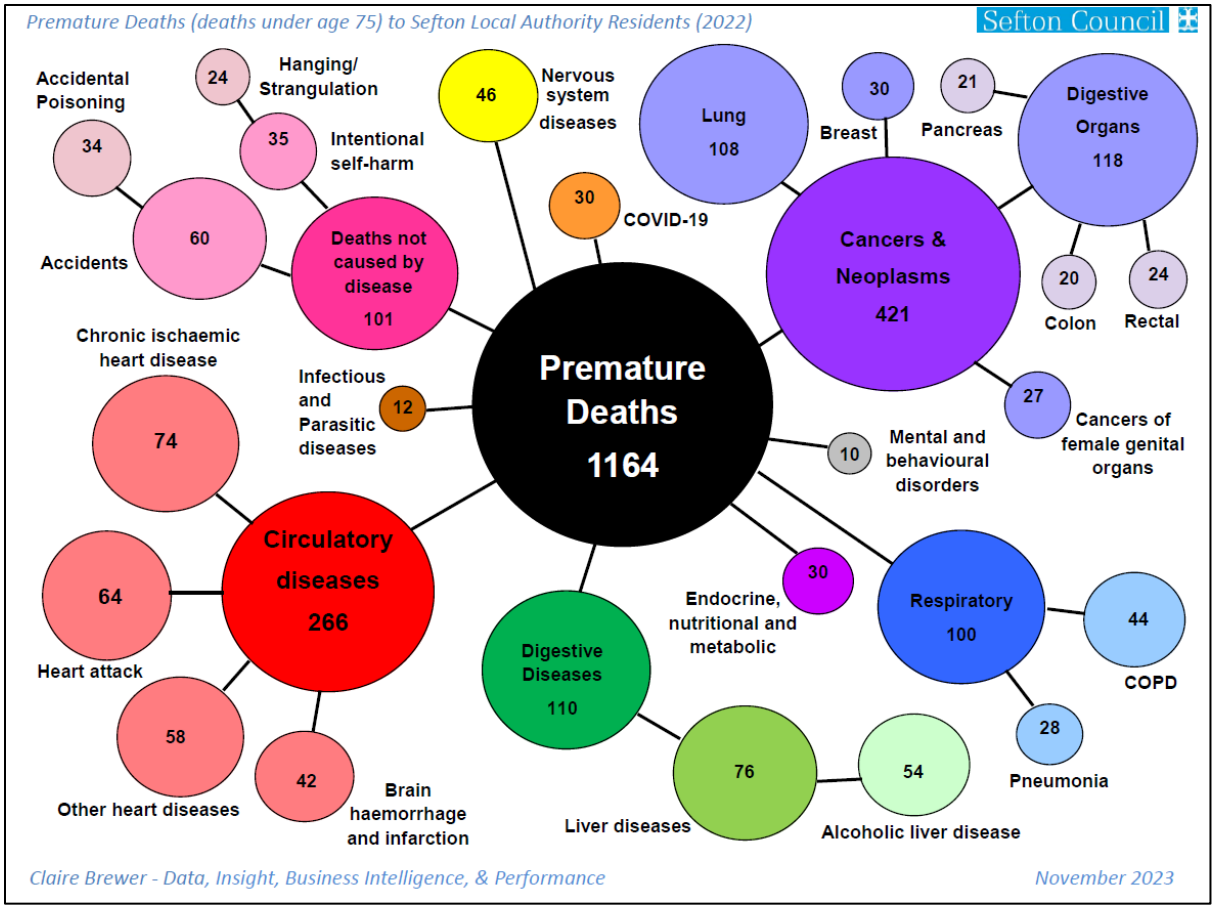
Apart from the very first months of life, **the number of deaths per head of population increases in step with rising age**.

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 preventable causes of death (blood vessel disease, cancers, and lung disease) stand out in the bubble chart, below, which shows numbers of deaths from all causes in Sefton in 2022.



Two noticeable differences in the premature deaths bubble chart, below, come from the larger proportions of 'deaths not caused by disease', and deaths due to 'digestive disease'. These include **alcoholic liver disease, for which 96% of deaths happened in residents under the age of 75, and deaths from intentional self-harm, in which 100% of deaths occurred in people under the age of 75.** These make up a small proportion of deaths but contribute a lot to the overall loss of potential and productivity.

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). From 2020, this definition also includes Covid-19.



Having multiple behavioural risks is strongly associated with greater social, economic, and environmental **deprivation**. **Psycho-social risk factors** e.g., chronic stress, past trauma, high uncertainty and low control over life events and choices favour development of health-risking behaviours. These same challenges often 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**[10]: level of education and training, occupational 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 inequality is a long-standing reason explaining why the Health and Care System is challenged to operate on a sustainable footing.**

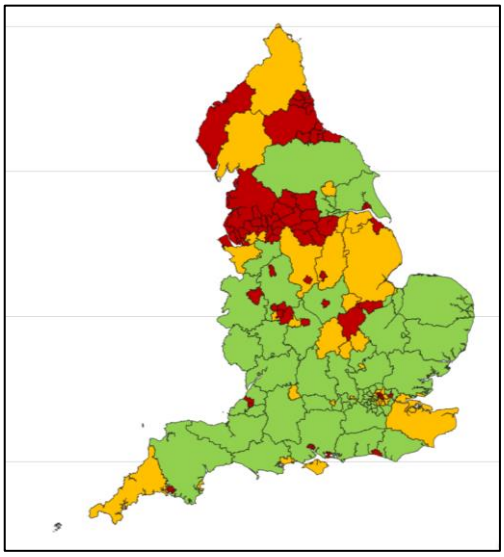
Key points

[10] Chapter 6: social determinants of health - GOV.UK (www.gov.uk)

- The latest one-year update to this indicator is for preventable deaths in 2022. **Sefton's rate of 196.0/100 000 (n=540) remains statistically significantly higher than England, but has fallen considerably since 2020**, before the introduction of vaccines against Covid-19.
- Prior to this, preventable premature mortality rates were declining at a faster rate than in England – mostly due to falling mortality in males, so this external health inequality was getting narrower.
- **Most local authorities in the North West and in LCR have higher rates than Sefton**. Only Cheshire East has a preventable mortality rate that is significantly lower than England's. Sefton has the highest preventable mortality rate from amongst statistical neighbours. **The map below shows spatial variation for this indicator in England**.
- In contrast to the trend for males in Sefton, which rose in 2020 but has dropped down since, **premature preventable mortality in females has continued to climb -** increasing from 115.4/100 000 to 162.8/100 000 in 2022. The rate in males remains a third higher than in females. This picture probably reflects historic and more recent differences in smoking, alcohol use, occupational risks, injury, and suicide.
- National data shows **a clear social gradient for this indicator, which underlines the preventable nature of the diseases involved**. Trends across the pandemic in different socio-economic groups also **illustrate the disproportionately worse impact of the pandemic on mortality rates in more deprived communities**.
- **The high prevalence of obesity poses risk for static or rising rates of preventable premature mortality in coming years.**

Map showing premature preventable mortality standardised rates in local authorities in England, 2022 with colour coding – green (significantly lower

than the national average), amber (no statistical difference), and red (significantly higher than the national average).



3.16 Under 75 cardiovascular mortality

Issue description.

This indicator captures premature death from circulatory diseases like 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 2022, there were 265 deaths in Sefton residents aged under 75 due to cardiovascular disease. **The standardised rate is significantly above that of England** (94.1/100 000 vs 77.8/100 000).
- **Most local authorities in the North West have higher rates than Sefton**, and in LCR only Wirral has a lower rate. **Most of Sefton's close statistical neighbours, like Wirral, have a lower rate of premature mortality from cardiovascular disease.**
- In the years leading up to 2017, rates of cardiovascular disease in Sefton followed a shallow decline, which had begun to level off. England data follows an almost identical trend**. Since then, rates have risen in Sefton, and more quickly than in England – increasing by 26.0% from 2017 to 2022 compared to 9.4% nationally.**
- This overall trend is driven by increasing rates in males only. Deaths under age 75 in males occur around twice as often as in females.

- It is not certain which factors have caused this change in trend – but it could include population changes in weight, exercise, and diet-related risk factors, as well as possible issues associated with healthcare. **National data, suggests that Sefton will have at least a two-fold higher rate of early cardiovascular death in the most, compared to least disadvantaged groups.** This gap is likely to increase as poorer population groups struggle to maintain healthy choices e.g. good quality diet, and more affluent groups are mostly protected from these effects.
- Preventative 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 418 deaths from cancer in individuals aged under 75 in Sefton in 2022.
- **Sefton's rate is significantly higher than the England average** (147.1/100 000 vs 122.4 /100 000), and Sefton is placed towards the higher end rankings for the North West, and amongst close statistical neighbours.
- Over the last two decades, Sefton's rate of premature cancer mortality fluctuated a little above the England rate but followed the same steady, downward trend overall. **Sefton's rate moved above England's in 2020 and has remained significantly higher**. 2022 was the first time that England's rate increased compared to the previous year. This suggests the involvement of systemic influences, including from stressed NHS capacity, and high costs of living. Sefton is clearly not immune to these. Another underlying factor may be the appearance of more cancer risk associated with higher rates of long-term obesity.
- **Premature death from cancer is more similar in males and females** than is the case for cardiovascular mortality and liver disease. Relatively higher rates in females in Sefton mean the rate difference between sexes is only 12% (there is a 23% difference between males and females in England).
- Based on the latest national health inequalities for this indicator, rates of **premature death from cancer are likely to be at least one third higher in Sefton's most deprived communities** in comparison with Sefton's least

deprived communities. The continuing social inequality in smoking behaviour is a major cause of this difference.

3.18 Under 75 liver disease

Issue description.

Almost all liver disease is preventable, caused by alcohol, obesity and blood borne hepatic viruses, which can cause liver failure and liver cancer. 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 2022, there were 91 deaths from liver disease in Sefton residents aged under 75.
- Like most North West local authorities, **Sefton's rate of premature liver disease is significantly above the England average** (34.0/100 000 vs 21.4/100 000). Seventeen local authorities including Liverpool, Knowsley and Wirral have lower rates than Sefton, but this only borders on a statistically significant difference for Wirral. As was the case in 2021, Sefton has the highest rate amongst close statistical neighbours.
- **The trend for premature liver disease deaths is different from other long-term conditions** because the data series for England from 2001 shows a trend made up of small rises and periods of stability, rather than the overall downward trend for other non-communicable diseases. **2020 showed an uptick in the national premature mortality rate, which has been maintained, and this is also seen in Sefton's figures in Sefton**.
- For around a decade, premature liver disease mortality rates in females have been around 50% lower than in males and have shared an overall increasing trend. **Recent rates in Sefton females are approaching twice the England average and are just below the England male rate.**
- In England, **there is a clear socio-economic gradient in premature mortality from least to most deprived populations.** Higher rates are particularly noticeable in populations from the 20% most deprived areas. **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 recent rise in premature mortality from liver disease is likely to reflect** the impact of the pandemic on alcohol behaviour and access to health and preventative services, as well as the longer-term influence of rising rates of obesity, and psycho-social stressors from the high cost of living.

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 - tobacco (49%), cold (22%), occupational exposure (11%), particulate air pollution (8%), and other preventable causes (10%).

Key points

- In 2022, there were 100 premature deaths from chronic respiratory disease in Sefton.
- **Sefton's rate is similar to England's (35.5/100 000** vs 30.7 per 100 000), and below the North West average (42.8/100 000). In LCR, only St. Helens has a slightly lower rate in 2022.
- **Looking at the trend using rolling three-year average rates, the downward trend in England is faster than in Sefton, where there are signs of levelling-off**.
- As has been observed for liver disease and cancer, mortality rates from respiratory disease are **more similar in females and males in Sefton.** This is because of the relatively higher rate in females. As well as reflecting some contemporary influences on health behaviours in males and females, this difference in respiratory disease deaths may continue to reflect older, historic patterns and differences - in smoking and occupational risk exposure for example.
- Data for England shows a large health inequality. **The rate of premature death in the most deprived ten per cent of the population is two and a half times that in the least deprived ten per cent**. The inequality in Sefton is likely to be at least this great. All socio-economic groups show a dip in premature deaths from respiratory disease in 2021, followed by a slightly larger rebound in 2022 when protective Covid-19 measures are no longer active.

Action and progress update

- The many service and population health programme updates in this report all contribute towards lowering future premature mortality. There is a particular focus on evidence-based primary prevention, improving the social and wider determinants of heath, and enabling opportunities for change across the life-course.
- Plans to further gear-up local action on child poverty continue and are summarised in a recent report to the Health and Wellbeing Board.[11]
- Two case studies on the Sefton Child Poverty Strategy and a pilot for a social determinants approach to preventing hospital admissions for respiratory

[11] (Public Pack)Agenda Document for Health and Wellbeing Board, 06/03/2024 14:00

illness in children were submitted to Cheshire and Merseyside ICB's refreshed All Together Fairer: Our Health and Care Partnership Plan.

- Senior members of the Public Health Team have continued to provide population health expertise towards development and implementation 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 Committee is recommended to,

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

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

Appendix A Public Health Performance Framework August 2024

Indicator	Unit	Geography	Baseline	Previous	Latest	Dir of Travel	Prev. NW	Latest NW	Prev. SNG	Latest SNG	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	9.1% 2022/23 Q1-4	8.1% 2023/24 Q1-4	▼	7	15	1	1			-0.20
Smoking at the time of delivery (Southport & Formby)	Percentage	CCG	11.7% 2013/14 Q1	7.4% 2022/23 Q1-4	5.4% 2023/24 Q1-4	▼	2	2	2	2			**-1.27**
Under-18 Teenage Conceptions	Rolling annual rate per 1000	LAD	33.5 1998	12.6 Jun-21	17.5 Jun-22	▲	6	12	2	4			0.08
Obesity in reception year*	Percentage	LAD	11.4% 2007/08	11.3% 2021/22	10.3% 2022/23	▼	22	20	6	5			0.28
Obesity in year 6*	Percentage	LAD	17.3% 2007/08	23.3% 2021/22	23.9% 2022/23	▲	15	19	5	6			0.16
Excess weight in adults	Percentage	LAD	68.4% 2015/16	71.2% 2021/22	69.2% 2022/23	▼	27	24	6	4			0.49
Physical activity in adults (active)	Percentage	LAD	66.4% 2015/16	65.9% 2021/22	63.3% 2022/23	▼	16	22	4	4			-0.38
Physical activity in adults (inactive)	Percentage	LAD	23.8% 2015/16	24.5% 2021/22	26.8% 2022/23	▲	20	24	5	4			0.45
Successful Completion of drug treatment (opiates), and didn't re-present within 6 months	Percentage	LAD	8.6% Nov 10 - Oct 11	3.0% Jan22-Dec22	3.2% Jan23-Dec23	▲	22	23	6	5			**-1.61**
Successful Completion of drug treatment (non-opiates), and didn't re-present within 6 months	Percentage	LAD	64.6% Nov 10 - Oct 11	17.6% Jan22-Dec22	22.3% Jan23-Dec23	▲	23	23	6	6			**-1.28**
Alcohol-related hospital admissions (narrow)	Directly Standardised Rate	LAD	654.0 2016/17	598.0 2021/22	514.0 2022/23	▼	32	26	4	4			0.46
NHS Health Checks (% of eligible population invited to screening)^	Percentage	LAD	6.1% 2011/12 Q1	0.5% 2023/24 Q1	0.3% 2024/25 Q1	▼	24	24	6	6			**-1.49**
NHS Health Checks (% of eligible population receiving screening)^	Percentage	LAD	2.2% 2011/12 Q1	0.4% 2023/24 Q1	0.2% 2024/25 Q1	▼	24	24	6	6			**-1.98**
ported wellbeing (low satisfaction score)	Percentage	LAD	5.7% 2011/12	6.2% 2021/22	7.7% 2022/23	▲	18	22	4	6			0.34
ported wellbeing (low worthwhile score)	Percentage	LAD	4.0% 2012/13	4.8% 2021/22	5.0% 2022/23	▲	13	12	4	5			0.10
ported wellbeing (low happiness score)	Percentage	LAD	9.6% 2011/12	9.5% 2021/22	10.3% 2022/23	▲	20	19	3	4			0.27
ported wellbeing (high anxiety score)	Percentage	LAD	22.0% 2011/12	22.6% 2021/22	24.3% 2022/23	▲	10	14	1	4			-0.01
75 mortality from causes considered preventable	Directly Standardised Rate per 100,000	LAD	241.5 2001	212.1 2021	196 2022	▼	17	18	5	6			-0.01
Under 75 cardiovascular mortality	Directly Standardised Rate per 100,000	LAD	170.0 2001	80.16 2021	94.1 2022	▲	11	13	6	6			-0.28
Under 75 cancer mortality	Directly Standardised Rate per 100,000	LAD	185.6 2001	135.4 2021	147.1 2022	▲	18	27	5	6			0.76
Under 75 liver disease mortality	Directly Standardised Rate	LAD	22.9 2001	30.5 2021	34 2022	▲	18	26	6	6			0.69
Under 75 respiratory disease mortality	Directly Standardised Rate	LAD	45.1 2001	35.6 2021	35.5 2022	▼	20	12	5	4			-0.62
Suicide and undetermined injury mortality	Directly Standardised Rate	LAD	12.7 2001-03	11.6 2020-22	13.1 2021-23	▲	16	16	4	4			-0.16

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 Sefto	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 North West. A score of ±1 shows Sefton is significantly different to the North West average

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.[12] 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[13].

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.

Interpretation

There 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.
    - 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 closer to 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.

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

- **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 - Aug 2024

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
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Smoking at the time of delivery (Southport & Formby)	Percentage	CCG	11.7% 2013/14 Q1	7.4% 2022/23 Q1-4	5.4% 2023/24 Q1-4	▼	2	2	2	2			**-1.27**
Under-18 Teenage Conceptions	Rolling annual rate per 1000	LAD	33.5 1998	12.6 Jun-21	17.5 Jun-22	▲	6	12	2	4			0.08
Obesity in reception year[a]	Percentage	LAD	11.4% 2007/08	11.3% 2021/22	10.3% 2022/23	▼	22	20	6	5			0.28
Obesity in year 6[a]	Percentage	LAD	17.3% 2007/08	23.3% 2021/22	23.9% 2022/23	▲	15	19	5	6			0.16
Excess weight in adults	Percentage	LAD	68.4% 2015/16	71.2% 2021/22	69.2% 2022/23	▼	27	24	6	4			0.49
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NHS Health Checks (% of eligible population invited to screening)[b]	Percentage	LAD	6.1% 2011/12 Q1	0.5% 2023/24 Q1	0.3% 2024/25 Q1	▼	24	24	6	6			**-1.49**
NHS Health Checks (% of eligible population receiving screening)[b]	Percentage	LAD	2.2% 2011/12 Q1	0.4% 2023/24 Q1	0.2% 2024/25 Q1	▼	24	24	6	6			**-1.98**
Self-reported wellbeing (low satisfaction score)	Percentage	LAD	5.7% 2011/12	6.2% 2021/22	7.7% 2022/23	▲	18	22	4	6			0.34
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Wirral	South Tyneside	Fylde & Wyre
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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

- The trend of increasing Y6 Childhood Obesity has continued and NW and SNG rankings have worsened for this time period. Sefton's rate does not differ significantly to England, NW or SNG averages, however.
- Successful completion of drug treatment is similar to last time period for opiates and has increased for non-opiates. However, Sefton has the second lowest rates of successful completion in the North West, only higher than Blackpool for opiates and Halton for non-opiates.
- Sefton's Under 75 mortality rates for causes considered preventable, cardiovascular diseases, liver disease and cancer are significantly higher than England averages and North West rankings have worsened. Sefton ranks highest amongst its statistical neighbours for all these indicators
- Sefton's rate of alcohol related hospital admissions is significantly higher the England and North West averages. Sefton's NW ranking has improved, moving from the 4th highest to the 10th highest rate in the North West. In LCR, only Wirral's rate is lower than Sefton.
- Sefton's proportion of active/inactive adults have worsened and the proportion of inactive adults is now significantly higher than England. NW rankings for both indicators have worsened compared to the previous time period.

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. Sefton has the second lowest rate of the LCR.
- Sefton's Suicide rate has increased, although its NW and SNG rankings remain the same. Sefton's rate does not differ significantly to the national and regional averages or to the LCR authorities
- All well being indicators have worsened this time period (athough these are not statistically significant differences). Sefton's SNG rankings have also worsened for all wellbeing indicaors and NW rankings have worsened for low satisfaction and high anxiety. Again, however none of Sefton's wellbeing scores differ significantly from England, NW or SNG.

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

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Sefton Council

Report Title:	Cabinet Member Update Reports		
Date of meeting:	7 January 2025		
Report to:	Overview and Scrutiny (Adult Social Care and Health)		
Report of:	Chief Legal and Democratic Officer		
Portfolio:	Public Health and Wellbeing and Adult Social Care		
Wards affected:	All		
Is this a key decision:	No	Included in Forward Plan:	No
Exempt/confidential report:	No		

Summary:

To submit the Cabinet Member – Public Health and Wellbeing and Cabinet Member – Adult Social Care reports relating to the remit of the Overview and Scrutiny Committee for November - December 2024.

Recommendation(s): That the reports be noted.

1. The Rationale and Evidence for the Recommendations

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 The most recent Cabinet Member reports for Public Health and Wellbeing and Adult Social Care.

2. Financial Implications

2.1 Any financial implications associated with the Cabinet Member reports that are referred to in this update are contained within the respective reports.

(A) Revenue Costs – see above

(B) Capital Costs – see above

3. Legal Implications

3.1 Any legal implications associated with the Cabinet Member reports that are referred to in this update are contained within the respective reports.

4. Corporate Risk Implications

4.1 Any legal implications associated with the Cabinet Member reports that are referred to in this update are contained within the respective reports.

5 Staffing HR Implications

5.1 Any staffing HR implications associated with the Cabinet Member reports that are referred to in this update are contained within the respective reports.

6. Conclusion

6.1 The Overview and Scrutiny Management Board has agreed for relevant Cabinet Member Reports to be submitted to appropriate Overview and Scrutiny Committees.

This report has therefore been submitted to comply with the decision of the Overview and Scrutiny Management Board.

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.

Equality Implications: There are no direct equality implications. Any equality implications arising from the consideration of any decisions contained in the update would have been/will be reported to members at the appropriate time. (Please note that Council have agreed care experience should be treated like a protected characteristic.)
Impact on Children and Young People: There are no direct children and young people implications. Any children and young people implications arising from the consideration of any decisions contained in the update would have been/will be reported to members at the appropriate time**.**
Climate Emergency Implications: The recommendations within this report will have a Neutral impact.

There are no direct climate emergency implications arising from this report. Any climate emergency implications arising from the consideration of any decisions contained in the update would have been/will be reported to members at the appropriate time.

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Cabinet Member Update Report is not subject to FD/LD consultation. Any specific financial and legal implications associated with any subsequent reports arising from the attached Cabinet Member update report will be included in those reports as appropriate.

(B) External Consultations

Not applicable.

Implementation Date for the Decision:

With immediate effect.

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 – Public Health and Wellbeing

Appendix B – Adult Social Care

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CABINET MEMBER UPDATE Overview and Scrutiny Committee (Adult Social Care and Health) 7 January 2025		
Councillor	Portfolio	Period of Report
Mhairi Doyle	Health, Wellbeing & Inclusion	Oct - Dec 24

Public Health

Public Health Risk Register
In October I received the updated public health department risk register. I was assured that all risks were being proactively managed within the service.

Health Checks
At the Cabinet Member Briefing on 1st October 2024, the Public Health Team updated me on developments around the NHS Health Check offer in Sefton. This included an update on the progress of delivery pilots with Southport, Formby, and South Sefton PCN, alongside an update on the Department of Health's Workplace Cardiovascular Checks pilot.

In April 2018, Sefton moved from a GP model of delivery on NHS Health Checks to an in-house community delivered offer. This has been delivered by the Active Sefton team, but currently a key challenge for the service is the available capacity to deliver NHS Health Checks. The current estimated eligible population in Sefton for NHS Health Checks equates to 71,222 people. This is delivered over a 5-year cycle, equating to approximately 14,245 people eligible each year, and the current offer is not reaching high numbers of the eligible population.

The public health team have been working closely with the Sefton ICB place team and PCN areas and are awaiting decisions and feedback regarding possible GP pilot delivery models that could potentially be rolled out.

In addition, during September 2024 it was announced that Sefton was selected as a pilot area for workplace cardiovascular disease health checks. This pilot will deliver CVD checks in workplace settings through the Active Sefton team until 31st March 2025. Active Sefton are currently recruiting two new staff who will provide a dedicated resource for both the workplace CVD pilot and to the NHS Health Check programme once the workplace pilot has completed.

Combatting Drugs Partnership 1 Year Progress Report
At the November Cabinet Member Briefing meeting, I was presented with a paper summarising the annual updates on Sefton's Combating Drugs Partnership (SCDP).

The paper outlined the progress of the SCDP during 2023–2024 and provided an overview of the partnership's background, developments, performance as well as its achievements in relation to national milestones. The report outlined the next steps for the partnership, highlighting key areas for future development and collaboration.

Public Health Performance Framework

I received a twice-yearly report on updated indicators in the public health performance framework. The report focused on 12 indicators for which new data was published in March to August 2024, reflecting outcomes that mostly occurred in the 'post-pandemic' period – 2022 to 2023. Indicators related to pregnancy, health behaviours, public health services and preventable deaths. Strong and improving measures were identified as follows: smoking in pregnancy, substantial progress in drug treatment, and alcohol-related hospital admissions. Points of note were overweight and obesity rates in adults (69.2%, 2022/23), which remain significantly higher than the national average (64.0%); physical inactivity (26.8%), also higher than the England rate, and delivery of NHS Health Checks as the programme undergoes redesign. Strategic and service-level improvements focused on population health improvement and reduction of health inequality were noted across all the areas discussed in the report. The contents of the report were noted and will also be presented at Overview and Scrutiny Committee (Adult Social Care and Health) on 7 January 2025.

Public Health Draft Workplan

I received the latest Public Health Service Plan, providing a high-level focus for the 2024-2026 delivery plan as well as a retrospective review of achievements and challenges from 2023/24. Section included:

- *Setting the scene*: a breakdown of key public health areas of practice and principles of how the department operates.
- *Where are we now*: included recent evidence of effectiveness as commissioners and partnership working.
- *Performance against objectives and key performance targets*: This section described how the service fulfils the criteria set out in the Public Health Grant and delivers on the priorities set out by the Office of Health Improvement and Disparities.
- *Key Achievements*
- *What requires improvement*
- *Key strategic priorities for the department for next 12-18 months*

Sexual Health Service Re-Procurement

Sefton Council commissions sexual health services in Sefton; these include contraception services, services for the prevention, detection, and treatment of sexually transmitted infections, teenage pregnancy services and health improvement and outreach services. Sexual Health Services are nationally mandated under the

Health & Social Care Act 2012.The incumbent provider for is Mersey and West Lancashire Teaching Hospitals NHS Trust.

The existing integrated sexual health service contract expires on the 31st March 2025. Sefton Council Public Health team wish to award the incumbent provider with a new contract, with a 4-year core contract period starting on the 1st April 2025, with 3x 12-month extension options available. I provided my endorsement for the Public Health team to seek Cabinet's approval to re-procure the integrated sexual health service via direct award process C of the Provider Selection Regime (2023) Regulations.

Smokefree Generation Plan

I received an update on the Smokefree Generation Plan. Tobacco is a uniquely harmful product. It is responsible for 1 in 4 of all cancer deaths and up to two-thirds of long-term users will die from tobacco related diseases and illness.

Moreover, the uniquely harmful effects of tobacco are not confined to those who smoke. Smoking causes indirect harm through exposure to second-hand smoke affecting children, pregnant women, and people with pre-existing health conditions.
In October 2023 the Government announced a comprehensive plan to create a smokefree generation and outlined a package of measures, including an additional £70 million per year over the next 5-years, to increase the support available for smokers to quit. An additional ringfenced investment was made available to local authorities to support the Public Health grant to allow local authorities to deliver an enhanced stop smoking support provision. An additional ringfenced investment of £231.529 for 2024/25 was made available to Sefton Council to support the Public Health grant to allow local authorities to deliver an enhanced stop smoking support provision. Modelling for Sefton suggests an expected increase in quits by year 5 of 962, from a current rate of 1,588 per year to 2,550.

Detailed spending/improvement plans have been submitted by Sefton Specialist Stop Smoking Service amounting to £162,490.00 leaving a projected underspend of £57,462.55. Authority was given to vary the current contract with the Specialist Stop Smoking Service to accommodate the proposed enhancements and increase the contract value. There was also agreement on a proposal to utilise the projected underspend to explore two further pieces of work; commissioning a short insight/engagement research project and commissioning local targeted promotions campaign.

We're Here Campaign Second Phase

I received an update about the second phase of Sefton's "We're Here" mental wellbeing campaign, which will launch in January 2025 and run for five weeks.

The We're Here campaign signposts residents to local support services for mental and physical wellbeing, via the Sefton in Mind Directory. The first phase of the campaign was recognised by the UK Faculty of Public Health as an example of best practice.

Phase two will combine similar community-based media methods (including bus, supermarket and phone kiosk advertising) with digital advertisements posted on Facebook, Instagram, Spotify and websites such as the Liverpool Echo. The online components have the advantage of enabling viewers to access the Sefton in Mind Directory through a single click. Utilising a combination of online digital and physical community-based advertising aims to further widen the reach of the campaign in the borough, building and reinforcing awareness of both the campaign itself and its core message.

Public Health Quarterly Dashboard

I was asked to approve the Q2 Public Health Quarterly Performance Dashboard at the December brief. The dashboard highlighted several areas where performance was considered to be going well.

These included:

- Substance use insight work
- Sefton sexual health service visit
- Suicide audit completion 2020-2022
- Health improvement activity

Residential Rehabilitation Placement DPS

At the December meeting a report was presented seeking Cabinet Member for Health, Wellbeing and Inclusion approval for the extension of the Dynamic Purchasing System (DPS) contracts for the provision of substance misuse residential rehabilitation placements for an additional year, from 1st April 2025 to 31st March 2026. Residential Rehabilitation is an integral part of any drug treatment and recovery system and a vital option for some people requiring treatment for dependency to substances. Sefton has a Dynamic Purchasing System (DPS) in place to manage providers of these placements. The current arrangements were agreed by Cabinet and have been in place since April 2022 for a period of 3 years. There is provision within the DPS to extend for 2 x 12 months. This report requests approval for the first 1year extension.

Research on the Socioeconomic Inequalities in Childhood Stunting in Sefton

Childhood stunting is a term used to identify children who are not meeting their full growth potential and is associated with long-term health problems. Previous research in the UK has shown socioeconomic inequalities in childhood height. This study used data from the National Childhood Measurement Programme (NCMP) in Sefton from 2013/14 to 2022/23 which measures the heights of children in reception (4-5 years) and year 6 (10-11 years). This data was used to assess for socioeconomic inequalities in childhood stunting in Sefton and examine possible

explanations for this. The rates of stunting in reception and year 6 pupils were higher in children from the most deprived 5th of the population versus the least deprived 5th. Proposed mechanisms for how socioeconomic deprivation could cause childhood stunting included low birth weight, pre-term birth, low breastfeeding rates, food insecurity, and lack of access to healthcare. In reception pupils, these proposed mechanisms did not explain the effect of socioeconomic deprivation on childhood stunting in Sefton. However, the proposed mechanisms explained most of the effect of socioeconomic deprivation on childhood stunting in year 6 pupils. Rates of childhood stunting did not significantly change in reception or year 6 pupils in Sefton between 2013/14 and 2022/23. The results of this research will be disseminated to relevant partners within Sefton. This research will be submitted for publication in a relevant academic journal in 2025.

CGL Southport Visit

On Monday, 2nd December 2024 I attended the relaunch of the recently renovated drug and alcohol service, Change Grow Live (CGL), Southport Hub. I had the privilege of formally opening the building by cutting a ribbon and toured the newly improved premises. Stakeholders, partners and service users were also in attendance, providing them with the opportunity to view the building and see the improvements.

During my visit I engaged in some of the group activities provided by CGL and interacted with service users who shared their experiences with me. They spoke about their personal journeys and highlighted how the support and resources offered by the service have been instrumental in their progress and recovery.

Leisure

Leisure Update

The report updated on activity and progress throughout August - September 2024.

As of 30th September 2024, there were a total of 14,538 members, which is an increase from the last report of more than 462 members from the same period last year.

Across all six leisure centres, the group exercise instructors have completed the on boarding process to be set up as council employees rather than freelance.

The options for repairs to the sports hall floor at Bootle leisure centre are being reviewed. The Bunk Barn and roof terrace is now complete with the grass roof now flourishing and the roof terrace now having received full sign off with Building Control allowing for groups to gather for events. Crosby Lakeside has successfully renewed its AALA licence which is required to oversee courses and activities on the lake. The health bus was at Netherton Activity Centre during August and September providing cervical screening services for the local community.

Whilst visitor numbers and income has been strong at Dunes Splash World, in the early part of the year visitor numbers decreased over the summer period. August,

saw a £75k decrease in income (compared to Aug 23) and September (24) income was down £12k in comparison to September 23. Macmillan have started a weekly swim session in Splash World to support those persons looking to regain fitness and enhance their well-being after surgery and treatment. These sessions are term time only on Wednesdays at 10.30am in Splash World.

The Active Lifestyles organised a falls prevention awareness event as part of falls prevention week, which was held at Netherton Activity Centre. The event consisted of talks on safety in the home from the fire service, demonstrations of basic strength and balance exercises followed by a talk/activity on trip hazards in the home. In addition, we also had organisations including South Sefton PCN, Affordable Warmth, Fire Service, Active Lifestyles Weigh Forward team to offer advice and information for those who attended.

During the 6-week summer holidays, Be Active took place at a number of sites across the borough, a total of **119** sessions and over **140** hours of activity were delivered, with approximately **818** participants taking part in a range of sessions.
Building the new leisure management system is underway with the aim of the new system going live in April 2025. The new is LMS training and building is well underway. The project team includes colleagues from finance and Agilisys to support the smooth implementation of the new LMS into our six leisure centres, programmes, and services.

Junior Park Run
The report updated on junior parkrun, with a new event at Hesketh Park, Southport which has been recently established, as well as the existing event at Derby Park, Bootle which was set up in January 2020.

Junior parkrun is a free timed 2km event which takes place every Sunday at 9 am in open spaces across UK, Ireland, and Australia, it is specifically for 4- to 14-year-olds. There are currently three very popular 5km parkrun events (taking place on Saturday mornings) in Sefton held in Crosby, Southport, and Kew Woods. Following the success of these there was a keen interest for a 2km junior event to be held in the borough, which would provide 4–14-year-olds the opportunity to increase their physical activity levels.

Although the events are free and entirely run by volunteers, there is an initial set up cost of £4,000 for each event. This covers the cost of the IT equipment, including a laptop and the software for the time keeping, as well as equipment for marshalling the route such as cones, markers, and start/finish flags.

The ethos of parkrun is to have an organic growth model, and not to advertise and be inundated as the event establishes, but instead to grow via word of mouth and local community networks. Information regarding the event has also been distributed through Active Sefton colleagues to use as an exit route for programmes such as Move It, 121 referral programme, and Active Schools. Green Sefton colleagues have

given permission to use the park and will advertise on the noticeboard in the park to make the local community aware and made the Friends of groups aware should they wish to be involved.

As the events grow, it will inevitably lead to bigger attendances and have a positive impact on the local community. Hesketh Park junior parkrun has seen the attendance grow from 35 participants at the test event, to over 100-week now. Derby Park junior parkrun has now held 157 events, with 416 different children attending.

Opportunities for further junior events can be explored, but this would depend on having the funding available, along with the volunteers and a suitable location for an event to take place.

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CABINET MEMBER UPDATE Overview and Scrutiny Committee (Adult Social Care) – 7th January 2025		
Councillor	Portfolio	Period of Report
Ian Moncur	Adult Social Care	October-December 2024

Introduction

As usual during the winter period, this time of year is busy for Adult Social Care; there is increased pressure on our hospitals and a need to discharge people quickly and safely, as well as a continued need to support people to remain well at home. Sefton Adult Social Care have worked hard to the bolster their services and integrate with health at the interface with the Hospitals, in preparation for the Winter challenges, and a presentation regarding the joint working and the impact of the Care transfer Hubs is due at the February Overview and Scrutiny Committee meeting. Teams will be working during the Christmas period to ensure support is available to those within the community and those being discharged from hospital.

Preparation for Care Quality Commission Assurance and Assessment

Adult Social Care have now received their notification for their onsite assurance visit. CCQ will be onsite anytime from the 27th January to the 30th January 2025. The service is fully focused on the preparation for the onsite visit including the pre-visit session with the Executive Director for Adult Social Care in early January 2024. I am also due to meet with CQC along with the Chief Executive and Chair of Overview and Scrutiny. During their onsite visit, the inspectors will meet with a range of front-line staff, people, and carers with lived experience. Corporate colleagues from across the Council are supporting the preparation, as are key partner organisations.

After their visit, CQC will meet with the Executive Director for Adult Social Care and Health on 4th February to provide initial feedback. Following assessment, CQC will produce a draft report. This will include scores for all the quality statements and an overall rating. As well as undergoing internal quality assurance, CQC will send Sefton a copy to check it is factually accurate.

For a period during initial formal assessments, CQC also undertake an internal bench-marking exercise to review and calibrate the scores and ratings. This is to ensure consistency across local authorities. As this will be carried out across small batches of assessments, there may be a short delay before publication of our final report. We expect our final report to be available within 5 months of the date of the visit.

Better at Home Transformation Programme

The Better at Home transformation programme continues at pace. Although in total it is a three-year transformation for Adult Social Care and Health, designed to support people to stay at home for longer with appropriate support and reduce the need for residential care, Adult Social Care is already seeing the benefits. Significantly, as we enter the Winter period, Sefton ASC are supporting more people to return home after a period in hospital rather than move into [illegible] or nursing placement.

Urgent Care and Improving Access to Adult Social Care

Work to review and improve how people first access support from the service has been progressing, and this programme of transformation is being developed with staff and individuals with lived experience. Following feedback, the name and remit of the existing triage team will be changed to the “First Contact Team.” Additional staff have been recruited to resolve more requests for support at the first point of contact, rather than needing to refer on to another team. As part of this approach, the service is also working closely with colleagues in the corporate Contact Centre to take live calls directly, which means people won’t need to wait for a call back. This is planned for March 2025.

Quality Assurance of Adult Social Care Practice

Work continues with Partners for Change and three innovation sites, with a further two innovation sites in January 2025 to embed the three conversations model and improve the experience of people accessing the service. Over the last 3 months the service has focused on the refresh of the Adult Social Care Audit programme to support the collating of the 50 cases for CQC. The Senior Manager for Quality Assurance and Safeguarding has recently held staff workshops and individual team sessions for 250 staff to date, focusing on CQC preparation and practice.

Workforce

A key enabler, if not the most pivotal to any of the Sefton ASC transformation programmes is the workforce, both the recruitment and retention of staff in what is clearly a challenging local and national social care market. Sefton ASC have developed a coproduced Workforce Offer and a Delivery Plan to assist in the recruitment and retention of staff. Reducing sickness and promoting wellbeing is also a key area of focus. Over the past 12 months the corporate performance information demonstrated that ASC turnover is relatively low, especially against other LA’s Adult Social Care departments. In addition, Sefton ASC have recently recruited permanently to a number of positions in both our hospital Social Work teams and the front door. Regardless, there is still a continued need to improve staff numbers and reduce the use of agency staff, and a wider piece of work reviewing the capacity and demand across the whole service has recently been undertaken to support future workforce planning. Adult Social Care has recently recruited a new Assistant Director for Commissioning who will commence in post in early 2025.

Occupational Therapy Practice and development

As Occupational Therapy (OT) practice continues to evolve in Sefton, the 3 Conversations Model plays a pivotal role in the delivery of person-centred care, enhancing outcomes and strengthening the relationship between therapists and the people they are working with. Occupational Therapists play a crucial role in supporting individuals to achieve independence and improve their quality of life, yet the demand for these services continues to rise, while the supply of qualified OT professionals nationally remains limited.

Sefton counteracted the trend, and after a successful recruitment drive earlier this

year, the OT Team has increased capacity; this includes 3 people undertaking the OT apprenticeship degree at Sheffield Hallam University. The new year welcomes new staff, and the return of staff will bring the team to full capacity. It is therefore key that investment in the recruitment and retention of OTs in Sefton is essential to the success of ASC transformation. Ensuring early access to occupational therapy support will be a key part of the "Adult Social Care" transformation programme.

Strategic Commissioning

New Directions

Work with Sefton New Directions is continuing with a focus on the joint transformation work and how New Directions can support the delivery of the Better at Home programme, such as through their Reablement service and Chase Heys care home. A report has been approved by Cabinet in December which gave an update on the transformation work and the company's budget position.

Domiciliary Care & Reablement

We continue to experience an improved position in Domiciliary Care with around 11 people awaiting commencement of a package of care as at early December, and average waiting times of 2-3 days. We have also expanded block-booking arrangements to ensure there is dedicated capacity to support Hospital discharges.

Demand for reablement services has increased significantly over the past 2 years. The total number of people going through reablement in the last 12 months is 43% higher than in 2022, with 550 people accessing services. The vast majority of this increase in demand (78%), has been met by the expansion of alternative to reablement provision, which has been provided by domiciliary care agencies, however this can be costly and not always deliver consistent "reablement" outcomes.

A deep dive to identify the long-term requirements for reablement services has been carried out and a detailed plan of action developed. Work is ongoing to commence a procurement exercise to commission additional provision and this is expected to be in place by March 2025.

Care Homes and Quality

The service is working with health teams to support care home improvements and is continuing to conduct compliance visits to care homes, working jointly with the Safeguarding Team and meeting with wider partners such as the Care Quality Commission (CQC), through the Care Quality & Risk meetings where intelligence on care homes is shared. The Quality Assurance (QA) team have a risk stratification model in place for all providers. Currently the QA Teams are working with 15-20 care providers which have been identified as having quality concerns, although risk is a dynamic variable and QA team aims to be as responsive as needed, so this figure can vary dependent on demands/concerns. The team works in partnership with social workers, therapists and health partners to provide additional support to providers and ensure risks are managed and addressed. From January 2025, Healthwatch colleagues will also be supporting with visits across the care ma

of the "Enter and View" programme.

Work continues between Safeguarding and Quality Assurance teams to develop the Organisational Safeguarding model. A process flow chart is being developed to provide a visual representation of the decision-making process.

2025/26 Fee Setting

Work is taking place on formulating proposals for fee consultations for 2025/26 rates, which considers factors such as wage increases and National Insurance changes.

It is envisaged that consultation with Providers will commence early in the New Year.

Carers Strategy

Using the building blocks of previous strategies, carers from across the borough, system partners and Sefton Council have come together to coproduce our new Carers Strategy 2025 – 2028. Carers developed the vision, and the strategy's six themes emerged through talking and listening. This strategy closely aligns with national and local policy drivers and has early intervention and prevention at its heart. It is intended for carers of all ages and sets out what we will do together to improve their health and well-being. The strategy and implementation plan also seeks to address feedback from carers received from the biannual carers survey.

In Sefton, we value the work that carers do and want to ensure they have the support they need for themselves and their caring role. This strategy and accompanying action plan commit to identifying carers early in their caring journey and recognise that seldom-heard groups may encounter barriers that impact their access to care and support. The Carers Strategy seeks to ensure fair access to care and support and to address any barriers that may have been identified.

The process of consultation and engagement in relation to the development of the Carers Strategy was previously presented to Overview and Scrutiny Commitee in February 2024 for consideration and comment. The finalised strategy and implementation plan will be re-presented to the Committee, made available to all Members and published on the Sefton Council website.

Early Intervention & Prevention Strategy

The role of Adult Social Care has evolved over the past two decades. While it was acceptable to focus on people with the highest level of needs, this is no longer the case.

Among statutory remits are promoting social inclusion and well-being and developing sustainable services that promote independence and minimise the need for more intensive services. The Care Act 2014 helped to broaden the role of adult social care with respect to well-being, bringing considerations of early intervention and prevention into sharp focus.

It is recognised that to deliver excellent adult social care, early intervention and prevention needs to be at the heart of our approach. There are several reasons for this:

- Focusing on early intervention and prevention achieves better outcomes for the individuals concerned their carers and their families.
- Most people want to continue

e. They want to be independent, make decisions, and be in close touch with family, friends, and communities.

- By intervening early, we work with individuals to prevent them from experiencing a crisis and needing long-term care.

A wider partnership approach is key, and colleagues from across a range of community and voluntary organisations recently held a workshop with people and carers who have experience of services. The purpose of the workshop was to:

1. Share some local examples of best practice in action
2. Coproduce a local definition of what early intervention and prevention means to people in Sefton
3. Consider what a 'Good Life' looks like and what needs to be present to achieve it
4. Consider feedback from the biannual carers and annual service user surveys
5. Identify high-level key priorities for the next two years.

The information gleaned through the session will guide the development of a draft Early Intervention & Prevention Strategy 2025 - 2028, which will be shared with the group to ensure that it reflects the voices heard on the day, with further dedicated work planned for January 2025 onwards. A full update and presentation on the strategy will be provided to the Committee in due course.

Adult Social Care Budget

The budget forecast for 2024/25 indicated a potential deficit of £5.352M for the year, based on expenditure as at the end of October and on current activity levels continuing for the remainder of the year. The most significant risk remains the costs of placements and packages of care, although there are pressures in other areas also. As would be expected due to the size of the budget and the inherent risks, updates are reported monthly to ASC senior managers and to the Cabinet Member.

The Council's overall Budget Monitoring report due to be presented to Cabinet in December reports the forecast outturn overspend of £2.254m. However, it should be noted that there are a number of significant assumptions and uncertainties that could impact on the position before the year-end, including the achievement of a significant savings programme and additional mitigations.

Adult Social Care Complaints, Compliments and MP Enquiries

In October and November 2024, ASC received twenty-five compliments highlighting the compassion, knowledge and professionalism of the Adult Social Care service. We received fourteen complaints and sixteen Elected Member enquiries.

At the time of writing the report, seven of the complaints received were responded to within the expected timescale, with five complaints received remaining open but within the timescale. 100% of the Elected Member enquiries were responded to within the expected ten-day timescale during this period.

In respect of the complaints received, those raised related to the following areas/themes: decision making (4), fees (1), Human Resource Issues (2), and the quality-of-service Provision (7).

Five complaints were upheld or partially upheld; three complaints were not upheld; one was resolved upon receipt and five remain under investigation. Complaints partly upheld included a complaint about delays in discharge from hospital, and communication when transitioning from Children's Services to Adult Social Care, with direct payments.

All complaints are reviewed by the senior leadership team within Adult Social Care so learning and improvements can be taken forward across practice, process, and care provision. Learning is shared with practitioners across a number of forums within ASC and where required directly with providers. Listen and Learn notifications are shared across the Service with specific themes for learning.

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Sefton Council

Report Title:	Work Programme 2024/25, Scrutiny Review Topics and Key Decision Forward Plan		
Date of meeting:	7 January 2025		
Report to:	Overview and Scrutiny (Adult Social Care and Health).		
Report of:	Chief Legal and Democratic Officer		
Portfolio:	Public Health and Wellbeing Adult Social Care		
Wards affected:	All		
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 2024/25, identify potential topics for scrutiny reviews to be undertaken by informal meetings of the Committee; to identify any items for pre-scrutiny by the Committee from the Key Decision Forward Plan; to receive an update on the Liverpool City Region Combined Authority Overview and Scrutiny Committee; to receive an update on the Joint Cheshire and Merseyside Scrutiny Committee, established to scrutinise the work of the Cheshire and Merseyside Integrated Care Board; and to receive an update by Healthwatch Sefton.

Recommendation(s):

That

(1) the Work Programme for the remainder of 2024/25, as set out at Appendix A to the report, be noted, along with any additional items to be included and agreed;

(2) the informal meetings of Committee Members and site visits to be undertaken during 2024/25, as set out at Appendix B be noted;

(3) items for pre-scrutiny from the Key Decision Forward Plan which fall under the remit of the Committee, as set out in Appendix C to the report, be considered and

any agreed items be included in the work programme referred to in (1) above;

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

(5) the update on the Joint Cheshire and Merseyside Scrutiny Committee, established to scrutinise the work of the Cheshire and Merseyside Integrated Care Board, be noted; and

(6) the update by Healthwatch Sefton be received.

1. The Rationale and Evidence for the Recommendations

To determine the Work Programme of items to be considered during the Municipal Year 2024/25; 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.

2. Work Programme 2024/25

2.1. The Work Programme of items to be submitted to the Committee for consideration during the Municipal Year 2024/25, as approved by Committee in June 2024, is set out in **Appendix A** to the report. The programme had been produced in liaison with the appropriate Executive Directors/Assistant Directors, whose roles fall under the remit of the Committee.

2.2 The Work Programme was produced based on items included in last year's Programme.

2.3 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 2024/25 to provide Members with the opportunity to add items to the Programme.

3. Scrutiny Review Topics 2024/25

3.1 It has been usual practise for the Committee to appoint a Working Group(s) to undertake a scrutiny review of services during the Municipal Year.

3.2 However, over the last number of years the Committee agreed to hold informal meetings to consider topics for review rather than establishing Working Groups.

3.3 A schedule of the informal meetings so far for 2024/25 and site visits to be undertaken, is set out at **Appendix B**. The schedule will be updated during the Municipal Year as lines of enquiry develop and sessions take place.

3.4 The Committee is requested to comment on the schedule of informal activities to be undertaken during 2024/25 and note that additional items may be added to the schedule at future meetings of the Committee.

3.5 The Committee is requested to note that a visit to North West Ambulance Service Headquarters has been arranged for Wednesday 29th January 2025.

4. Pre-Scrutiny of Items in the Key Decision Forward Plan

4.1 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.

4.2 The pre-scrutiny process assists Cabinet Members to make effective decisions by examining issues beforehand and making recommendations prior to a determination being made.

4.3 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.

4.4 The most recent Forward Plan was published on 29 November and covers the period 1 January 2025 – 30 April 2025 and it is attached at **Appendix C** for this purpose. For ease of identification, items listed on the Forward Plan for the first time appear as shaded.

4.5 There is one item within the current Plan that falls under the remit of the Committee on this occasion, namely:

- Gross Payments

4.5 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.

4.6 The Committee is asked to give consideration to items for pre-scrutiny from the Key Decision Forward Plan as set out in Appendix C to the report, which fall under the remit of the Committee and any agreed items be included in the Work Programme referred to above.

5. Liverpool City Region Combined Authority Overview and Scrutiny Committee

5.1 As Members will be aware, the Overview and Scrutiny Management Board and the four Overview and Scrutiny Committees considered a report on the guidance Page 89 Agenda Item 8 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 (LCRCAO&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 LCRCAO&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 Hinde. Councillor Hart is Sefton's Scrutiny Link.

5.6 **Chair**

The Chair of the LCRCAO&S cannot be a Member of the majority group. The Chair and Vice-Chair of the Committee for 2024/25 are Councillors Steve Radford and Pat Moloney respectively.

5.7 **Quoracy Issues**

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 – 27th November 2024

Matters considered at the meeting related to the following items:

- Mayors Update – Devolution and Local Growth Plans
- Equality, Diversity and Inclusion Strategy 2022-26 Update
- Financial Performance Report and Mid-Year Treasury Management Strategy Update
- Performance Reporting on the Combined Authority Corporate Plan
- Work Programme 2024-25

The next meeting is scheduled to take pl[illegible] 2nd January 2025.

5.9 The Committee is requested to note the update on the Liverpool City Region Combined Authority Overview and Scrutiny Committee.

6. CHESHIRE AND MERSEYSIDE INTEGRATED CARE SYSTEM JOINT HEALTH SCRUTINY COMMITTEE

6.1 On 1 July 2022 the Health and Care Act required the Cheshire and Merseyside Integrated Care Board to commence operation.

6.2 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. Sefton's representatives are Councillor Brodie-Browne and Councillor Lunn-Bates.

6.3 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.

6.4 The most recent meeting of the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee was held on 8 November 2024, in Huyton

6.5 Sefton's representatives on the Joint Health Scrutiny Committee for 2024/25 are Councillors Conalty and Desmond

6.6 Details of the meeting 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

6.7 The Committee is requested to note the update on the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee.

7. Financial Implications

7.1 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/informal meeting review will be reported to Members at the appropriate time.

(A) Revenue Costs – see above

(B) Capital Costs – see above

8. Legal Implications

8.1 None. Any legal implications arising from the consideration of a key decision or relating to a recommendation arising from a Working Group/informal meeting review will be reported to Members at the appropriate time.

9. Corporate Risk Implications

9.1 None. Any risk implications arising from the consideration of a key decision or relating to a recommendation arising from a Working Group/informal meeting review will be reported to Members at the appropriate time.

10 Staffing HR Implications

10.1 None. Any staffing/HR implications arising from the consideration of a key decision or relating to a recommendation arising from a Working Group/informal meeting review will be reported to Members at the appropriate time.

11 Conclusion

11.1 The Committee is requested to determine the Work Programme of items to be considered during the Municipal Year 2024/25 and identify scrutiny review topics which would demonstrate that the work of the Overview and Scrutiny 'adds value' to the Council.

The pre-scrutiny process assists Cabinet Members to make effective decisions by examining issues before making formal decisions.

Alternative Options Considered and Rejected

No alternative options have been considered as the Overview and Scrutiny Committee needs to approve its Work Programme and identify scrutiny review topics.

Equality Implications: There are no equality implications.
Impact on Children and Young People: There are no direct children and young people implications arising from this report. Any children and young people implications arising from the consideration of reports referred to in the Work Programme will be contai

 eports when they are presented to

Members at the appropriate time.
Climate Emergency Implications: The recommendations within this report will have a Neutral impact. 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.

What consultations have taken place on the proposals and when?

(A) Internal Consultations

This report is not subject to LD and FD comments. Any specific financial and legal implications associated with any subsequent reports arising from the report will be included in those reports as appropriate.

(B) External Consultations

None

Implementation Date for the Decision:

With immediate effect.

Contact Officer:	Laura Bootland
Telephone Number:	0151 934 2078
Email Address:	Laura.bootland@sefton.gov.uk

Appendices:

Appendix A - Overview and Scrutiny Committee Work Programme for 2024/25

Appendix B – KDFP

Appendix C – Informal Meetings and Visits

Background Papers:

Agenda Item 14

There are no background papers available for inspection.

OVERVIEW AND SCRUTINY COMMITTEE (ADULT SOCIAL CARE AND HEALTH)
WORK PROGRAMME 2024/25

Tuesday, 18 June 2024, 6.30 p.m., Town Hall, Bootle		
No.	**Report/Item**	**Report Author/Organiser**
1.	NHS Cheshire and Merseyside, Sefton – Update Report	Deborah Butcher/Lisa Gilbert
2.	NHS Cheshire and Merseyside, Sefton - Health Provider Performance Dashboard	Luke Garner
3.	Public Health Performance Framework	Margaret Jones/Helen Armitage
3.	Cabinet Member Update Reports x 2	Julie Leahair/Julie Elliot/Laura Bootland
4.	Work Programme Update	Laura Bootland/Debbie Campbell

Tuesday, 3 September 2024, 6.30 p.m., Town Hall, Southport		
No.	**Report/Item**	**Report Author/Organiser**
1.	Shaping Care Together - Case for Change	Lisa Gilbert/Alexandra Kopec
2.	NHS Cheshire and Merseyside, Sefton - Update Report	Deborah Butcher/Lisa Gilbert
3.	NHS Cheshire and Merseyside, Sefton - Health Provider Performance Dashboard	Luke Garner
4.	Adult Social Care Assurance	Sarah Alldis
5.	Cabinet Member Update Reports x 2	Julie Leahair/Julie Elliot/Laura Bootland
6.	Work Programme Update	Laura Bootland

APPENDIX A

Tuesday, 15 October 2024, 6.30 p.m., Town Hall, Bootle		
No.	**Report/Item**	**Report Author/Organiser**
1.	North West Ambulance Service	Ian Moses
2.	NHS Cheshire and Merseyside, Sefton - Update Report	Deborah Butcher/Lisa Gilbert
3.	NHS Cheshire and Merseyside, Sefton - Health Provider Performance Dashboard	Deborah Butcher/Luke Garner
4.	Adult Social Care Performance Report	Sarah Alldis
5.	Cabinet Member Update Reports x 2	Julie Leahair/Julie Elliot/Laura Bootland
6.	Work Programme Update	Laura Bootland

Tuesday, 7 January 2025, 6.30 p.m., Town Hall, Southport		
No.	**Report/Item**	**Report Author/Organiser**
1.	Shaping Care Together Programme	Halima Sadia/Alex Kopec
2.	Proposed Changes to NHS Funded Gluten Free Prescribing	Matthew Cunningham
3..	NHS Cheshire and Merseyside, Sefton Place - Update Report	Deborah Butcher/Lisa Gilbert
4.	NHS Cheshire and Merseyside, Sefton - Health Provider Performance Dashboard	Deborah Butcher/Lisa Gilbert
5.	Right Care, Right Person Initiative	Matt Walton
6.	Hospital Discharges and Adult Social Care	Andrew McDonald and Geraldine Murphy
7.	CQC Update	Sarah Alldis
8.	Domestic Abuse Update	Mel Ormesher/Janette Maxwell
9.	Public Health Outcomes Framework (Min. No. 44 (4) of 03/01/23)	Helen Armitage

10.	Cabinet Member Update Reports x 2	Julie Leahair/Julie Elliot/Laura Bootland
11.	Work Programme Update	Laura Bootland

Tuesday, 25 February 2025, 6.30 p.m., Town Hall, Bootle		
No.	**Report/Item**	**Report Author/Organiser**
1.	Cancer Alliance Update	Jon Hayes
2.	Supported Housing Provision	Steve Metcalf
2.	Public Engagement and Consultation Panel Annual Report 2024	Jayne Vincent/Cllr Dowd
3.	NHS Cheshire and Merseyside, Sefton Place - Update Report	Deborah Butcher/Lisa Gilbert
4.	NHS Cheshire and Merseyside, Sefton - Health Provider Performance Dashboard	Luke Garner
5.	Cabinet Member Update Reports x2	Julie Leahair/Julie Elliot/Laura Bootland
6.	Work Programme Update	Laura Bootland

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Overview & Scrutiny

OVERVIEW AND SCRUTINY COMMITTEE (ADULT SOCIAL CARE AND HEALTH)
INFORMAL MEETINGS / WORKSHOPS 2024/25

Day/Date/Time/Venue to be arranged.		
No.	**Report/Item**	**Organiser**
1.	Meeting with Adult Social Care Teams - **16th October** With a view to arranging a meeting/event with social workers TBC	Laura Bootland
2.	Visit to Southport Hospital – **13th September**	Laura Bootland
3.	Primary Care Services and the state of Primary Care Estate – **19th November**	Jan Leonard
4.	Joint Meeting with Overview and Scrutiny Committee (Children's Services and Safeguarding) on the Support to Schools following the Southport Incident - **28th November 2024**	Nadine Carroll
5.	Visit to North West Ambulance Service HQ – **29th January 2025**	Ian Moses/Laura Bootland

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SEFTON METROPOLITAN BOROUGH COUNCIL
FORWARD PLAN

FOR THE FOUR MONTH PERIOD 1 JANUARY 2025 - 30 APRIL 2025

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

Appendix C

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:-

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 PorterChief Executive

FORWARD PLAN INDEX OF ITEMS

SEFTON METROPOLITAN BOROUGH COUNCIL
FORWARD PLAN

Details of Decision to be taken	**Gross Payments** To seek approval to implement gross payments for Adult Social Care residential and nursing care homes.			
Decision Maker	Cabinet			
Decision Expected	9 Jan 2025			
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 - Adult Social Care, Health and Wellbeing (Place Director)			
Persons/Organisations to be Consulted	Finance and legal department. External partners (care homes)			
Method(s) of Consultation	Meetings and emails			
List of Background Documents to be Considered by Decision-maker	Gross Payments			
Contact Officer(s) details	Karen Lee karen.lee@sefton.gov.uk			

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