Public Document Pack

WIRRAL

Health and Wellbeing Board

Date:	**Wednesday, 29 September 2021**
Time:	**2.00 p.m.**
Venue:	Floral Pavilion, Marine Promenade, New Brighton, CH45 2JS

Contact Officer:	Daniel Sharples
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AGENDA

Members of the public are encouraged to view the meeting via the webcast, (see below) but for anyone who would like to attend in person, please contact the box office at the Floral Pavilion by telephone on 0151 666 0000, in advance of the meeting. All those attending will be asked to wear a face covering (unless exempt) and are encouraged to take a Lateral Flow Test before attending. You should not attend if you have tested positive for Coronavirus or if you have any symptoms of Coronavirus.

This meeting will be webcast at
https://wirral.public-i.tv/core/portal/home

1. DECLARATIONS OF INTERESTS

Members of the Board are asked whether they have any personal or prejudicial interests in connection with any application on the agenda and, if so, to declare them and state the nature of the interest.

2. APOLOGIES FOR ABSENCE

3. MINUTES (Pages 1 - 4)

To approve the accuracy of the minutes of the meeting held on 20 July 2021.

4. PUBLIC AND MEMBER QUESTIONS

Public Questions

Notice of question to be given in writing or by email by 12 noon, Friday, 24 September 2021 to the Council's Monitoring Officer (committeeservices@wirral.gov.uk) and to be dealt with in accordance with Standing Order 10. For more information on how your personal information will be used, please see this link: Document Data Protection Protocol for Public Speakers at Committees | Wirral Council

Statements and Petitions

Statements

Notice of representations to be given in writing or by email by 12 noon, Friday, 24 September 2021 to the Council's Monitoring Officer (committeeservices@wirral.gov.uk) and to be dealt with in accordance with Standing Order 11.

Petitions

Petitions may be presented to the Committee. The person presenting the petition will be allowed to address the meeting briefly (not exceeding one minute) to outline the aims of the petition. The Chair will refer the matter to another appropriate body of the Council within whose terms of reference it falls without discussion, unless a relevant item appears elsewhere on the Agenda. Please give notice of petitions to committeeservices@wirral.gov.uk in advance of the meeting.

Questions by Members

Questions by Members to be dealt with in accordance with Standing Orders 12.3 to 12.8.

5. FORMATION OF THE COMMUNITY, VOLUNTARY AND FAITH SECTOR REFERENCE GROUP (Pages 5 - 10)

6. WORKING WITH THE COMMUNITY, VOLUNTARY AND FAITH SECTOR: UPDATE REPORT (Pages 11 - 22)

7. HEALTHWATCH WIRRAL UPDATE (Pages 23 - 30)

8. PUBLIC HEALTH ANNUAL REPORT (Pages 31 - 128)

9. WIRRAL PHARMACEUTICAL NEEDS ASSESSMENT (PNA) 2022 – 2025 (Pages 129 - 134)

10. INTEGRATED CARE SYSTEM DEVELOPMENTS (Pages 135 - 150)

11. SECTION 75 AGREEMENT (Pages 151 - 162)

12. WORK PROGRAMME (Pages 163 - 168)

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HEALTH AND WELLBEING BOARD

Tuesday, 20 July 2021

Present:

Councillor Yvonne Nolan	Chair
Councillor Tom Anderson	Wirral Council
Councillor Phil Gilchrist	Wirral Council
Simone White	Director of Children, Families and Education
Julie Webster	Director of Public Health
Dr Paula Cowan	Chair, NHS Wirral Clinical Commissioning Group
Dr Faouzi Alam (In place of Sheena Cumiskey)	Cheshire and Wirral Partnership NHS Foundation Trust
Warren Ward	Director, Community Action Wirral
Jason Oxley (In place of Graham Hodkinson)	Assistant Director Care and Health and Commissioning for Peopl
Sam Curtis (In place of Karen Howell)	Wirral Community NHS Foundation Trust
Nick McCormack (In place of Mark Thomas)	Merseyside Fire and Rescue Service
Mike Maier	Chair, Cheshire and Wirral Partnership NHS Foundation Trust

12 **DECLARATIONS OF INTERESTS**

Members were asked to consider whether they had any disclosable pecuniary interests and/or any other relevant interest in connection with any item(s) on this agenda and, if so, to declare them and state what they were.

No declarations were made.

13 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Wendy Clements, Councillor Janette Williamson, Karen Howell, Karen Prior, Louise Healey, Michael Brown, Sir David Henshaw, Sue Higginson, Graham Hodkinson, Paul Satoor, Simon Banks, Alan Evans, Janelle Holmes, Sheena Cumiskey, Supt Martin Earl and Liz Bishop.

14 **MINUTES**

Resolved – That the accuracy of the minutes of the meeting held on 16 June 2021 be agreed.

15 **PUBLIC AND MEMBER QUESTIONS**

The Chair reported that no questions from either members of the public or Members had been submitted. Nor were there any statements or petitions to receive.

16 **INTEGRATED CARE SYSTEM AND INTEGRATED CARE PARTNERSHIP DEVELOPMENTS**

Paul Edwards, Director of Primary Care and Corporate Affairs, NHS Wirral Clinical Commissioning Group introduced the report of the Chief Officer, NHS Wirral Clinical Commissioning Group, which set out the policy context for the development of Integrated Care Systems in the NHS in England, specifically highlighting the work to create a Cheshire and Merseyside Integrated Care System. The report also set out the emerging guidance around developing Integrated Care Partnership in "place" and specifically in Wirral.

It was reported that since the publication of the report, the Health and Care bill had passed its second reading in parliament, and within the legislation there was no mentioned which it was felt was a positive step to ensuring that 'places' would be able to design their own arrangements. The Board was informed that the conversations were ongoing in Wirral to develop those place partnership arrangements and the role of the Health and Wellbeing Board would be significant. Further information was provided on the decision to be taken locally, where it was anticipated that approximately 85% of commissioning would be taken at place level, with services commissioned at Cheshire and Merseyside being limited to those services where it made more sense to commission at scale such as cancer care.

Further clarification was sought on the standardisation at scale across Cheshire and Merseyside, where the Board was advised that there was still uncertainty about the allocation of resources but that there was already services being undertaken at scale when appropriate such as Alder Hey, and that Wirral had a strong case for more services to be commissioned at place given the existing pool fund arrangements.

Resolved – That

1) **The report be noted.**

2) **further reports on the progress of the development of the Integrated Care System and Integrated Care Partnerships be provided at future meetings.**

17 **THE DEVELOPMENT OF A SPORT AND PHYSICAL ACTIVITY STRATEGY FOR WIRRAL**

Nicki Butterworth, Director of Neighbourhood Services introduced the report which provided an update on the development of the Sport and Physical Activity Strategy for Wirral Leisure Services. The Board was advised that the outline strategy was endorsed by the Tourism, Communities, Culture and Leisure Committee which included developing the framework for the strategy and engaging with residents, communities and other stakeholders to design and develop the strategy which would outline the priorities for sport and leisure across the borough and aim to redress the balance between being a provider of facilities and tackling inequality through preventative, outreach and early intervention work.

Members were informed that Sports England had helped shape the thinking to improve broader health outcomes and that a diagnostic assessment of the Sport

England Strategic Outcomes Planning Guidance for Wirral Council had been undertaken, the outcomes of which were included within the report.

The Board welcomed the report and discussed the wider social benefits of sport and physical activity as well as the importance of involving younger people in the strategy via schools. Further information was sought on the preventative methods undertaken to use sport and physical activity to improve health outcomes.

Resolved – That the report be noted.

18 **PUBLIC HEALTH ANNUAL REPORT 2020/21 EMERGING RECOMMENDATIONS**

Julie Webster, Director of Public Health introduced the report which provided the Board with the emerging recommendations of the forthcoming 2020/21 Public Health Annual Report. Members were advised that the report was a statutory report produced independently by the Director of Public Health. The 2020/21 report detailed the enduring health inequalities in Wirral, the impact of the Covid-19 pandemic on those differences in health outcomes and the recommended actions needed to improve everyone's health.

Further information was provided on the details within the report, which would report on the key statistics within the borough including the 9 year difference in life expectancy from East to West as well as those compared nationally where many were worse than the England average, whilst also acknowledging the positives such as smoking prevalence in adults in Wirral being the third best performance in the country. Additional issues to be covered included fuel poverty and benefit claimants, the increase support required to children and young people and the importance of prevention and working with partners. The final report would be published in September 2021 and be presented back to the Health and Wellbeing Board.

The issue of housing standards was raised, and the Director of Public Health outlined the work ongoing on this include the Healthy Homes Initiative, and reported that further detail would be included in the final report.

Resolved – That the report be noted.

19 **WORKING WITH THE COMMUNITY, VOLUNTARY AND FAITH SECTOR**

Julie Webster, Director of Public Health introduced the report which provided an update on the work with the Community, Voluntary and Faith (CVF) Sector to improve and reduced inequalities. The Board was reminded that at its meeting on 31 March 2021, members endorsed an approach to working with the sector and the report sought to update on that work. This included a conference being held on 9 June 2021, designed and facilitated by and with the sector and led by a task and finish group comprised of representatives from a range of CVF organisations. It was reported that 38 local CVF sector representatives attended, and the key themes and outcomes were provided within the report. The Board was advised that a second conference was scheduled for 9 September and a further update would be provided at the next meeting of the Health and Wellbeing Board.

Members acknowledged the valuable contribution the Community, Voluntary and Faith sector played as providers and the need for the sector to be included in the integration of health and care. The Chair advised the Board that given the breadth of the sector, it was difficult to have one representative of the whole sector, therefore a Reference Group was in development to feed into the Health and Wellbeing Board collectively.

Resolved – That the report be noted.

20 **WORK PROGRAMME**

Vicki Shaw, Head of Legal Services introduced the report of the Director of Law and Governance which provided the Board with its current work programme and gave opportunity to propose additional items for consideration at future meetings.

The importance of an update on the Integrated Care System at each meeting was emphasised. A further discussion was had around the most appropriate time to consider the item on restoration and development of NHS
services after Covid-19. It was proposed that the Board receives a further update on the Council's Leisure Strategy and on Cheshire and Wirral Partnership's Community Services.

Resolved – That

1) **the work programme be noted.**

2) **the Leisure Strategy be added to the work programme.**

3) **an update from Cheshire and Wirral Partnership on Community Services be added to the work programme.**

WIRRAL

HEALTH AND WELLBEING BOARD

29 September 2021

REPORT TITLE:	**FORMATION OF THE COMMUNITY, VOLUNTARY AND FAITH (CVF) REFERENCE GROUP TO THE HEALTH AND WELLBEING BOARD**
REPORT OF:	**COMMUNITY, VOLUNTARY AND FAITH SECTOR REFERENCE GROUP**

REPORT SUMMARY

This report relates to the working relationship of the Community, Voluntary and Faith Sector Reference Group and the Health and Wellbeing Board.

This report affects all wards within the borough.

It is not a key decision.

RECOMMENDATION/S

The Health and Wellbeing Board is recommended to:

1. Note the establishment of a Community, Voluntary and Faith Sector Reference Group;

2. Support the development of a progressive and effective working partnership with the Community, Voluntary and Faith sector through the Reference Group;

3. Support the principal aim of the Reference Group, to build and support the development of local infrastructure, in support of ongoing programmes and plans to meet the health and wellbeing needs of Wirral's communities and residents;

4. Support the secondary aim of the Reference Group, to work in full partnership to bring forward the opportunities and benefits for communities and residents arising from Government programmes and new legislation; and

5. Support the use of all available data sources by the Reference Group to inform its contribution to plans and programmes.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 The White Paper, '**Integration and Innovation: working together to improve health and social care for all',** (February 2021) places particular emphasis on 'The Primacy of Place' and the full involvement of the Community, Voluntary and Social Enterprise sector in the development of locally designed and developed systems for tackling health inequalities. The **Health and Care Bill** currently progressing through parliament creates the legal framework to support these working together principles.

1.2 The 'refreshed' Wirral Plan 2021 - 2026, Equity for People and Place, was approved by Full Council on 6th September and fully supports these principles and in addition emphasises the need for communities and residents to play a full part in the local design process.

1.3 The impending legislation places a particular responsibility on the local Health and Wellbeing Boards in relation to the development of working partnerships, the involvement of the CVSE sector and the involvement of communities and residents in the design of new local informed approaches within the new legal framework.

1.4 The Reference Group, in developing its relationship with the Health and Wellbeing Board, has the opportunity through working in partnership to assist the development of local infrastructure and systems to enable community and residents to play their fullest part in keeping people healthy and safe.

2.0 OTHER OPTIONS CONSIDERED

2.1 An alternative option would be to co-opt a representative of the Community, Voluntary and Faith Sector to the Health and Wellbeing Board. It is felt that the sector is too wide to be represented by one individual.

2.2 A further option would be to not have the Community, Voluntary and Faith Sector represented on the Health and Wellbeing Board. This was discounted given the key role the sector has in the Health and Wellbeing of Wirral residents.

3.0 BACKGROUND INFORMATION

3.1 A literature search conducted by Community Voice (CV), the broker asked to form the reference group, found no evidence of a CVF Reference Group being formed by a Health and Wellbeing Board whose aim was to further engagement between the sector and between communities and residents. Reference Groups are regular features in the sciences and, by and large, populated by peers and experts.

3.2 In the absence of any guidance and or best practice in this setting, CV developed a design proposal as both a discussion document and an aid.

3.3 During the pandemic, and in anticipation of a much-changed landscape for the delivery of social care, CV carried out a comprehensive study of emerging and established best practice.

3.4 Prior to the pandemic, and as part of a review of the Constituency Model for Neighbourhood Working, members of the Community of Practice and Community Representatives produced a report based on the full involvement of communities and residents.

3.5 Central government has made several key statements with reference to reducing the health inequalities in the UK. Such statements as 'Building back better', 'Levelling Up', 'Looking after left behind communities' etc, to the point, that there is strong potential that associated funding streams will be made available through the new structure.

3.6 The appointment of the 'Marmot Team' and the establishment of Cheshire and Merseyside as a 'Marmot Region' in Nov 2019, refreshed recently (June 2021) establishes the five Beacon Indicators in the borough, viz.

1. Workforce education and training
2. Working with individuals and communities
3. Health sector as employer's anchor organisations
4. Working in partnerships
5. Workforce as advocates

Sir Michael Marmot advises 'telling the truth, the evidence can make a real difference'.

3.7 In the Health and Care Bill, Health and Wellbeing Boards continue to have the statutory role for improving health and wellbeing, using joint Strategic Needs Assessment (JSNA) to set local priorities. Health and Wellbeing Boards are a key component of the new legal framework with a key role to support place-based working and the development of local Integrated Care Boards.

4.0 FINANCIAL IMPLICATIONS

4.1 Building infrastructure to support working partnerships involving the CVF sector, communities and their residents will require a significant proportion of central government funding associated with 'levelling up' etc. This funding aimed at 'keeping people well' will need to be invested wisely and against appropriate investment return criteria based on social value and public value.

4.2 Building infrastructure to support working partnerships involving the CVF sector, communities and their residents is likely to require significant investment

4.2.1 The favoured approach in best practice is the establishment of Community Investment Funds, initially as pump priming, but then, by returning a proportion of savings accruing from social and public value benefit streams, such funds can be replenished and developed to serve more and more local working partnerships to generate further value and benefits to communities and residents in need.

5.0 LEGAL IMPLICATIONS

5.1 Establishing Reference Groups to inform decision making from the knowledge and perspectives of these groups can and must be a key component of place-based partnership working.

5.2 The Health and Wellbeing Board may invite representatives of other bodies to participate in Board discussions to support effective decision-making. The report seeks the approval for the establishment of a Community, Voluntary and Faith Sector Reference Group to be established to contribute to place-based partnership working in the interest of communities and residents.

5.3 The Reference Group will be required to inform the Health and Wellbeing Board as to how it will carry out its role and to inform and discuss with the Board any subsequent changes.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 No additional resources for the formation and operation of a Reference Group are anticipated. All contributions to the Reference Group are to be on a voluntary basis.

7.0 RELEVANT RISKS

7.1 There is a risk that the Community, Voluntary and Faith Sector are not fully and actively engaged in matters relating to the Health and Wellbeing of Wirral residents. This report seeks to mitigate that risk.

8. 0 ENGAGEMENT/CONSULTATION

8.1 Engagement with communities and their residents will be at the centre of all aspects of partnership working, aided by the development of local infrastructure to support place-based activities to improve health and wellbeing.

8.2 The current wider CVF and ongoing task and finish process being conducted, will serve to encourage collaborative working partnerships involving key stakeholders and further enable and inform community representation and involvement.

8.3 Consultation, with the full involvement and participation of locally elected representatives and with the providers of services. will always be considered as an essential. The level of participation and involvement to be discussed and agreed locally.

9 EQUALITY IMPLICATIONS

9.1 The Council has a public sector equality duty under the Equalities Act (2010) to have due regard to:

- tackle discrimination and victimisation of persons that share the characteristics protected under S4 of the Act. These include the characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (formerly gender) and sexual orientation;
- advance equality of opportunity between people who share those protected characteristics and people who do not;
- foster good relations between people who share those characteristics and people who do not.

9.2 The CVF-RG, being a non-statutory organisation with representation from the CVF sector, will carry forward the statutory requirements placed on its individual members and on the HWB.

9.3 The membership of the Reference Group will be taken from across different sections and will seek to be as representative as possible.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 Environmental factors are, in many ways, acknowledged as a key driver for supporting good health and have been recognised as such for decades.

10.2 Open space for recreation and exercise can play a significant part in keeping people well and safe.

10.3 Looking after the environment is a global challenge needing the full attention of all levels of society as it is widely accepted that failure to do so is adversely affecting the climate.

10.4 The challenge of looking after the local environment, within a place-based system for improving health and wellbeing, can create a strong sense of ownership at community level and pride in joint ownership.

REPORT AUTHOR:
The Community, Voluntary and Faith sector Reference Group

Leader: **Keelan Early**

BACKGROUND PAPERS
Designing a Wirral Health and Wellbeing Board CVF Reference Group: May 2021.
'Doing it to, doing it for, doing it with'. CV, Jan 2021.
Proposals for a Revised Method of Neighbourhood Working, June 2018.
The White Paper, 'Integration and Innovation: working together to improve health and social care for all'
The Health and Care Bill

SUBJECT HISTORY (last 3 years)

Council Meeting	Date

WIRRAL

COMMITTEE: HEALTH & WELLBEING BOARD

Date: 20t2021

REPORT TITLE:	**WORKING WITH THE COMMUNITY, VOLUNTARY AND FAITH SECTOR: UPDATE REPORT**
REPORT OF:	**DIRECTOR OF PUBLIC HEALTH**

REPORT SUMMARY

At the meeting of the Health and Wellbeing Board on 31st March 2021 a proposed approach to working with the community, voluntary and faith sector to improve health and reduce inequalities was presented and endorsed.

A progress report was provided to the Board on 20th July 2021 and this report provides a further update on the work programme.

This matter affects all wards within the Borough; it is not a key decision.

RECOMMENDATION/S

The Health and Wellbeing Board is recommended to note and comment on the update provided within this report and endorse the ongoing work programme included.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 To provide members of the Health and Wellbeing Board with an update on work to enhance working with the community, voluntary and faith sector.

2.0 OTHER OPTIONS CONSIDERED

2.1 This report is for information and therefore no other options are considered.

3.0 BACKGROUND INFORMATION

3.1 The Health and Wellbeing Board supported the proposed approach to working with the Community, Voluntary and Faith Sector on 31st March 2021 and the establishment of a working group to oversee the work programme.

3.2 The Working Group, which is made up of a variety of representatives reflective of the Community, Voluntary and Faith Sector (see Appendix 1), has led the development of work through the following thematic focused groups:

- Increasing collaboration
- Community, Voluntary and Faith Sector representation
- Modernising volunteering
- Behaviours that reflect values
- Tackling health inequalities

3.3 These groups have identified opportunities and proposals against each theme building on the Community, Voluntary and Faith Sector conference held in June 2021. This work was presented at a further workshop held with the Community, Voluntary and Faith Sector on 3rd September 2021 to enable wide engagement and input. 35 local community, voluntary and faith sector groups attended along with several senior Council officers and Cllr Yvonne Nolan as Chair of the Health and Wellbeing Board.

3.4 A report outlining the outputs from this work to date is provided in Appendix 2 which includes the following recommendations:

Continue to develop this work with ongoing leadership from the Sector in collaboration with key partners

The representatives of the sector, who have dedicated time to this work, will continue to contribute to its ongoing development providing leadership and working with key stakeholders. This should now extend to sector partners to reflect and develop these recommendations and identified action further. Updates will continue to be provided to the Health and Wellbeing Board, as the sponsor committee for this work programme, by the working group.

Dedicate resources to support and progress the actions identified

The Public Health Grant has provided a small resource to support the work being undertaken by the sector as part of this work programme. To enable the ongoing progression and delivery of this work it is recommended that a longer term approach and delivery plan is developed.

It is therefore proposed to work with stakeholders to develop a delivery plan and business case to ensure adequate resources to deliver action identified for 2022/2023 and beyond.

Create the right conditions and culture for collaboration

A commitment is needed from all public sector partner organisations across Wirral to work with the Community, Voluntary and Faith Sector to co-design a collaboration framework. Previously example of this type of framework include COMPACT.

It is proposed that partners from stakeholder organisations are convened to form a steering group alongside Community, Voluntary and Faith Sector representatives which will lead the development of a collaboration framework.

Develop a representative and engagement arrangement for the Community, Voluntary and Faith Sector

A new representative mechanism is needed for the Community, Voluntary and Faith Sector to fully participate in strategic planning. It is proposed that partners work together in a dedicated group to develop this arrangement.

Enabling infrastructure that support the sector to operate

The Community, Voluntary and Faith Sector needs dedicated support with communication, a dedicated catalogue/website to aid collaboration and roles which can help gather, share, and facilitate this. It is proposed that interim secondments or dedicated resources within these specialist areas to support communication on an interim basis is provided from public sector partners until the development programme in concluded and a delivery and business plan is developed.

A system volunteering development group is needed to bring together skills, strengths, and resources for the benefit of Wirral. Partners are recommended to identify how this can be taken forward collectively.

Digital infrastructure such as a Community, Voluntary and Faith Sector website, catalogue and voting tool is required to underpin/improve collaboration, communication, and representation. Financial support is requested to procure the necessary digital infrastructure.

3.5 It is proposed that the Community, Voluntary and Faith Sector working group continues to develop the recommendations identified in 3.4 developing a delivery plan and business case to support a long-term approach. Engagement to date has focused on the Community, Voluntary and Faith Sector to develop an approach, partners will now be engaged further to inform the ongoing work programme. Resource will be provided, via the Public Health Grant, to support the development

of this work whilst a long term delivery plan which identifies required resources is being developed.

3.6 A further update will be provided to the next meeting of the Health and Wellbeing Board in November 2021.

4.0 FINANCIAL IMPLICATIONS

4.1 The work programme outlined within this report will inform future financial implications and any subsequent commissioning intentions which may include pooling resources across the Council and or with Partners.

4.2 The Public Health Grant will be utilised to fund this development work programme. Subsequent resource requirements will be identified in the delivery plan and business case for consideration for members.

5.0 LEGAL IMPLICATIONS

5.1 There are no legal implications arising from this report, however future actions taken may have legal implications which will need to be addressed at the relevant time and any future procurement will need to be conducted in accordance with the Council's contract procedure rules.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 The work described within this report will identify any future resource requirements.

7.0 RELEVANT RISKS

7.1 Continuing engagement from the Community, Voluntary and Faith Sector is key as is the contribution from Wirral partners. As part of this work relevant risks will be identified related to the workstreams outlined.

8.0 ENGAGEMENT/CONSULTATION

8.1 A fundamental tenet of this work is to enable a co-produced programme of work engaging with the many local Community, Voluntary and Faith networks, and organisations to inform how the Council and sector will work together in the future to improve health and wellbeing.

9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

9.2 This report has no impact on equalities, however we will ensure that any associated actions meet our obligations under the Equality Act 2010 and the Public Sector Equality Duty, such actions will be subject to individual Equality Impact Assessments where appropriate.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 All meetings and workshops have been undertaken by virtual means helping to reduce the borough's carbon footprint.

REPORT AUTHOR: **Name Julie Webster**
Title Director of Public Health
email: juliewebster@wirral.gov.uk

APPENDICES

1.CVF Sector Working Group and Task and Finish Group Membership

2.Community, Voluntary and Faith Sector Task and Finish Group Report September 2021

BACKGROUND PAPERS

Wirral Community Wealth Building Strategy

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Health & Wellbeing Board	31st March 2021
Health & Wellbeing Board	20th July 2021

APPENDIX 1

CVF Sector Working Group and Task and Finish Groups Membership

CVF Sector Working Group and Communication Channels

Communities of Practice Group

Chief Officers Group

Humanitarian Cell

Faith Cell

BAME Cell

Thematic Groups

A number of thematic groups have been established to across the five themes. Membership for each group is as follows:

Volunteering

Zel Rodgers- Community Action Wirral
Jenni Jones- Leasowe Development Trust
Sandra Gilbert- Wirral Mind
Micha Woodworth- Healthwatch Wirral
Chris Allen- Make it Happen
Myrtle Lacey- Salvation Army
Julie Kay- Older People's Parliament
Lisa Leece- Forum Housing

Behaviours

David Maguire- Wired
Tiffany Subinyoung- Wirral Change
Aline Macready- WMO
Lewis Macdonald- Eastham Delamere Centre
Julian Eyre- Wirral Community Trust
Amy Butterworth- Make it Happen
Chris Allen- Make it Happen

Strategic Influence and Development support

Jamie Anderson- Age UK
Sandra Gilbert- Wirral Mind
Bev Morgan- Koala NW
Alex Fisher- Community Voice
Natalie Calvert-Young- PCW GP Federation
Keith Addenbrooke- Faith sector leader- Bidston and St James
Carol Johnson-Eyre- Wirral CAB

Tackling Inequalities Together

Laura Stevenson- WEB Wirral
Alex Fischer- Community Voice
Bev Morgan- Koala NW
Tiffany Subinyoung- Wirral Change
Julie Kay- Older People's Parliament
Sharon Nicholson- Wirral Mencap
Keith Addenbrooke- Faith Sector Leader- Bidston and St James.
Louise Healy- DWP
Carol Johnson-Eyre – Citizens Advice Wirral

Collaboration and Equal Partnerships

Keelan Early- Cradle to Career
Zel Rodgers- Community Action Wirral
Sonia Holdsworth- One Wirral CIC
Sharon Nicholson- Wirral Mencap
Justine Molyneux- Involve Northwest
Phil Dickinson- Faith sector leader
Anna-Louise Van Der Merwe- Foundation Years Trust

APPENDIX 2

Community, Voluntary and Faith Sector Task and Finish Group Progress Report

September 2021

1.0 Background

The community, voluntary and faith (CVF) sector plays a hugely important role in Wirral, contributing to the local economy and providing a wide range of activities and services to residents that improve health and wellbeing. The sector is therefore a key partner in the delivery of the Wirral Plan and an important bridge between the public sector and local people.

In March 2021 the Health and Wellbeing Board supported the development of a work programme to build momentum on the considerable work already undertaken with the CVF sector during the pandemic and to look to identify opportunities for working collaboratively in the future to improve health.

To inform this work programme a CVF conference was held in June 2021 to begin exploring the role the sector has played during the pandemic, the potential for further growth to help tackle local challenges and to understand how the CVF could be further empowered and enabled. From the conference key themes emerged from the discussions which laid the foundations for further CVF led work; these themes were:

- Increasing collaboration
- CVF Representation
- Modernising Volunteering
- Behaviours that reflect values
- Tackling health inequalities

A working group including a range of representatives from the CVF, and with input from Council Officers, came together and have been working with the wider sector to build on the themes that emerged during the June conference.

This report details the outputs from this work to date and sets out recommendations for the next stages of this work programme.

2.0 CVF-led Approach

Following the June conference, single topic groups were arranged to enable participants to discuss what is already in place, what can be built upon and what is needed to empower, enable and grow. From these sessions smaller groups of volunteers came forward, forming task and finish groups; offering a safe space to define the CVF ‘offer’ and ‘ask’.

The Humanitarian Cell, Faith Cell, Communities of Practice group and Chief Officers groups have acted as the formal communication channels and conduit to the wider CVF to encourage openness around the process and conversations, and to encourage participation and inclusiveness. What has become apparent during this time is the interdependence of

sectors within the borough and the desire and willingness from the CVF to work with partners to truly make Wirral the place it could and should be.

A follow up conference in September brought together the findings and gathered further insight into what the CVF proposals should be for inclusion in this report.

3.0 Findings

Each task and finish group explored the themes in more detail but was clear in its aim to develop ideas and solutions and a blueprint for a longer-term development programme. The principles that emerged were:

- Democratic ways of working
- Co-designed by the CVF
- A learning and adaptive mechanism
- Inclusive
- Respectful
- Being willing to challenge
- Solution focused

The following summaries outline the work areas identified for action from each of the Task and Finish groups.

3.1 Representation Task and Finish Group

The group agreed there was a need for a single representative mechanism for the CVF sector. It should be democratic and will facilitate the voice and expertise of the CVF in developing local strategy and action alongside public sector partners. This new mechanism will learn from the past and ensure robust and clear communication channels, defined roles and a code of conduct.

The CVF sector recognise that there will be occasions where specific organisations need to be engaged rather than a CVF representative which is understood but for true representation, partners must use the agreed mechanism and are asked not to circumvent this.

3.2 Collaboration Task and Finish Group

Collaboration within the CVF and with external stakeholders is a key component in our collective ability to deliver on our vision for Wirral. Existing examples of local good practice should be more widely adopted. These include the early years alliance model and the Brighton and Hove collaborative framework.

Having a co-designed collaborative framework creates a common understanding of why and how we collaborate. Working outside of this should be open to respectful challenge to ensure these refreshed ways of working are embedded at all levels across the Wirral system.

To complement this a network of CVF champions within partners organisations would develop a better understanding of the sector, help develop meaningful relationships and aid communication and implementation of the framework, especially helpful within very large organisations.

3.3 Behaviours Task and Finish Group

Collaboration is dependent on mature relationships and trust. Open and frank discussions were had regarding stakeholder behaviours including the Sector, citizens, partners and elected members. There was some concerns raised about how willing and/or able the CVF were to hold people to account over behaviours that negatively impact on relationships; this emphasises the importance of addressing behaviours. It was agreed that some common understanding and expectations around how we work together is important and should be developed. Without this collaboration is going to be challenging.

3.4 Volunteering Task and Finish Group

Volunteering delivers benefits for the volunteer, the organisation, the local community and Wirral partners. The group felt that there was opportunity to work more as a system to encourage and develop volunteering in Wirral. A system wide plan and commitment to working collaboratively to recruit, mobilise, support, recognise and develop volunteers has been identified. Smaller organisations who often feel disadvantaged in securing volunteers as they are not able to offer what larger organisations are.

The need to modernise our approach whilst not losing what we know works was also recognised. Digital infrastructure is important but we must also offer a more human option, providing advice, support, buddies to help people make the first step. Organisations have begun to be more creative and flexible rather than maintaining traditional ways of involving volunteers and this has achieved great outcomes which should be shared and more widely adopted.

3.5 Health Inequalities Task and Finish Group

The role of the CVF in understanding and tackling health inequalities could certainly be expanded. Although Infobank is a great resource for members of the public to find local services it does not provide a platform for the CVF to connect and collaborate. It was felt that something separate and dedicated to the sector should be created. CVF organisations do not always have the resources for more specialist roles such and communication or data analyst roles, however by having some CVF specific roles we could gather more insight from communities to build a better picture of what's strong and where there are needs or gaps.

There was agreement to build on what's strong and to learn lessons from the past so we avoid making the same mistakes time and time again.

4.0 Recommendations

Based on the work undertaken the following recommendations have emerged:

1. Continue to develop this work with ongoing leadership from the Sector in collaboration with key partners

The representatives of the Sector, who have dedicated time to this work, will continue to contribute to its ongoing development providing leadership and working with key stakeholders. This should now extend to Sector partners to reflect and develop these recommendations and the identified action further as well as continuing engagement across the Sector building on the two conference events. Updates will continue to be provided to the HWBB, as the sponsor Committee for this work programme, by the Working Group.

2. Dedicate resources to support and progress the actions identified

In addition to the investment into the infrastructure support commission, which ceases at the end of September 2021, the Public Health Grant has also provided a small resource to support the work being undertaken by the Sector as part of this work programme. To enable the ongoing progression and delivery of this work it is recommended that this small investment continues to support the development of a longer term approach and delivery plan.

CVF organisations require local funding opportunities, both grants and contracts to support work around health inequalities. Core funds should also be considered to allow the CVF sector to be able to engage in representation in addition to delivering their services. This will increase the sectors' ability to influence and local policy will be strengthened from the knowledge the CVF will bring.

It is therefore proposed to work with stakeholders to develop a delivery plan and business case to ensure adequate resources enable the action identified for 2022/2023 and beyond.

3. Create the right conditions and culture for collaboration

A commitment is needed from all public sector partner organisations across Wirral to work with the CVF to co-design a collaboration framework as well as implement in their respective organisations and contribute to evaluation. Support to revisit ABCD with senior leaders across the system and then defining the professional behaviours that support ABCD principles is recommended as part of this.

It is proposed that Sector partners from stakeholder organisations are convened to form a steering group alongside CVF representatives which will lead the development of a collaboration framework. This will also be an opportunity to engage Partners in the work that has been developed and to inform the ongoing work programme and business case.

4. Develop a representative and engagement arrangement for CVF

A new representative mechanism is needed for the CVF to fully participate in strategic planning in a democratic way. It is proposed that a collective team of partners work together in a dedicated group to develop this arrangement. Partners will need to identify where they have CVF representation and where they require CVF representation. As well as formal governance arrangements, roles and responsibilities additional support to enable wide ranging participation and inclusion should be developed as part of this to ensure that no one is disadvantaged from participating.

5. Enabling infrastructure that support the sector to operate

CVF needs dedicated support with communication, a dedicated catalogue/website to aid collaboration and roles which can help gather, share and facilitate this. It is proposed that interim secondments or dedicated resources within these specialist areas to support communication on an interim basis is provided from Public Sector Partners until the development programme in concluded and a delivery and business plan is developed.

A system volunteering development group is needed to bring together skills, strengths, and resources for the benefit of Wirral. Partners are recommended to identify how this can be taken forward collectively.

Digital infrastructure such as a CVF website, catalogue and voting tool is required to underpin/improve collaboration, communication and representation. Financial support requested to procure the necessary digital infrastructure.

Next Steps

This report will be presented to the Health and Wellbeing Board on 29th September 2021 at which support for the continued development of this work programme will be sought.

Report by: Karen Livesey on behalf of CVF Sector Working Group Membership

WIRRAL

HEALTH & WELLBEING BOARD

29 September 2021

REPORT TITLE:	**HEALTHWATCH WIRRAL UPDATE SEPTEMBER 2021**
REPORT OF:	**CHIEF EXECUTIVE OFFICER, HEALTHWATCH**

REPORT SUMMARY

The purpose of the report is to share with the Health and Wellbeing Board the emerging trends and themes gathered from public views and personal experiences relating to health and care. The information collected, to form this update, is sourced from the people who have contacted Healthwatch via email, phone or by using the Feedback Centre, or during community engagement work.

RECOMMENDATION/S

The Health and Wellbeing Board is recommended to note and comment on the report.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 The quarterly report submitted to Health and Wellbeing Board is compiled from the users and front-line deliverers of service. It is imperative that we learn from them and take them on the journey as change evolves**.**

2.0 OTHER OPTIONS CONSIDERED

2.1 Other options included reporting into the Health and Wellbeing Board on less regular basis, however it is felt that quarterly reports provide contemporary information for the Board.

3.0 BACKGROUND INFORMATION

3.1 Healthwatch Wirral exist to ensure the views of local people on health and social care services are heard. Every voice counts and we reach deep into our communities through our outreach work. We have good knowledge of our Borough and strong relationships with all partners including LA, NHS and 3rd sector and have the flexibility within our remit to be unbiased, open and honest.

3.2 The report provides a summary of the feedback provided to Healthwatch Wirral on local health and care services. The report was requested on a quarterly basis as part of the work programming for the Health and Wellbeing Board.

4.0 FINANCIAL IMPLICATIONS

4.1 The report is for information purposes only and there are no financial implications.

5.0 LEGAL IMPLICATIONS

5.1 Health and Wellbeing Board is charged to work with HealthWatch in Wirral to ensure appropriate engagement and involvement within existing patient and service user involvement groups takes place.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 The report is for information purposes only and there are no resource implications.

7.0 RELEVANT RISKS

7.1 The Health and Wellbeing Board is keen to work with its partners to improve health outcomes for local people. The feedback provided within the report provides an insight into how people feel about local health and care services and failure to consider the feedback would increase the risks of not being able to improve health outcomes.

8.0 ENGAGEMENT/CONSULTATION

8.1 A key source of the feedback used to collate the information within the report was from Healthwatch's Community Engagement work.

9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

9.2 This report is for information purposes only and the content will be supplied by a partner agency. The Health and Wellbeing Board is committed to ensure that the work it does has equality at its heart and does not discriminate against anyone. Any associated actions may need an Equality Impact Assessment.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 There are no direct environment or climate implications as result of this report. However, Wirral Council and its Committees will consider the Climate Emergency Declaration within all the work it does and will continue to incorporate this into their work programme and hold all partnerships to account.

REPORT AUTHOR: Name: Jenny Baines and Mike Shakeshaft on behalf of Karen Prior, for Healthwatch Wirral.

Title Karen Prior, CEO Healthwatch Wirral
email: karen.prior@healthwatchwirral.co.uk

APPENDICES

Appendix 1 – Healthwatch User Feedback

BACKGROUND PAPERS

Wirral Healthwatch Vaccination Site Feedback April 2021

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Health and Wellbeing Board	11 March 2020 13 November 2019 14 November 2018

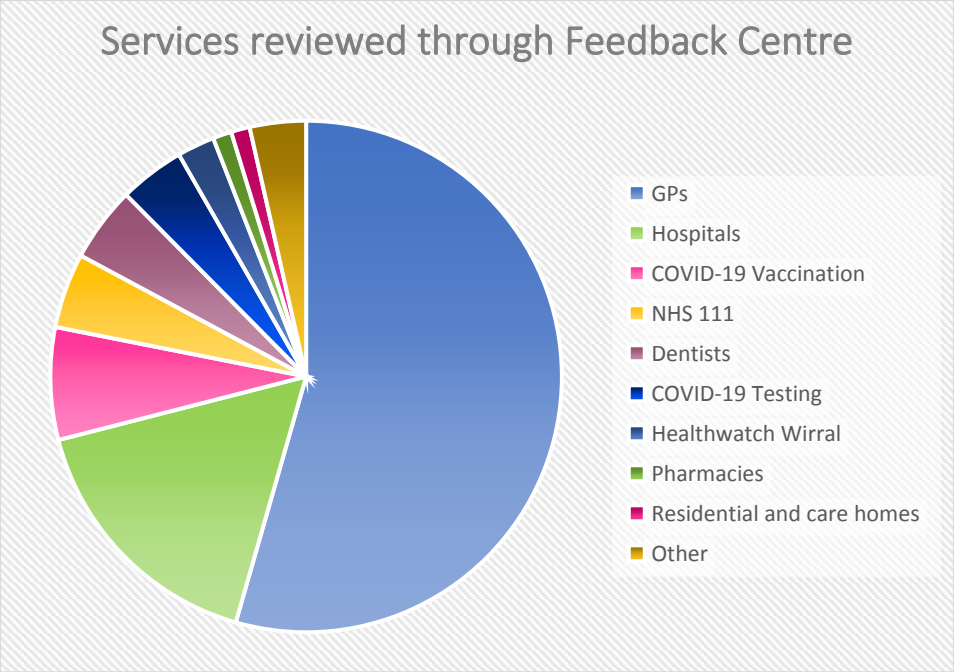
The information below may not be suitable to view for people with disabilities, users of assistive technology or mobile phone devices. Please contact karen.prior@healthwatchwirral.co.uk if you would like this document in an accessible format.

Appendix 1

Feedback Centre – August 2021 Quarterly Report data (exported 24th Aug)

This report covers feedback received during the period Jun 2021-August 2021. During June Healthwatch Wirral staff were working in partnership with Wirral Council to support one of the Mobile Testing Units and to get feedback from members of the public face-to-face, so many of the themes and trends from this time period come from this community engagement work.

Services reviewed

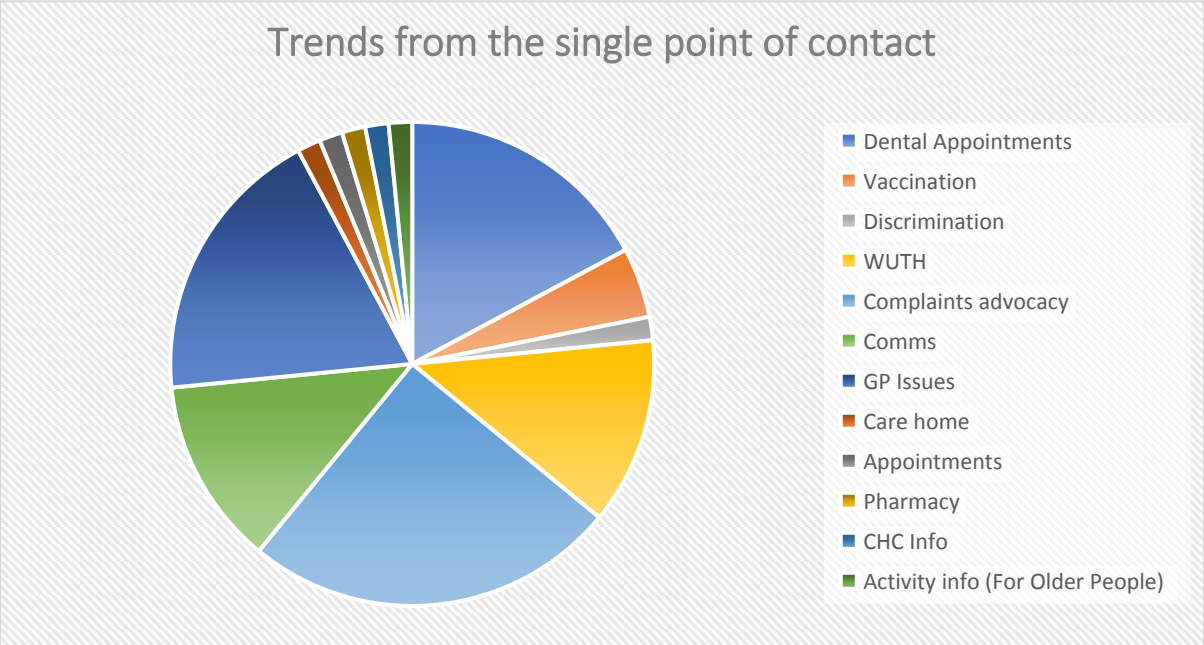


- **54%** of all feedback was about **GPs**
- **17%** of feedback covered **hospitals** (Including WUTH, Clatterbridge, Clatterbridge Cancer Centre and Wirral Women's and Children's Hospital)
- We received limited feedback on services including COVID-19 vaccination, NHS 111, dentists, COVID-19 testing, pharmacies and residential and care homes
- **'Other'** covers services where we only received one review – this includes the Integrated Discharge Team, North West Ambulance Service, Podiatry, Transfer to Assess, Arrowe Park Urgent Treatment Centre and the 0-19 Health and Wellbeing Service

- Partner organisations and members of the public can now also leave feedback about Healthwatch Wirral on the Feedback Centre

Single point of contact

the single point of contact encompasses issues that are relayed to Healthwatch Wirral Via phone or email that have not gone directly to the Healthwatch Wirral feedback centre



As you can see above the greatest topic of conversation was Healthwatch Wirral's complaints advocacy service (25%) followed by issues surrounding GPs (19%) and dental appointments (17%).

Demographics

- **7%** of all respondents answered the monitoring questions
- Of the people who answered the monitoring questions:
    - **46% 25-49 years old; 38% 50-64 years old; 16% 65 years or older**
    - **54% female, 46% male**
    - **All from a White background**
    - **64% heterosexual, 9% gay woman/lesbian, 9% other, 18% prefer not to say**
    - **50% Christian, the rest either no religion or prefer not to say**
    - **33% identified as carers**
    - **38% considered themselves to have some form of disability** (including long-standing illness and mental health conditions as well as physical, sensory and learning disabilities)

Overall themes

- **Access to appointments** is the main issue highlighted across most services, especially GPs and dentists. Access issues include:
    - Some people struggle with or are unable to use e-consult
    - Unable to get through on the phone
    - Long waiting times for appointments
    - Unable to get a face-to-face appointment
- Experiences of appointment access vary even within practices and services
- Multiple people reported having to **attend A&E** after being **unable to access primary care** or getting **no response from NHS 111**
- Nearly all feedback about the **COVID-19 Vaccination** programme has been **extremely positive**, with praise for kind staff and efficient systems
- There have been some issues getting **results of COVID-19 tests**, especially for those without a mobile phone or email address

GPs

GPs were the most common service we received feedback about during our work with the Mobile Testing bus. Experiences of GP services were extremely mixed – some people felt their GPs had gone above and beyond during the pandemic, while others had struggled to contact their GP or access appointments.

Positive themes:

- Excellent experiences ordering repeat prescriptions online
- Quick referrals
- Good access to appointments – able to see or speak to a doctor
- Caring staff
- Positive experiences of phone appointments

Negative themes:

- Unable to get through on the phone
- Unsatisfied with diagnosis over text message
- E-consult remains difficult for many
- Long waiting lists for appointments (leading to A&E attendance for some)
- Unable to access face-to-face appointments
- Lack of communication between GPs and consultants/specialists
- Inaccurate medical records
- Carer records not kept up to date

Wirral University Teaching Hospital

Positive themes:

- Praise for A&E staff
- Positive experiences of treatment for COVID-19
- Excellent staff at Rheumatology clinic:
  "*excellent nurse who asked me if I could read letters sent by hospital and if*

I could hear ok on phone and then if I had any problems at home very thorough and caring following access to information guidelines."

Negative themes:

- Long waiting times at A&E
- Delays to handling complaints
- Lack of discharge support/felt discharged too soon
- Long waiting times for operations and lack of support while waiting
- Lack of outpatient support
- Long waiting times for referrals

Clatterbridge Hospital

Positive themes:

- Quick scan results

Clatterbridge Cancer Centre

Positive themes:

- Excellent staff

Negative themes:

- Discharged over Zoom – felt alone

Wirral Women and Children's Hospital

Positive themes:

- Excellent consultants during pregnancy

Negative themes:

- Staff could be more compassionate at times
- Negative experience of giving birth

COVID-19 Vaccination

Positive themes:

- Excellent staff and procedure:
  "Kind friendly staff make you feel calm about receiving the vaccine the questions they ask are thorough and necessary for your wellbeing area is laid out well and cleanliness is a priority"
- Supportive staff for anxious patients:
  "My sister is needle phobic and was very nervous to attend. I called in advance and spoke to Sharon who was so helpful. At the appointment everyone was so kind and it was such a stress free process - special mention to Janette Nurse who is an absolute gem and a credit to your team!"
- Good attention to cleanliness

Negative themes:

- Long waiting time for second vaccine [in June]

For more feedback about the Wirral COVID-19 Vaccination Programme, please see our April report covering all vaccination sites: https://healthwatchwirral.co.uk/wp-content/uploads/2021/05/April-Vaccination-Report-all-sites.pdf

NHS 111

Positive themes:

- Helpful and patient staff
- Short wait
- Able to access phone consultations, home visits and GP appointments

Negative themes:

- Unable to get through
- Wrong advice given for (what turned out to be) broken wrist

Dentists

Positive themes:

- Able to access appointments and check-ups

Negative themes:

- No appointments available and/or long waits
- Unresponsive
- Only doing emergency work

COVID-19 Testing

Positive themes:

- Professional and caring staff
- Efficient and easy process

Negative themes:

- Results don't always come through
- Access issues for those without email or mobile number

HEALTH AND WELLBEING BOARD

DATE: 29TH SEPTEMBER 2021

REPORT TITLE	Public Health Annual Report 2020/21
REPORT OF	Julie Webster, Director of Public Health

REPORT SUMMARY

The Public Health Annual Report (PHAR) is the independent annual report of the Director of Public Health and is a statutory requirement. The 2020/2021 Report describes enduring health inequalities in Wirral, the immediate impact of the COVID-19 pandemic on these differences in health outcomes and recommended actions that we need to take to improve everyone's health.

The Public Health Annual Report is an important vehicle to identify key issues, flag up problems, report progress and inform local inter agency action. The purpose of the PHAR is to draw attention to issues of importance which have an impact on population health. Since the Council took back responsibility for Public Health in 2013, we have published six reports on:

- Social isolation
- Healthy schools and children
- Domestic violence
- The roles of the Council and NHS in promoting health and wellbeing
- Problem gambling
- The role of culture in health and wellbeing

These reports have led to action in the reduction of people smoking in the borough to levels below the national average; increased support for people who were feeling socially isolated plus significant activity across a range of partners to highlight and reduce the damage caused to our communities from alcohol abuse and gambling.

The 2020/2021 Report seeks to direct action that we need to take to reduce the impact of health inequalities on our residents and improve health for everyone in our borough.

RECOMMENDATIONS

The Health and Wellbeing Board is requested to endorse the recommendations detailed within the Public Health Annual Report.

SUPPORTING INFORMATION

1.0 REASONS FOR RECOMMENDATION/S

1.1 The production of an annual report is a statutory requirement of the Director of Public Health. The Council has a duty to publish the report.

2.0 OTHER OPTIONS CONSIDERED

2.1 The publication of the Public Health Annual Report is a legal requirement, no other options have been considered.

3.0 BACKGROUND INFORMATION

3.1 The global COVID-19 pandemic has created unprecedented challenges and new experiences for everyone. However, whilst the pandemic has affected us all, the burden has not been shared equally. The long-standing problems associated with health inequality have endured; vividly exposing the impact of these unacceptable differences on people and communities. The pandemic has also made these health differences worse, and the heaviest impacts have fallen on the lives of people already experiencing health, economic and social inequalities.

3.2 Whilst we have made great progress to support people to live healthier lives in Wirral, health inequalities are stubbornly persistent. Prior to COVID-19, Wirral already had some of the poorest health outcomes in the country, with high numbers of socially and economically vulnerable people and extensive, prevailing health inequalities. Within Wirral the difference in life expectancy between those living in the most and least deprived areas is 10.7 years for men and 11.2 years for women. The impacts on individuals, communities, services, and the economy are enormous, and the repercussions of the pandemic will aggravate these further.

3.3 Continuing to tackle health inequalities, and reduce its impact on our community, will be a key task long into the future and one which will benefit every resident. Although some things that influence our health cannot be changed, such as our age and genes, there are many important factors that, collectively, we can change. Issues such as poverty, unemployment, poor housing, and unhealthy environments are major contributors to this health gap. The pandemic has shown us what we can achieve when we all work together and the speed at which we can make change happen.

3.4 The report identifies five key recommendations which intend to direct the action we need to take together to improve health for everyone in our borough and support the delivery of the Wirral Plan. The recommendations are as follows:

- Prioritise economic regeneration and a strong local economy
- Safeguard a healthy standard of living for all
- Increase support for children, young people, and families

- Strengthen action to address differences in health outcomes and prevention
- Residents and partners continue to work together

3.5 A detailed, technical supplementary report has been developed and is appended to the Annual Report. This provides information that is summarised within the main report.

4.0 FINANCIAL IMPLICATIONS

4.1 There are no financial implications arising directly from this report. However, in order to implement the recommendations resources will be required.

5.0 LEGAL IMPLICATIONS

5.1 The Public Health Annual Report is a statutory duty on Directors of Public Health. There are no specific legal implications arising from this report.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 This report has been financed from within existing resource and the main inputs have been staff time of officers in Public Health.

7.0 RELEVANT RISKS

7.1 The impacts of the pandemic on the health and wellbeing of the local population are still emerging and therefore not fully understood. The recommendations presented therefore take account of some of this uncertainty. Ongoing surveillance, intelligence and insight will be required to ensure Partners are responding to the needs of the local population.

7.2 Wirral Partners remain in both emergency and recovery response therefore resources are pressured, and services stretched. The recommendations are however intended to support and inform the local system to plan for the future and enable the borough to recover effectively for everyone.

8.0 ENGAGEMENT/CONSULTATION

8.1 The Health and Wellbeing Board was consulted on the emerging recommendations of this year's Public Health Annual Report in July 2021. Internal and external stakeholders have been integral to the development of the PHAR and insight generated throughout the pandemic from local people has been used to inform the report.

8.2 The Public Health Annual Report is intended to emphasise the collective contribution, and responsibility for health and wellbeing. The PHAR therefore has an important and continuing role to play as a spur to action in the wider system and as part of our ongoing public communications and engagement strategy.

8.3 The finalised PHAR will be shared at various Council and partner committees. It will also be disseminated electronically to community stakeholders and published on the Council and Wirral Intelligence Service websites.

9.0 EQUALITY IMPLICATIONS

9.1 An Equality Impact Assessment has been undertaken and is located: - https://www.wirral.gov.uk/communities-and-neighbourhoods/equality-impact-assessments

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 The content and/or recommendations contained within this report are expected to have no impact on emissions of carbon dioxide.

REPORT AUTHOR: **Julie Webster**
Director of Public Health
telephone: (0151 666 5142)
email: juliewebster@wirral.gov.uk

APPENDICES

APPENDIX 1: Public Health Annual Report 2020/2021

APPENDIX 2: Public Health Annual Report 2020/2021 Technical Briefing

BACKGROUND PAPERS

Wirral Intelligence Service (2021) Health Inequalities
https://www.wirralintelligenceservice.org/jsna/health-inequalities/

Health Equity in England: The Marmot Review 10 Years On (2020)
https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

Build Back Fairer: The COVID-19 Marmot Review (2020)
https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review

HM Government (2021) Build Back Better: our plan for growth
https://www.gov.uk/government/publications/build-back-better-our-plan-for-growth

Public Health England (2020) COVID-19: review of disparities in risks and outcomes
https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes

SUBJECT HISTORY

Council Meeting	Date
Health and Wellbeing Board	20th July 2021
Adult Care and Health Overview and Scrutiny Committee	19th November 2019
Health and Wellbeing Board	13th November 2019
Council	14th October 2019
Cabinet	30th September 2019
Health and Wellbeing Board	18th July 2018
Cabinet	16th July 2018

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Embracing optimism

Living with COVID-19

Annual Report of the Director of Public Health for Wirral

2020-2021

Contents

Foreword

This is my first Public Health Annual Report since all our lives have been changed by the COVID-19 pandemic. The impact has been devastating but our community has been extraordinary.

In January 2020 Wirral became one of the first places in the world responding to COVID-19 when we hosted British residents from Wuhan. Since then, we have all worked hard together to Keep Wirral Well.

I have seen the commitment of people working relentlessly in the NHS and care sector, the endurance of people to stay at home doing things we have never done before, the kindness and compassion of our communities and the hard work and creativity of schools, businesses, community and voluntary sector groups and all our public sector partners to protect us.

I extend my sincere gratitude to everyone for the part they have played and my condolences to the families of those who have succumbed to the virus. Although COVID-19 has been the biggest health challenge to affect us all for generations, many of the enduring health problems we faced before the pandemic have worsened as a result. And, whilst the pandemic has touched us all some people have felt the impact of the virus and the measures to control it worse than others.

As COVID-19 becomes something we have to live with we must remain dedicated to improving the health and wellbeing of Wirral residents. To do this we will need to build on the shared commitment and effort demonstrated by residents and partners during the pandemic. This report looks at the health of the Wirral population, how the pandemic has impacted our community's health and wellbeing and sets out the things that we all must do, addressing some of the old challenges and tackling new ones, to Keep Wirral Well.

Julie Webster

Julie Webster
Director of Public Health

Executive Summary

When everyone is healthy, everyone benefits. We have made great progress to support people to live healthier lives in Wirral. However, some communities continue to experience better health than others.

The pandemic has made these differences worse, and the heaviest impacts have fallen on the lives of people already experiencing health, economic and social inequalities.

These differences are the most significant health challenge in Wirral. They impact on the quality of people's lives; the way residents use services and how individuals and the economy prosper.

Differences in health occur because of the social, economic, and environmental conditions in which people live. Protective factors include having good quality employment, a safe and warm home, and the best start in life. Urgent action to tackle longstanding health inequalities in Wirral is now required. The pandemic has however shown us what we can achieve when we all work together and the speed at which we can make change happen.

Crucially we are presented with the opportunity to reduce the gap in health between our communities and the rest of England or face the possibility that failure to act together and at pace increases poor health in Wirral. Tackling health inequalities is good for everyone and is everyone's business. This is a once in a generation opportunity to do things differently.

We all want Wirral to be a place where every community is healthy and doing well and this report sets out the following five recommendations to achieve this.

1

Prioritise economic regeneration and a strong local economy

2

Safeguard a healthy standard of living for all

3

Increase support for children, young people and families

4

Strengthen action to address differences in health outcomes and prevention

5

Residents and partners continue to work together

Introduction

COVID-19 has created unprecedented challenges and new experiences for everyone. However, whilst the pandemic has affected us all, the burden has not been shared equally.

High levels of deprivation, driven in part by major and longstanding challenges with local economies and employment, are important reasons for poor health outcomes.

COVID-19, has had its greatest effects on those with chronic health conditions and has reinforced variations in health. It is important we do not lose sight of these enduring health challenges as we continue to respond to the pandemic which is still evolving.

Whilst we have made great progress to support people to live healthier lives in Wirral, health inequalities are stubbornly persistent. For many years some Wirral residents have had some of the poorest health outcomes in the country. Within the borough we see differences in life expectancy of 10.7 years for men and 11.2 years for women. Action to tackle health inequalities and reduce its impact on our community, will be a key task long into the future and one which will benefit every resident. Although some things that influence our health cannot be changed, such as our age and genes, there are many important factors that, collectively, we can improve. Issues such as poverty, unemployment, poor housing, and unhealthy environments are major contributors to this health gap. The pandemic has shown us what we can achieve when we all work together and how quickly we can make change happen.

This report looks at health inequalities in Wirral, the initial impact of COVID-19 locally and what we need to do collectively to improve health for everyone in our borough.

Health inequalities are ultimately about differences in the status of people's health. They occur due to factors often outside of people's direct control and as a result people can experience systematic, unfair, and avoidable differences in their health, the care they receive and the opportunities they have to lead healthy lives. Everyone is affected by health inequalities at some point in life, however, there are some individuals and communities who are impacted more so than others by these differences including but are not limited to:

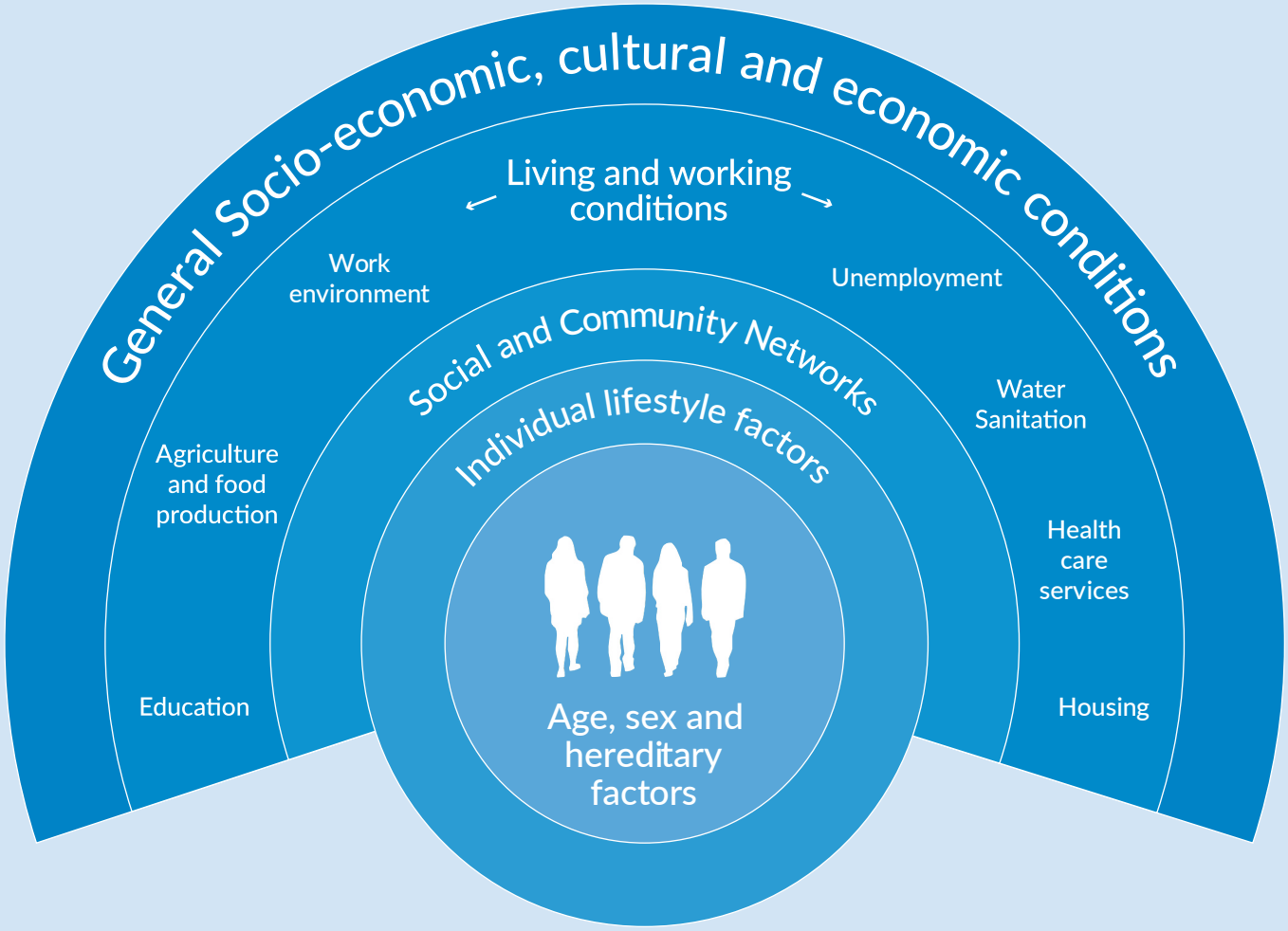
- Those who are more financially disadvantaged
- Gender (depending on the issue)
- Ethnic communities
- Sexual orientation and identity (including transgender, non-binary, and intersex people)
- Older people
- Those with disabilities (including invisible and learning disabilities)

Ultimately however everyone is impacted by health inequalities and when everyone is healthier, everyone benefits.

Research has shown that health inequalities occur because of the different conditions into which we are born, grow, live, work and age. Our health and wellbeing is influenced by not only genetics and behaviours, but importantly, the wider determinants of health such as housing, employment, and the environment.

In fact, the wider determinants have a greater influence on health than health care, behaviours, or genetics. This diagram shows how these factors interact and can often be experienced together. Particular groups can be affected across a number of factors, and these can be mutually reinforcing.

The Dahlgren and Whitehead Health Determinants Model (1991)



From Wuhan to Wirral

The World Health Organisation was informed of an outbreak of an unknown disease in Wuhan City, Hubei Province of China on 31st December 2019 which was later identified as COVID-19 on 7th January 2020.

In the earliest phase of the pandemic Wirral successfully hosted groups of British nationals from Wuhan to quarantine for 14 days at Arrowe Park Hospital.

This response demonstrated the agility of Wirral Partners to respond to a quickly emerging situation and provided learning which supported our response in subsequent months. The first case of COVID-19 in Wirral was detected on 6th March 2020, with the first recorded COVID-19 death on 20th March 2020.

During this time pressure also started to increase on the North West Ambulance Service as did calls to 111 reflecting growing community transmission. As COVID-19 cases began to spread across the globe, it became clear that significant action was required to manage the virus. On 23rd March, following a further rise in cases, the UK Government announced the first national lockdown which ended in July.

The second national lockdown took place between 5th November and 2nd December 2020, following a period of regional, tiered restrictions in September across the Liverpool City Region. The third national lockdown started on 4th January 2021; ongoing easing of restrictions commenced in March 2021, Step 4 of the national roadmap was introduced on the 19th July 2021.

First UK Response

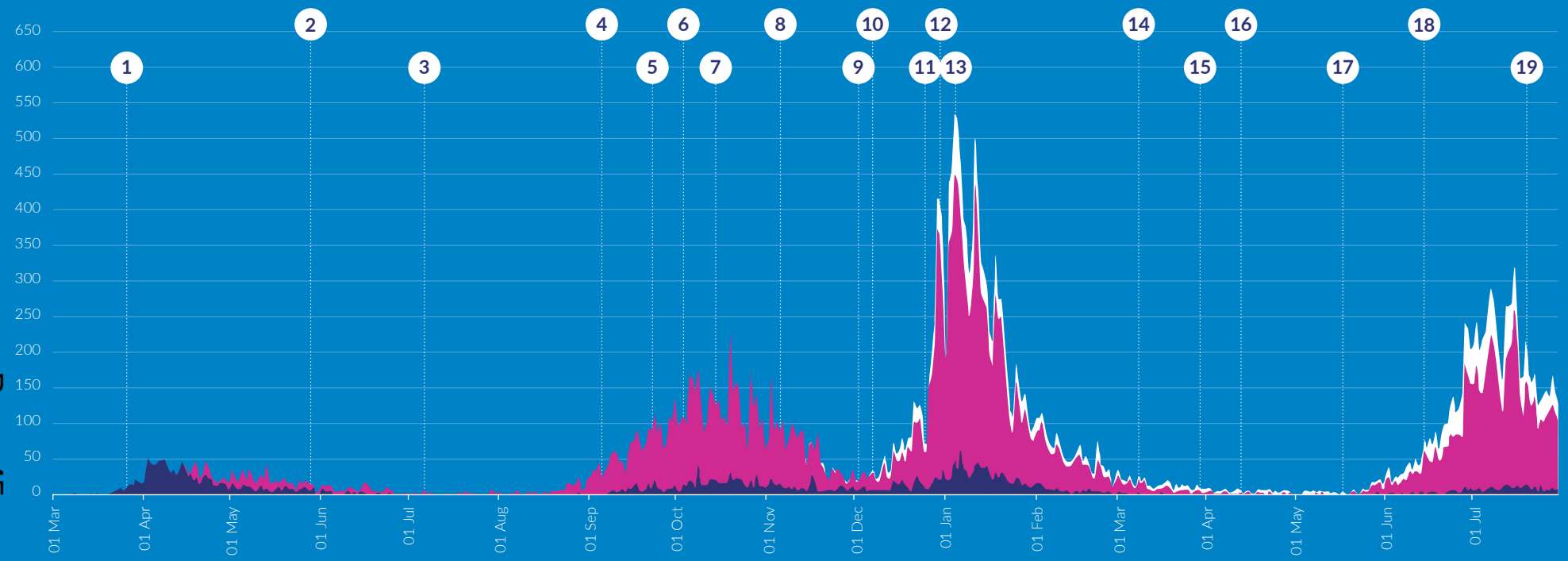
Wirral led the first national response to the pandemic, successfully hosting repatriated UK nationals from Wuhan in January 2020. This required rapid, local collaboration to ensure a safe and effective response at a time when the UK had not been managing COVID-19 as an emergency.

The guests were monitored and supported around the clock for 14 days. This involved the speedy development and implementation of new procedures and systems as well as a humanitarian response to support them, their families and friends. Ensuring that local residents felt safe and protected was a further part of our approach.

Being the flagship UK responder prepared Wirral for what followed; providing important lessons about working with the NHS and creating dedicated teams across the Council to deal with, and quickly adapt to, different ways of working. As a result, Wirral has been tackling COVID-19 longer than any other local authority in the country.

In September 2020 the Local Government Association (LGA) reviewed the work of Wirral's response to the pandemic and concluded that it had been 'incredible'- highlighting key themes such as the importance of effective communication, pace of response to an ever-evolving crisis, the value of partnership working and the need to be proactive and forward thinking in terms of delivering services digitally.

Number of COVID-19 positive cases in Wirral and local, national and international response.



1. Lockdown measures imposed
2. 'Conditional' reopening
3. Wider reopening
4. Schools reopened (1)
5. Local restrictions (first stage)
6. Local restrictions (second stage)
7. Tier 3 restrictions imposed
8. Lockdown measures imposed (2)
9. Tier 2 restrictions imposed
10. Asymptomatic Testing Launched (Wirral)
11. Lockdown measures relaxed (Xmas)
12. Tier 3 restrictions imposed
13. National lockdown (3)
14. Roadmap 1a (inc schools reopening)
15. Roadmap 1b
16. Roadmap 2
17. Roadmap 3
18. Full lockdown removal delayed to 19th July
19. Restrictions lifted

- Swab testing in labs and NHS hospitals for those with clinical need
- Whole population PCR testing
- Lateral Flow Testing

Health in Wirral

The information presented in this report describes the health of Wirral residents drawn from validated data sources.

The impact of the COVID-19 pandemic will not currently be reflected in local indicators as it continues to emerge and will be reported upon as the data becomes available.

Due to the volume and depth of information available a technical intelligence commentary, with source data and references, is provided as a detailed supplement to this report.

Health inequalities can be measured in many different ways. As a key measure of a population's health status, life expectancy is one of the foremost measures of health inequality. Life expectancy at birth in England has shown dramatic increases throughout the twentieth century as health and living conditions improved. However, in England prior to the pandemic, life expectancy was stalling and health inequalities widening. In 2017-19, life expectancy at birth in Wirral was 78.5 years for males and 82.3 years for females (both increases on 2016-18) compared to 79.8 and 83.4 respectively in England. Nationally, studies have estimated that, as a result of the COVID-19 pandemic, life expectancy at birth in 2020 had fallen by 0.9 and 1.2 years for females and males respectively relative to 2019 levels in England and Wales.

Increases in life expectancy have not been uniform across all people; marked rises have occurred amongst more affluent communities, while progress has been significantly slower for people living in less affluent areas. In 2019 35% of the population of Wirral were living in deprivation, a similar proportion to previous years. The proportion of children (aged 0-15) living in income deprived families in Wirral was 22%, however

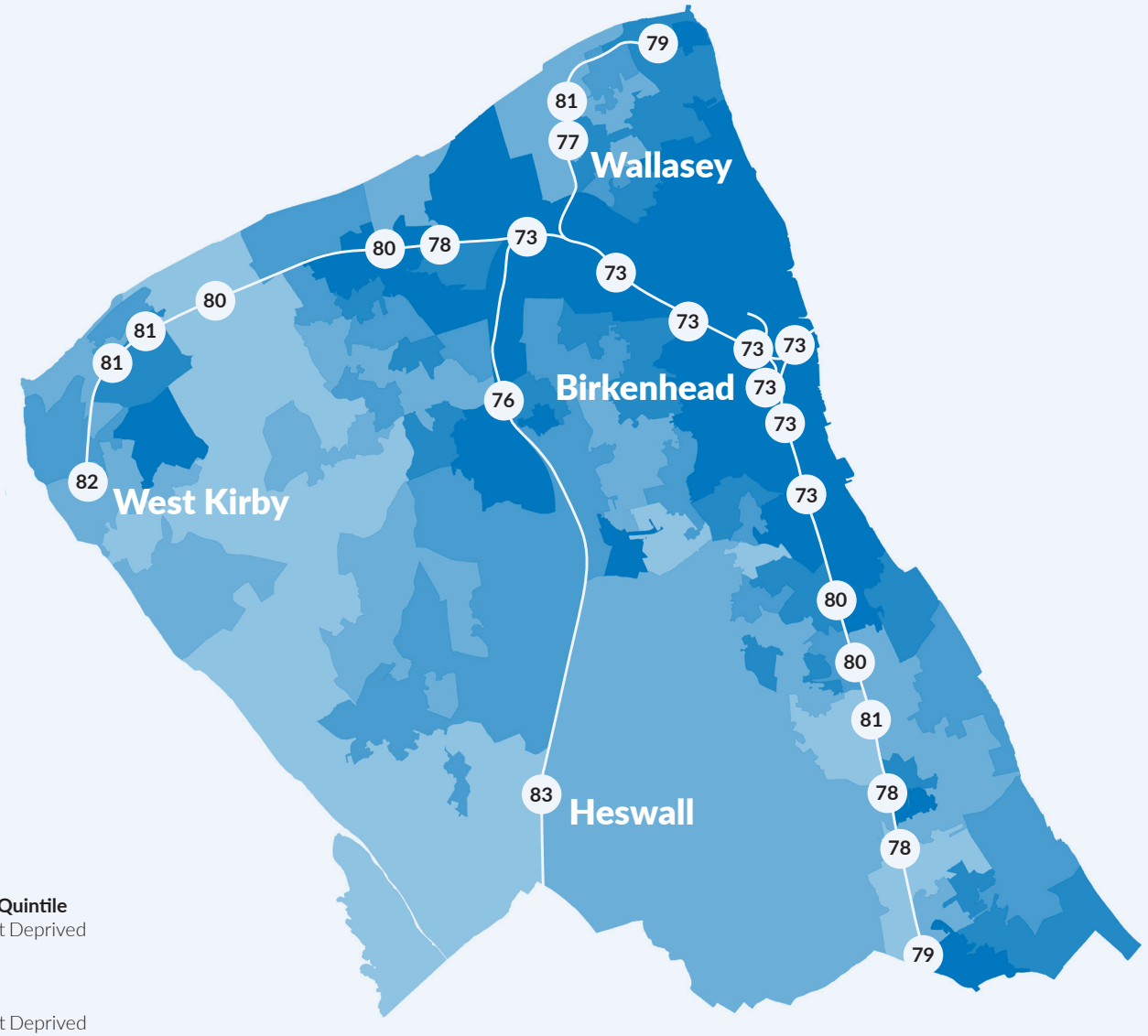
this varies between wards from 62% in Bidston & St. James to 0% in West Kirby & Thurstaston. Differences in life expectancy between those living in the most and least deprived wards in Wirral equate to 10.7 years for men and 11.2 years for women.

Birkenhead & Tranmere was the ward with the lowest life expectancy at birth for males (72.8), whilst Greasby, Frankby & Irby had the highest (83.5). For females, Rock Ferry had the lowest life expectancy (76.5) whilst Wallasey had the highest (87.7).

The gap between life expectancy at birth at ward level in Wirral has widened for females (from 9.8 years to 11.2 years) but shortened for males (from 11.8 years to 10.7 years) compared to the previous period of 2016-18. The gap between life expectancy at birth between males and females in Wirral has remained the same (3.8 years) when compared to 2016-18.

Male Life Expectancy at Birth by Wirral Railway Station 2017-2019 (3 Years Pooled) Underlaid with IMD 2019 Deprivation Quintile

Station life expectancy is based on the Wirral ward life expectancy that the station is located in.



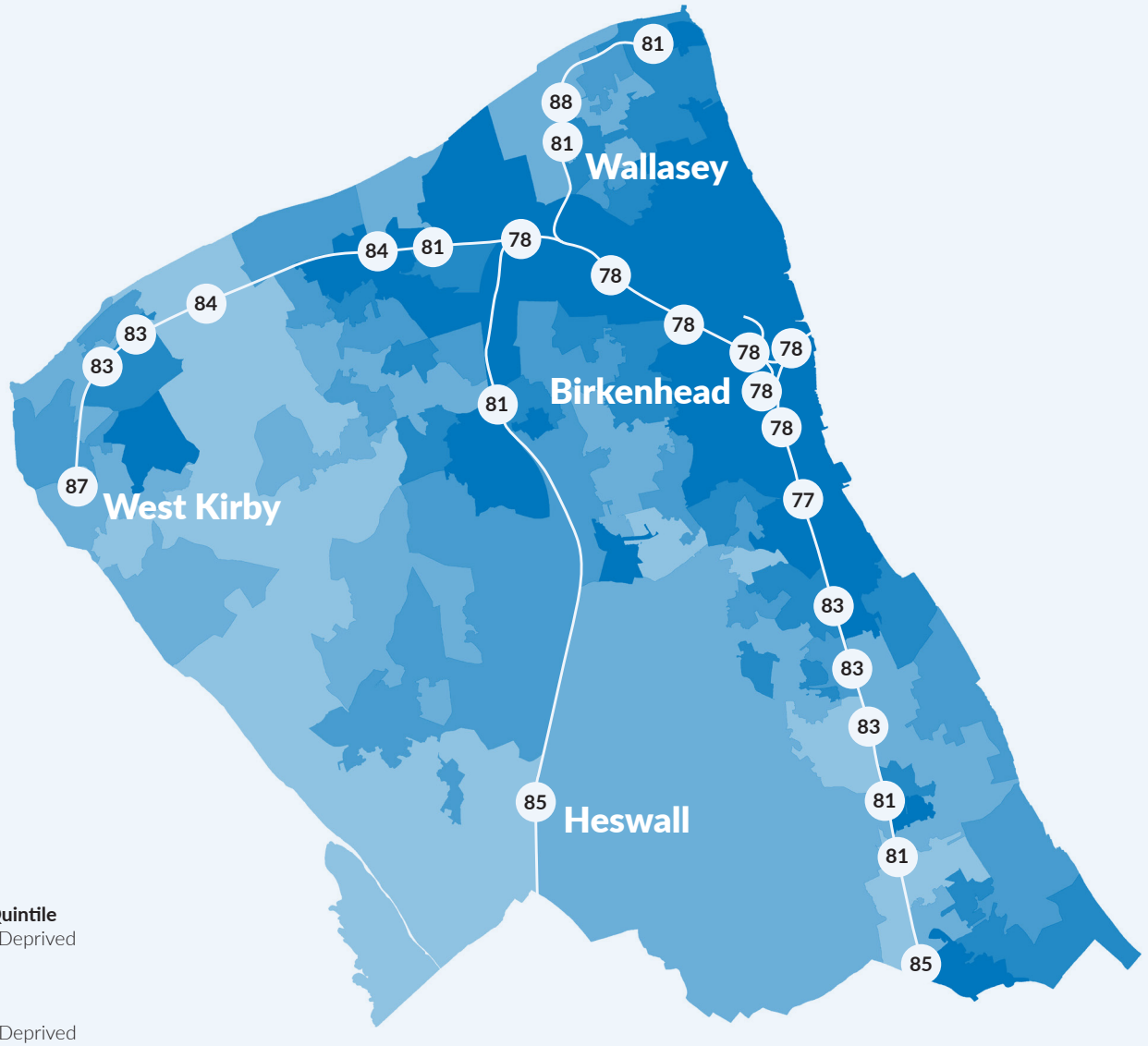
Healthy life expectancy at birth is the average number of years a person would expect to live in good health based on contemporary death rates and prevalence of self-reported good health. Increases in healthy life expectancy have not matched the gains in life expectancy, meaning that although people are living longer, their later years are spent in poorer health, creating greater demands on health and social care services. In 2017-19, healthy life expectancy in Wirral was 60.9 years for men compared to 63.2 years for men in England, which is significantly worse than England.

People in Wirral spend just three-quarters of their life in good health (78.6% for men, 77.6% for women) and these 'Healthy Life Expectancy' figures show wide variation, with those in more deprived areas spending even less of their lives in good health, compared to those living in more affluent areas. Targeting the causes of death which contribute most to the life expectancy gap between Wirral and England will have the biggest impact on reducing inequalities. The largest contributors to the gap were the same for both males and females in Wirral; namely respiratory disease (for example Chronic Obstructive Pulmonary Disease) followed by cancer.

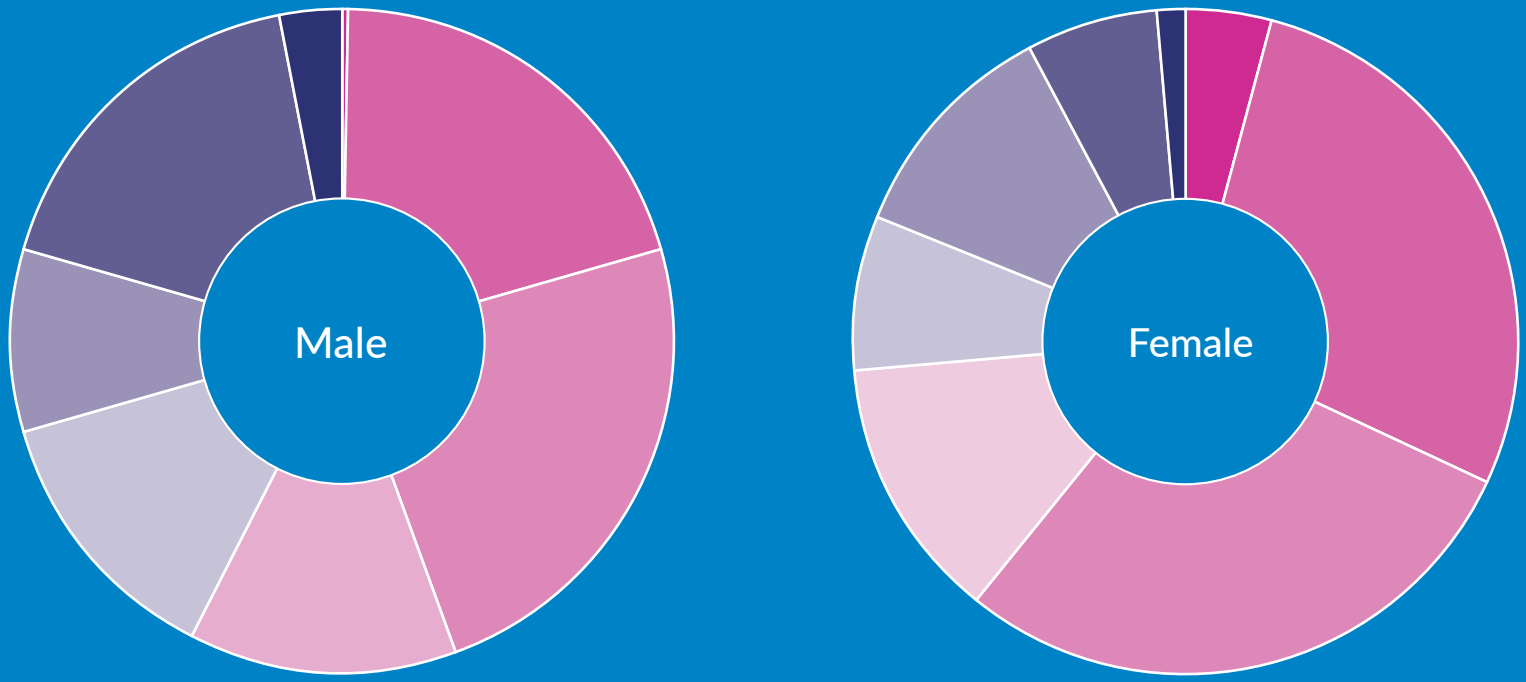
In males, respiratory disease contributed to 23.8% of the gap, followed by cancer at 20.2%. In females, respiratory disease contributed 28.8% of the gap followed by cancer at 27.9%. Poor mental health also affects communities in Wirral differently with referrals to mental health services three times higher in areas of deprivation than more affluent areas. Prevalence of depression is much higher in Wirral than England; at 18% of adults compared to 11% nationally according to GP records. In areas of higher deprivation as many as 1 in 3 residents are recorded as having depression.

Female Life Expectancy at Birth by Wirral Railway Station 2017-2019 (3 Years Pooled) Underlaid with IMD 2019 Deprivation Quintile

Station life expectancy is based on the Wirral ward life expectancy that the station is located in.



Proportional (%) breakdown of the life expectancy gap between Wirral and England, by broad cause of death *(2015-17):*



- Circulatory: 0.2%
- Cancer: 20.2%
- Respiratory: 23.8%
- Digestive: 13.2%
- External causes: 12.9%
- Mental and behavioural: 9.1%
- Other: 17.4%
- Deaths under 28 days: 3.2%

- Circulatory: 4%
- Cancer: 27.9%
- Respiratory: 28.8%
- Digestive: 12.7%
- External causes: 7.7%
- Mental and behavioural: 11%
- Other: 6.3%
- Deaths under 28 days: 1.6%

Source: Segment Tool, Public Health England, 2019

The causes of health inequalities in Wirral

As this report describes, there are many reasons why people do not have the same experience of health as others. The places we live and work, the people we know and how we live all affect our health and wellbeing.

Most experts agree that these 'broader determinants of health' are more important than health care in ensuring a healthy population. The diagram on this page shows how some of these factors affect the health of Wirral residents throughout life.

Whilst this shows measures in which we are doing better than England it also highlights important areas for improvement including giving children the best start in life, the availability of money and resources and living and keeping well.

Wirral life course statistics 2021 - A comparison to England

The conditions in which we live and work

Good work

Being in good employment protects health, while unemployment, particularly long-term, contributes significantly to poor health.

Good employment opportunities are therefore a fundamental part of our collective effort to improve health outcomes. As well as being vital to individual health, an economically active population also enables more economically prosperous communities that are sustainable for the future. Unemployment and health related worklessness have presented longstanding challenges within the borough.

In response, Wirral has sought to address health related worklessness and has reduced it at a rate that is double the national average. However high levels remain that exceed regional and national averages.

At the beginning of the pandemic in March 2020, 20.6% of the working age population were unemployed (39,700 people), the same proportion as in England overall. By December 2020, this figure had increased to 26.1% (over 50,000 people) but in England overall, this figure had decreased to 20.5%. Rates of unemployment also vary significantly within Wirral reflecting patterns of deprivation. Sarah's story illustrates the complexity and impact of health and employment.

Evidence shows that good quality work is beneficial to an individual's health and wellbeing.

Money and Resources

Economic hardship is strongly associated with poor health. Preliminary data estimates that Wirral currently has 17.4% of children living in 'relative low-income' (child poverty). This rate is slightly up from 17.2% in 2019 and equates to an estimated 10,490 children affected by poverty in the borough. This overall figure masks huge differences across wards, with just four wards (Seacombe, Birkenhead & Tranmere, Bidston & St. James, Rock Ferry) accounting for 41% of the total number of children living in low income families across the borough.

Our surroundings

The environment in which we live has a major impact on our health. In 2019 35% of the population of Wirral were living in deprivation. Deprivation is measured in deciles that are based on the Index of Multiple Deprivation 2019 which is the official measure of relative deprivation.

Sarah's Story

Sarah had previously worked as a theatre nurse in hospitals around England. She had to leave work due to stress and anxiety. Sarah disclosed that during the following months her mental health and wellbeing deteriorated significantly.

Sarah applied for Universal Credit. During the six weeks before she received her first universal credit payment, Sarah started drinking, became socially isolated and built up rent arrears. She is currently paying back payments on her rent, leading her to require the use of the Foodbank on several occasions and social supermarkets.

During her first meeting with the Connect Us team, a local service that encourages independence and provides support, Sarah became upset and angry at the situation; she started to shout and then broke down saying she "never used to be like this". She told us that she has lost motivation in life and no longer looks after her personal care as she used to.

Sarah does not have a smart phone or access to the internet meaning she is unable to access her journal to keep in touch with her Job Coach. This is aggravating her anxiety about the situation which leads her to drink more. The stress of this has caused her to consider suicide. Sarah is working with the Connect Us team to enable her to get where she wants to be.

This map illustrates areas of deprivation in Wirral as defined by the Index of Multiple Deprivation.

Whilst all Wirral residents have good access to green and blue spaces, variation in usage is prevalent.

Air pollutants (specifically NO2 and PM2.5) have a negative impact on health and are consequently monitored across Wirral. Deaths attributable to particulate air pollution in Wirral (3.9%) is estimated to be lower than both the North West (4.1%) and England (5.1%).

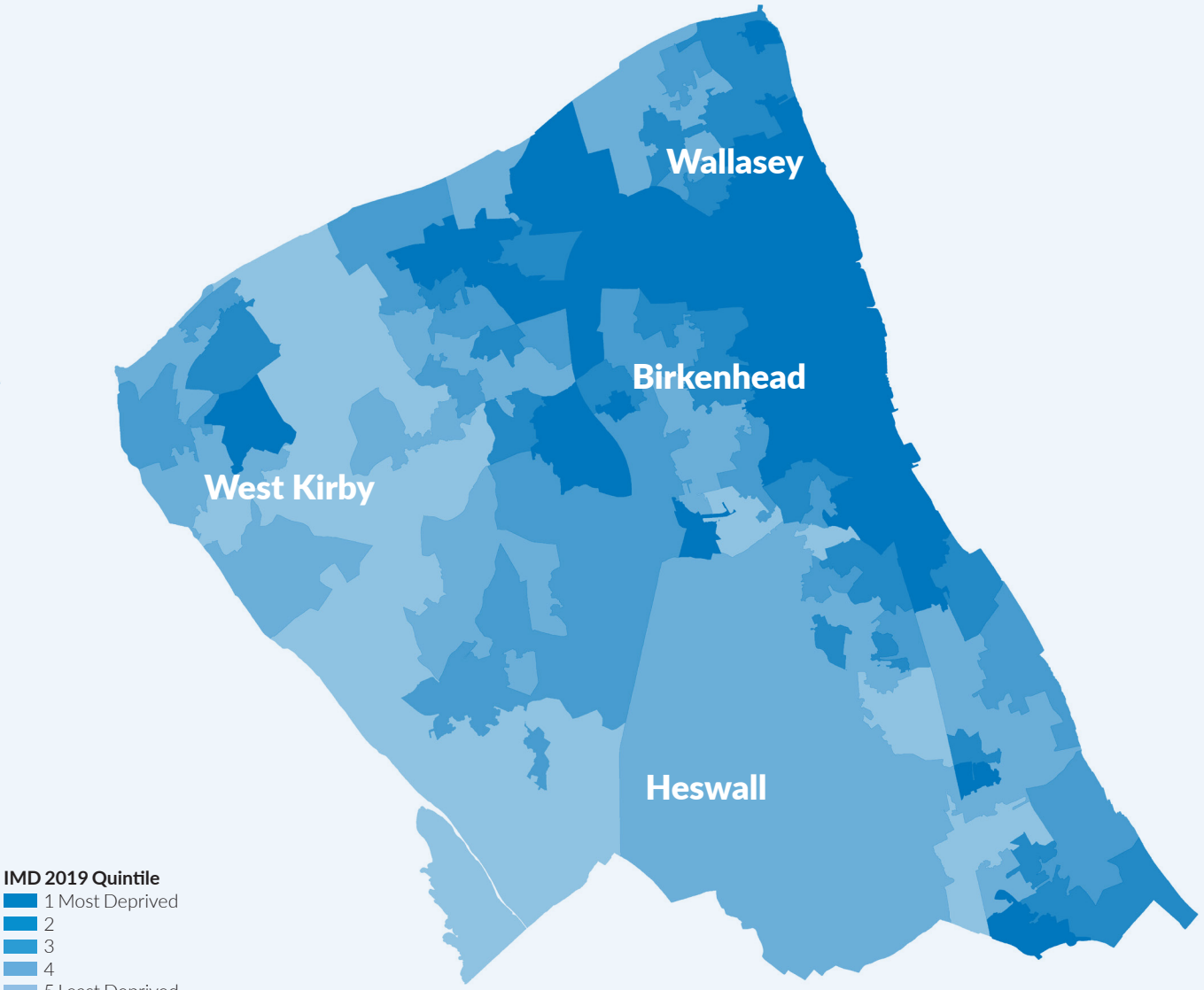
Wirral residents consider low levels of crime and anti-social behaviour to be the most important aspect of a good neighbourhood. Wirral's crime rate is the lowest in Merseyside. However, levels, and types of crime vary across Wirral. Birkenhead and Wallasey have higher rates of anti-social behaviour and crime (per 1,000 population). By contrast neighbourhoods in West Wirral and South Wirral, have some of the lowest anti-social behaviour and crime (per 1,000 population) in England.

Higher crime and anti-social behaviour in north and east Wirral ...

Lower crime and anti-social behaviour in west and south Wirral

Levels of Deprivation within Wirral

Poorer health outcomes mirror this pattern.



Health and Housing

Where we live, the conditions we live in and whether we can afford to appropriately heat our home all impact on our health and wellbeing. House prices are lower in Wirral than average, reflecting a lower cost of living. Privately renting a home is the only housing option available to some people and in some areas, properties in the private rented sector are more likely (than both privately owned and socially owned housing) to suffer from poor conditions and inadequate management.

In order to ensure the safety and wellbeing of residents, councils have the duty to ensure that remedial action is taken on private properties where there are serious hazards that affect the health, safety and wellbeing of the occupiers. There were a total of 774 interventions in the two years of 2017 and 2018, 1 in 5 of these were concentrated in just two Wirral wards – Birkenhead & Tranmere and Seacombe.

55.6%

of households in Birkenhead and Tranmere had no access to a vehicle according to the 2011 census

Poor conditions can worsen the physical and mental ill health of those who live there. Damp and cold can make respiratory conditions worse and living in disrepair can be extremely stressful.

Education and Skills

Increased levels of educational attainment are strongly and significantly related to improved health outcomes. Wirral has relatively high skill levels, when compared to the other benchmark areas, with 39% of the working age having Level 3 or 4 qualifications.

Rates of unemployment also vary significantly reflecting patterns of deprivation.

Wirral also has a significantly low proportion of its population with No Qualification (around 23%) or Level 1 qualifications, which is below the regional average but slightly above the England and Wales average of 22%. Wirral also has a relatively low rate of young people Not in Employment, Education or Training (NEET). In Wirral 63% of working-age residents do not hold a degree level qualification (over 120,000 people), which is higher than the national average.

Transport

Access to a car means someone can be more socially mobile as well as access services more easily. According to the 2011 Census, 28% of Wirral households had no access to a vehicle; this differed from 55.6% of households in Birkenhead & Tranmere to 10% of households in Heswall. This has implications for the ability to get to work, connect with others and receive healthcare.

Sandra's Story

Sandra was first referred to Connect Us with issues relating to food/fuel poverty and benefit delays. Priority referrals were made to the Foodbank and debt welfare team.

Through discussions with her connector Sandra disclosed that she had a 2 year old living at home with her, one child placed in foster care and adult children living independently. Sandra also shared that she has PTSD and had been in a domestic abuse situation for 20 years that ended 3 years ago. Sandra shared a variety of highly sensitive and complex family issues that had left her struggling to cope.

Sandra was supported to liaise with the child's social worker and put an agreed plan together. She was also referred to the Household Into Work team to support her adult children and, with encouragement, attended her local community centre where, after building relationships, she started to volunteer. Sandra also attended a variety of courses through the links made in community settings including paediatric first aid, introduction to volunteering, food hygiene and resilient parenting. Sandra is no longer volunteering at the centre but continues to access support through the service to maintain her health and wellbeing.

39%
of working age people have **Level 3 or 4 qualifications**

10K
children in Wirral are estimated to be **affected by poverty**

60.9
healthy life expectancy in Wirral for men compared to 63.2 years for men in England

35%
of the population **live in deprivation**

1 IN 3
residents recorded as **having depression in areas of higher deprivation**

Our social and community networks

Community life, social connections and having a voice in local decisions are all factors that can help buffer against disease and influence our behaviour. Our social environment impacts on our health and wellbeing as much as our physical environment.

There are estimated to be more than 4,000 local community, voluntary and faith sector organisations in Wirral providing a range of activities and services for local people. The 'Community Needs Index' measures multiple types of social connectivity. A higher score indicates that an area has higher levels of community need. The overall score for Wirral in 2019 indicated a higher level of need compared to England (68 in England, compared to 96 in Wirral), but also that there were significant differences within Wirral; for example, scoring by ward varied from 122 in Bidston & St. James to 41 in Clatterbridge.

Connecting with friends, family and our community is not however limited to physical spaces. The Internet and digital spaces are also ways for people to remain connected and can be sources of emotional support to help with maintaining good levels of wellbeing. However, they may not be accessible for everyone if they cannot afford devices to use or the monthly bill to maintain them or lack the skills to use the internet to connect with others. Reflecting patterns of deprivation, access to digital services varies across Wirral. Whilst computer usage in Wirral libraries is 12 times higher in areas of deprivation; eBook and loans are higher in more affluent areas.

Access to health and care services

The location of our homes can impact on how easy it is for us to access health care services and subsequently our health. These services include GP surgeries, hospitals, pharmacies and dentists. In Wirral, accessibility is limited both in some areas of deprivation (Bidston, Beechwood, parts of Seacombe, Poulton and Moreton for example), but also in some affluent areas (such as Caldy, Spital, Dibbinsdale, Irby and Thornton Hough).

4,000
local community, voluntary and faith sector organisations in Wirral providing a range of activities and services for local people

How we live our lives

In Wirral there are more children and adults who are overweight or obese than in England with admissions for drug-related, mental and/or behavioural disorders more than double the national rate. Deprivation is strongly associated with increasing prevalence.

The proportion of adults classified as either overweight or obese varies from 66.6% of adults in the least affluent parts of Wirral compared to 58.8% of adults in the most affluent.

Harmful alcohol consumption patterns match deprivation across the borough. The most deprived wards in Wirral had the highest rate of mortality that was specifically caused by alcohol; Birkenhead & Tranmere had a rate of 36.7 alcohol related deaths per 100,000 people, compared to Heswall ward where the rate was 1.9 alcohol related deaths per 100,000 people.

Whilst Wirral's smoking prevalence (10.7%) is lower than national comparisons, this varies significantly between communities. These differences are also evident during pregnancy with smoking in pregnancy, and at delivery, higher in less affluent communities and breastfeeding is lower.

Harmful alcohol consumption patterns match deprivation across the borough.

Inequalities and COVID-19

The impact of COVID-19 on the health of our population has been significant, not only for those who have sadly died from the virus but also the impact of national lockdowns on residents' mental and physical wellbeing.

To date (up to 11/9/2021) 38,861 residents have contracted the virus, 2,519 have been hospitalised as a result and sadly 1,002 local people have died.

In August 2020, Public Health England published a report on the impact of COVID-19 – Disparities in the risks and outcomes of COVID-19. They reported that people living in deprived areas had higher death rates from COVID-19 than those living in less deprived areas. A report for Wirral exploring the themes identified in the Public Health England report highlighted the following similar findings:

- Age: COVID-19 deaths were strongly associated with age in Wirral (and nationally).
- Sex: Men were at higher risk of dying from COVID-19 in Wirral (and nationally).
- Deprivation: both positive cases and death rates from COVID-19 were highest in the most deprived areas of Wirral (once Care Home deaths were excluded).
- Ethnicity: the considerable number of deaths where ethnicity was unrecorded in Wirral, combined with the (relative to England) low BAME population, mean the impact of ethnicity is unclear locally.

National disparities in the risk and outcomes of COVID-19

Age

COVID-19 diagnosis rates **increased with age** for both males and females

Sex

Working age males diagnosed with COVID-19 **were twice as likely to die** as females

Ethnicity

Deaths from COVID-19 were highest among people of **Black and Asian ethnic groups**

Deprivation

Mortality from COVID-19 in the most deprived areas **more than double** the least deprived area

Occupation

A significantly higher rate of death from COVID-19 for those working in lower skilled jobs

Co-morbidity

Morbidity increased for those people with existing diseases or for those who are obese

- Occupation: most deaths in Wirral occurred in the retired population, but among those of working age, the largest proportion of deaths from COVID-19 locally were in those working in Health and Social Work, Construction and the Motor Trade, Wholesale and Retail sectors.

- Co-morbidities: the majority of people who died from COVID-19 in Wirral had at least 1 pre-existing condition (or co-morbidity), the average number was 3.

Living through the pandemic

Living through a global pandemic has had a huge impact on the health and wellbeing of all our residents. However, it is not only the virus itself that has affected our communities differently, the impact of the measures to contain COVID-19 has also varied. Measures designed to control the spread of infection, such as lockdown and social distancing, have had their own effects on health and wellbeing through isolation and loneliness, job losses, financial difficulties, school closures, and reduced access to services.

The emerging data and evidence suggest that there are a number of health indicators that have worsened in Wirral as a result of the pandemic, which were in some cases already worse than England.

Lockdown and social distancing, have had their own effects on health and wellbeing.

The information below sets out some of the early and emerging impacts of COVID-19. This is based on research nationally and regionally exploring the impact of the pandemic on health and wellbeing. As validated intelligence systems often have substantial time lag this information has been locally collated. It will need to be regularly reviewed, updated, and validated to better understand the wider impact of the pandemic in order to deliver strategies, services and programmes relevant to Wirral residents.

38,861

residents have **contracted the virus** up to 11/09/2021, and sadly...

1,002

local people have **died**

The conditions in which we live and work

Money and Resources

Since the start of the COVID-19 pandemic Wirral has recorded a 65% increase in Universal Credit claimants. Young workers and low earners have been impacted the most and household incomes have fallen particularly among lowest earners. Prior to the pandemic, Wirral had made significant progress closing many of the gaps with national averages. However, the pandemic exposed other areas of concern, and highlighted new challenges including:

- An unprecedented fall in employment, including self-employment
- Increased health-related inactivity, including mental health
- A need for re-skilling in the post-pandemic world
- The challenges with high levels of precarious work and zero-hour contracts
- The impact on young people of disrupted education

20,000

emergency food hampers distributed in Wirral during lockdown

following an emergency response to food and welfare support

The pandemic brought an unprecedented demand for emergency food and welfare support. The number of adults who are food insecure is estimated to have quadrupled. Foodbanks have experienced a rapid increase in demand but alongside this have seen reduced volunteer numbers.

A new, co-ordinated emergency response to food and welfare support in Wirral was implemented within a week at the start of the pandemic which distributed more than 20,000 emergency food hampers during lockdown. The Council also issued more than 8,000 emergency and crisis financial awards with food, utilities, white goods, essential furniture, and other items throughout the pandemic.

Children eligible for free school meals increased from 10,848 (Jan 2020) to 12,652 (Jan 2021). Data provided by Wirral Met College has also shown that 317 of their 835 students who were supported with meals during the lockdown period, would not previously have met the Free School Meal (FSM) criteria and had been identified through enhanced college support.

Fuel debt has been of increasing concern to agencies across the borough and through COVID-19 funding from the Department for Work & Pensions, the Council, working with Citizens Advice Wirral and Energy Projects Plus, has been able to significantly reduce or clear more than a total of £150,000 of utility debt from vulnerable households. This has improved many individuals' physical and mental health, breaking the cycle of

debt, and enabling access to better energy tariffs, in turn giving access to heating that either had to be severely rationed or not turned on at all even in the coldest of weather.

Citizen Advice nationally report at present ½ million private tenants in the UK are behind on their rent. The average tenant owes more than £700 in arrears and 1 in 4 private tenants have been threatened with eviction or cancellation of contract by their landlord. Easing of evictions has been very supportive during the pandemic however with the policy due to change nationally and evictions beginning to re-commence many underlying debt issues have not been addressed.

It should be recognised that the overall estimate of families struggling financially is likely to be a significant underestimation, as there will be families yet unknown that have been impacted for the first time during the pandemic. The impact of the financial burden on families will be seen for years to come.

4,707

new housing applications have been received and there will be an increase in demand.

Living conditions

People have spent far more time at home during lockdown which may play a role in exacerbating poor health and wellbeing impacts arising from poor quality or inadequate housing.

Approximately 400 proactive housing standard inspections have had to be restricted in line with Government guidance on a risk based assessment, with priority for inspections given to high risk cases. There has also been a significant increase for homelessness and rehousing services generally that has occurred during the pandemic, directly arising from the Government's Everyone In campaign but also from people spending more time at home.

Since 1st April 2020, 4,707 new applications have been received and there is likely to be an increased demand for housing options advice due to the courts reopening and the use of Section 21 – no fault eviction notices that the Council is aware have or are being issued. As a result of the pandemic, there has also been an increase in people working, accessing services and socialising from home.

These practices are likely to continue to some degree in the short term at least. However, a large number of people in communities have found themselves digitally excluded due to the pandemic with low income households having no or limited access to the internet or hardware devices or lack of skills to be able to access the internet.

This was further compounded for many where English was not their first language, or they had learning difficulties, mental health problems, were deaf, blind or had other cognitive impairments. It is likely also that older residents will find it the most difficult to adapt to the increasing use of digital and

online technology, as firms and service providers may permanently adopt some of the new practices they have employed during the lockdown.

During the pandemic recognising the limitations of having a digital offer available, the Connect Us service delivered over 30,000 leaflets to residents across the borough reinforcing key prevention messages but also offering their service as a way of supporting residents. During the pandemic they have completed more than 13,000 wellbeing calls to individuals as well as completing other tasks such as supporting with prescription pick-ups, carrying out shopping for people and walking dogs.

Education and Skills

There is emerging evidence to suggest that children and young people may be hit hardest by the COVID-19 control measures which risks exacerbating existing inequalities in educational attainment. On average, pupils in Wirral leave primary education with significantly lower attainment than pupils in England. By contrast pupils in Wirral have a relatively high level of attainment upon leaving secondary school compared to the national average. However, it remains the case that many pupils in secondary education will be negatively affected by the closure of schools during the lockdown.

National estimates suggest that during the first lockdown, the disadvantage gap amongst 7 year olds increased by 40%. Poorer 7 year olds are now estimated to be seven months behind their more affluent peers. Furthermore, pupils in Wirral are more likely to leave secondary education with lower attainment than disadvantaged pupils in England.

In line with the national trend, there has been a significant increase locally in the number of electively home-educated children (EHE). For primary school age children for example, the figure of EHE has risen from 38 prior to the pandemic, to 65 following full school re-opening. Whilst many parental decisions to withdraw their children from school have been driven by COVID-related anxiety, there are also some additions to EHE where parents found home-learning over lockdown to be a positive experience which they wanted to continue.

For children attending Early Years settings, there was evidence of increased need across the 14 months of the pandemic period (most noticeably half-way through). There was a 52% increase (from 192 to 291) in referrals to the Early Years Special Educational Needs and Disability (SEND) Officer during the period of the 1st of September 2019 to the 31st August 2020, compared to the previous year.

This upwards trend in need has continued into 2021, with 299 new referrals from 1st September 2020 up to 24th May 2021. By far the most

Jane's Story

Jane was referred to Citizens Advice Wirral after being discharged from hospital, where she had been very unwell with Coronavirus.

Despite her having recovered from the virus, she remained very poorly. As a result, she was unable to work and received Statutory Sick Pay only.

She was worried about her ability to pay for food and fuel, along with looking after herself as she lived alone and was still very weak. The Citizens Advice adviser helped support Jane with a claim for Universal Credit, and liaised weekly with the Emergency Food Hub to arrange regular food parcels to be delivered, along with vouchers for fuel.

The service has also helped Jane with an application for help with her personal care, and appointed a Social Prescriber who checked in weekly on her wellbeing. Jane continued to receive food and fuel support, which is helping her recovery.

She has also been assessed as entitled to a care package that includes two home visits per day, that ensures she is receiving all the personal care that she requires. As she has continued to suffer with ongoing poor health, Citizens Advice Wirral has also assisted her with an application for the benefit Personal Independence Payment and she is awaiting the outcome.

65%
increase in **Universal Credit claimants**

8K
emergency and crisis **financial awards issued by the Council**

13K
wellbeing calls made to individuals as well as many other supportive tasks

5%
of 16-17 year olds in the district **are NEET**

52%
increase in referrals to the Early Years SEND Officer

common reason for referral is for support with 'Communication and Language'. Lack of access to physical one-to-one support during this time is likely to have resulted in delays to many children reaching key developmental milestones. The number of permanent closures (primarily due to financial instability) amongst local Early Years settings during the pandemic period rose by 52%, despite national/local packages of support.

Those with no, or not many, qualifications will be most vulnerable to increases in unemployment and will be least able to take advantage of new opportunities when the economy starts to recover. Short-term job risk is highly correlated with level of education.

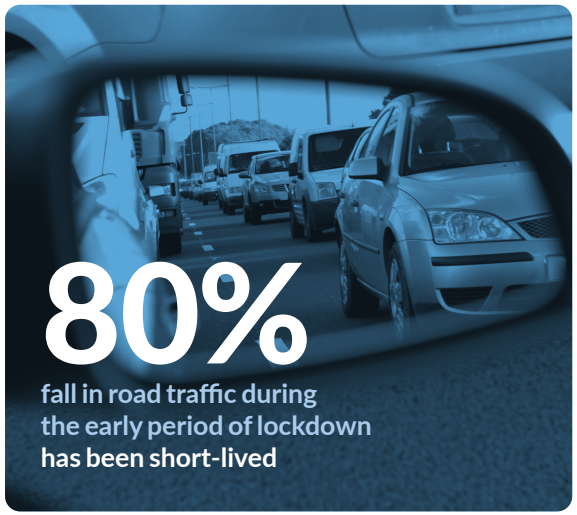
Wirral has a high level of skilled residents however there are still large numbers without any formal qualifications. Wirral has a relatively low rate of young people Not in Employment, Education or Training (NEET); and the temporary closure of schools, colleges and training facilities during the pandemic will likely increase the number of young people who are classed as NEET. Around 5% of 16-17 year olds in the district are NEET, compared to 5.5% of 16-17 year olds in England overall.

Enrolments in apprenticeships within Wirral have been falling in recent years and has been exacerbated by the pandemic restrictions in 2020/21 with lockdown leading to a further drop in vocational training participation. Younger apprentices seem to be particularly badly affected, with surveys of providers in the Liverpool City Region suggesting that around 40% of apprentices aged 16-18 had been placed on furlough in May 2020. The longer-term effects of this are yet to be realised.

Transport

The impact on transport has been mixed. Falls in road journeys during the early period of lockdown have generally been short-lived. A positive impact has been seen with more people cycling, but it is unclear whether the changes to cycling infrastructure will have a lasting impact.

In line with national trends, road traffic levels fell very markedly during the first period of lockdown in spring 2020 and fell as low as 20% of pre-COVID-19 levels in April 2020. Public transport usage fell markedly as a result of the stay at home instruction and capacity restrictions, reducing the numbers able to travel from 192 on standard three car service to 50 passengers. Patronage on intercity services fell to single digit percentages compared to pre-COVID-19 levels. Currently levels of traffic on the roads have grown faster than equivalent levels of public transport.



Our social and community networks

The COVID-19 pandemic has had both positive and negative impacts on social and community networks. There is evidence of increased civic participation in response to the pandemic and a positive impact on social cohesion. Thousands of new volunteer groups have been established in communities across the country.

However, social isolation and loneliness have impacted on wellbeing for many and increased stress due to isolation, employment issues, difficulties of home-schooling and additional financial strain. These factors, combined with the reduced access to services for vulnerable children and their families has meant that the risk of family violence, neglect or abuse, mental health problems and financial struggles have all increased.

1,000+

volunteers expressed interest to provide support and help in the pandemic

Not all impacts of the pandemic have been negative however. One indirect impact that COVID-19 brought was a shared sense of neighbours and communities looking out for each other, boosting social cohesion across the country and Wirral. The Office for National Statistics (ONS) conducted research nationally and the majority of people who responded believed that society will be much kinder to each other as a result of the pandemic experience.

In Wirral during the height of the second lockdown, there were expressions of interest from more than 1000 volunteers to support and help in the pandemic. Community Action Wirral placed more than 700 of these into organisations locally, who were in addition to the huge number of volunteers already aligned with those organisations. In November 2020, the Volunteer Responders National Scheme reported that they had received expressions of interest from 2427 volunteers in the Wirral area. They had 621 referrals with 4610 tasks undertaken. At the beginning of the third lockdown in January, a further 270 volunteers came forward to become Volunteer Marshalls to support the COVID-19 Vaccination sites.

The COVID-19 Humanitarian Cell, consisting of more than 70 established local community, voluntary and faith sector groups, reported supporting first time service users seeking assistance for employment, new skills, homelessness, mental health and financial concerns due to policy changes introduced during the pandemic.

Micha Comments

The COVID-19 pandemic has highlighted that we should all feel confident that we are either giving or receiving quality care and treatment.

We have got some way to travel before we see true equity in accessing care and treatment. We should all be supported in our journey to know our choices and options and how to have a voice around the services we access.

The hurdles ahead will require the support of our NHS, local government and third sector partners. With services facing a backlog of care caused by the response to COVID-19 and many communities facing an uncertain economic future.

It shouldn't matter who you are, we must do all we can to stop existing health inequalities from becoming worse.

Micha Woodworth,
Project Manager
Healthwatch Wirral

Access to health and care services

The COVID-19 pandemic has both disrupted and changed the delivery of NHS and social care services.

It is expected that long-term conditions will have worsened for many people over the course of lockdown and there are particular concerns about the impact of delayed cancer diagnoses and the knock-on effects as NHS services are resumed. There is also increasing evidence that people with mild to moderate COVID-19 disease may experience a prolonged illness with frequent relapses.

In Wirral, waiting lists for hospital treatment have increased by 11% compared to March 2020; totalling 2,500 patients, with more patients now waiting longer for planned treatment.

8.5million

adults and 1.5 million children in England will need support for mental health difficulties in the coming months and years

The number of people waiting for over a year has grown significantly from 15 in March 2020 to 1,280 in March 2021. The length of time to treatment has also increased in the following services: Dermatology, ENT, General Surgery, Gynaecology, Ophthalmology, Oral Surgery, Trauma and Orthopaedics and Urology.

The percentage of patients starting treatment within 62 days following referral from a national cancer screening service was down to 92.6% in March 2020 and fell even more dramatically in March 2021 to 66.7%. This follows breast and bowel screening services being paused locally in March 2020.

Experience from previous pandemics suggests that mental ill health will increase, although the scale is difficult to predict. A range of factors may be drivers of poor mental health, including those directly related to COVID-19 (e.g., more generally or because of the loss of family and friends to COVID-19) and those indirectly related through the effects of the social distancing and lockdown measures (e.g., through social isolation or because of financial insecurity).

A nationwide study from the Centre for Mental Health estimates that 8.5 million adults and 1.5 million children in England will need support for depression, anxiety, post-traumatic stress disorders and other mental health difficulties in the coming months and years. This is the equivalent of 20% of all adults and 15% of all children. The IAPT Service in Wirral has seen an increase of 12% in referrals from the position during the same period in 2019. The position between 2019/20 and 2020/21 shows an increase of 43% when comparing a single month position.

Wirral already faces mental health challenges across its whole population. The rate of hospitalisation amongst those under 18 because of mental health conditions is significantly above the national average and the highest within the Liverpool City Region.

The lack of visibility of most families during lockdown will inevitably have led to 'hidden harm', where potential safeguarding issues have been largely hidden from view. It must also be acknowledged that many families that were not particularly vulnerable prior to the pandemic, will now have become so. Nationally, it is estimated that the number of children harmed by abuse or neglect rose by 27% in the first lockdown.

For Wirral, referrals into children's social care fell by 25% from April 2020 to the end of March 2021, compared to the same period in the previous year. As schools are consistently one of the largest sources of referral into children's social care, this period of significantly reduced access to educational settings has had a worrying impact and highlights the ongoing concerns about 'hidden harm' during lockdown. Over the same time period, the number of children in formal child protection increased slightly, owing to numbers of Children in Need (CIN) growing during the pandemic.

25%

fall in children's social care referrals from April 2020 to the end of March 2021

How we live our lives

The wider determinants of health both shape the distribution of, and trigger stress pathways associated with the adoption of unhealthy behaviours. Lockdown has impacted on these behaviours in different ways. People who were drinking alcohol the most often before lockdown are also the ones who are drinking alcohol more often and in greater quantities on a typical drinking day. People already drinking alcohol the least often have cut down in the greatest number.

The impacts on smoking appear to be more positive, with smokers showing an increased motivation to quit and to stay smoke free during the pandemic. Findings are less clear in relation to diet. Non-UK studies show decreased physical activity and increased eating and snacking during lockdown. In England, physical activity behaviours among children and adults have been disrupted by lockdown. Although some groups have continued to be physically active, groups that were least active before lockdown are finding it harder.

Tackling health **inequalities**

This report shows that good health is not experienced evenly across our borough. People born in certain parts of Wirral can unfortunately expect to live shorter lives than those born in other areas.

Rather than any biological difference, this is due to preventable and avoidable factors based on the wide range of issues that impact on health over someone's lifetime.

Health inequalities are not however inevitable, and the gaps in good health are therefore not fixed. Evidence shows that a comprehensive approach to tackling them can make a difference. Taking action to improve living and working conditions, the support available to people and how they look after themselves will make the biggest impact on reducing inequalities, targeting the causes of death which contribute most to the life expectancy gap in Wirral.

There has been considerable research carried out, over many years, to determine the best interventions to minimise the gap in health between people. The most recent being the 'Fair Society, Healthy Lives' report, published in 2010, by Professor Sir Michael Marmot. This concludes the following areas as key to reducing health inequalities:

- Give every child the best start in life: This can be done by more investment of spending on early years, with allocation of funding proportionately higher for more deprived areas with the goal of reducing child poverty.
- Enable all children, young people, and adults to maximise their capabilities and have control over their lives: Reducing differences in

childhood educational attainment by investing in preventative services to reduce exclusions and support schools to stop off-rolling pupils.

- Create fair employment and good work for all: Investing in good quality active labour markets and increasing the number of post-school apprenticeships as well as support in-work training throughout the life course. Also reducing the high levels of poor-quality work and precarious employment.
- Ensure a healthy standard of living for all: Put health equity and wellbeing at the heart of local economic planning and strategy by adopting inclusive growth and social value approaches locally to value health and wellbeing as well as, or more than, economic efficiency.
- Create and develop healthy and sustainable places and communities: Invest in the development of economic, social, and cultural resources in the most deprived communities.

We have made great progress to support people to live healthier lives in Wirral. However, the impact of COVID-19 has reaffirmed the need to prioritise action to tackle health inequalities, accelerate it at pace and augment it at scale.

Whilst the pandemic has been unprecedented it has also led to increased connectivity across organisations, sectors, and residents in the borough, building upon a strong co-operative ethos that has developed over a very long time.

This was also in part because everyone had a shared vision to Keep Wirral Well. The pandemic has demonstrated what we can achieve together and the speed at which change can happen. Maintaining this, with a focus on health inequalities, presents an opportunity to improve everyone's health.

Reflecting on the key challenges and opportunities highlighted in this report, the following recommendations have been made to improve health and wellbeing and reduce health inequalities in Wirral.

1

Prioritise economic regeneration and a strong local economy

It is an exciting time for Wirral. The programme of regeneration in the borough is one of the biggest in Europe and will create a world class standard of economic opportunity, digital connectivity and growth for Wirral and our residents.

This economic regeneration has been a cornerstone of Wirral's plan to improve outcomes for local people and tackle health, economic and social inequalities.

However, unemployment, health related worklessness and poverty have been prevailing in some of our communities for generations. The pandemic has also heightened the need to rapidly augment support for people to enter the job market and maintain economic independence to minimise the impact on already vulnerable communities. The economy and health are interdependent; focusing on health outcomes allows the economy to flourish in the longer term, which is supportive of better health.

I therefore recommend that:

- Economic development plans are reviewed to ensure that they respond to the impact of the pandemic on residents and communities.
- Economic Regeneration and Development Committee, working with the Health and Wellbeing Board, should consider the development of an Economic Inequalities Strategy for Wirral.
- Employment support services and skills development programmes are available, accessible and sustainable to ensure income maximisation and support those most susceptible to job loss and job insecurity.
- Partners embed a 'Health in All' policies approach to regeneration planning. We can use this approach to ensure that the wide breadth of health impacts of the pandemic is part of routine decision making and to reduce health inequalities.

2

Safeguard a healthy standard of living for all

The place where we spend most of our time has a huge influence on how healthy we are. Everyone in Wirral should have access to safe, secure and affordable places to live that better prevent ill health.

Ensuring that the homes people live in are safe and warm and that residents have support to prevent homelessness and to assist them if they are homeless is a key priority in the aftermath of the pandemic as well as a key long term action to improve health and reduce health inequalities.

I therefore recommend that:

- Wirral's Housing Strategy is reviewed to reflect the changing needs of residents and to address the challenges that have emerged during the pandemic.
- There is an integrated information and advice offer to enable people to access support when they need it.
- We build on the progress made during the pandemic to support people who are homeless.
- We define and streamline fuel poverty support pathways with partners across Wirral learning from the COVID-19 response.
- Relevant partners use Health Impact Assessment in spatial planning to identify risks to good health and ways to mitigate them.

3

Increase support for children, young people and families

Having the best start in life has lifelong impacts on someone's health and wellbeing which leads to better economic prospects and reduced long-term illnesses.

We therefore recommend that:

- The impacts of the pandemic on our young people are examined to ensure that children and families have the support they need, to predict future areas requiring action and inform the offer for early years' support from the Council and other partners.
- Work continues to develop the early help and intervention model underpinned by a prevention framework.
- Work with families, early years, schools, further and higher education sectors continues to ensure all children and young people fulfil their potential through a 'cradle to career' approach.
- Ensure that services are maximising opportunities to mitigate the impact of the pandemic on children, young people and families with a focus on physical and mental health.
- Review existing support and services for our most vulnerable children, young people and families to ensure they are resilient, accessible and driving progress.

4

Strengthen action to address differences in health outcomes and prevention

The pandemic has highlighted the importance of being in good physical and mental health to reduce the risk of morbidity and mortality from COVID-19. Restoring services is vital as is ensuring that they are used by those who need them most.

All residents should have equal opportunities to access quality care, treatment and support that improves health and wellbeing and builds resilience.

I therefore recommend that:

- Local health and care partners focus on tackling inequalities in healthcare provision - this is their direct responsibility and must be the prime focus of their action.
- Local NHS partners ensure they can access high-quality data to measure performance on reducing health inequalities across services. This includes being able to breakdown outcome and performance data by deprivation and ethnicity.
- NHS partners use their role as local anchor institutions and the choices they make as an employer and a purchaser to reduce inequalities.
- Preventative programmes and proactive health management for groups at greatest risk of poor health outcomes are accelerated across key service areas as outlined within the NHS Long Term Plan.
- The developing integrated care system and local providers have a named executive board-level lead for tackling health inequalities and access training made available by local and national partners.
- Local NHS partners engage with and play a supportive role in multi-agency action to improve the social, economic and environmental conditions in which people live.
- Health and care partners focus on good infection prevention control to ensure avoidable infections are prevented.

5

Residents and partners continue to work together

The prevalent theme throughout the pandemic has been the importance and effectiveness of the partnerships across Wirral.

The landscape has changed for good and the pandemic has presented us with an opportunity to build on our partnership working and work together to Keep Wirral Well by ensuring health inequalities is everyone's business.

The pandemic has reinforced what we already knew in Wirral – that having the voice of the people present in everything we do is so important. While we have always prioritised this, our response to COVID-19 has shown that there is room for improvement in terms of capturing communities' experiences and how to work effectively with local people.

I therefore recommend that:

- All partners should continue to build on the strong partnership work developed through our COVID-19 response by implementing the action emerging from the Health and Wellbeing Board Community and Voluntary Sector work.
- All partners fully engage local people to co-design services and initiatives to enable residents to recover and improve their health and wellbeing. We need to prioritise our more vulnerable residents who have been disproportionately affected by COVID-19 and use tailored communication methods.
- We undertake a resident listening exercise to learn from the experience of the pandemic to understand local people's experiences and aspirations for the future. This work should be a blueprint for developing a sustainable model for the use of insights gathered from local people.

WIRRAL

Acknowledgements

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References and further information are available online at Wirral Intelligence Service www.wirralintelligenceservice.org/jsna/public-health-annual-reports

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Technical Briefing: Public Health Annual Report 2020/2021

Wirral Intelligence Service

2020/2021

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For further information please contact:
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Contents

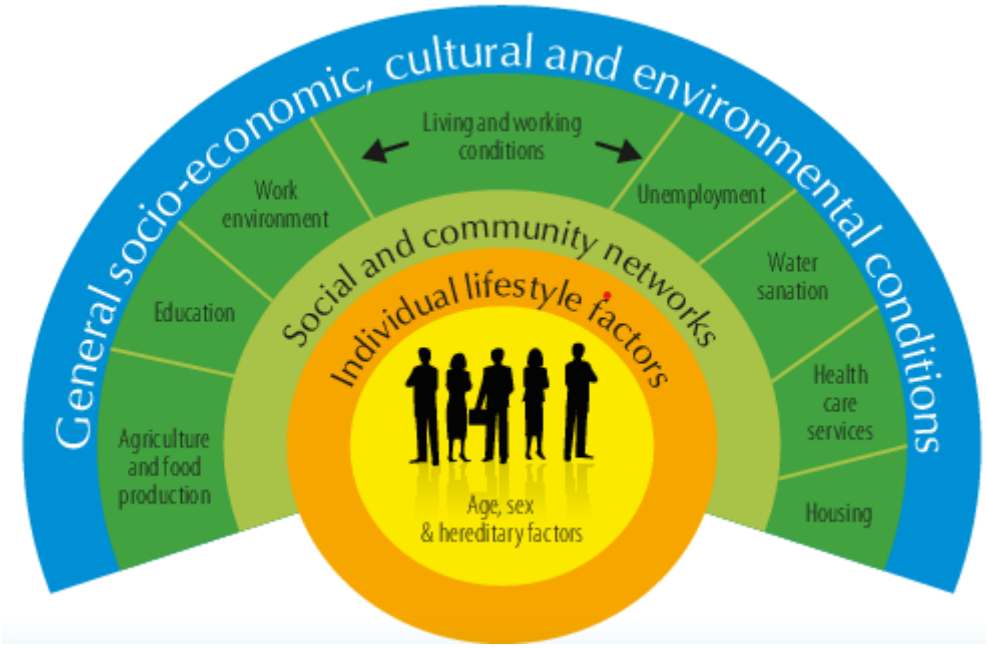
Introduction

This technical document is designed to accompany the Director of Public Health's Annual Report for 2021, for those who wish to see the more detailed data, intelligence and analysis which underpins the report.

The Director of Public Health's Annual Report this year concentrates on inequalities; for more information on inequalities, deprivation, how these indicators are calculated and what this means for Wirral, please see our report on the Wirral Intelligence Service website.

The main Director of Public Health's Annual Report (and consequently, this Technical Document), contains information on what are known as the 'wider determinants of health'. This is because as little as 10% of our health outcomes are affected by the healthcare we receive. In fact, the wider determinants have a greater influence on health than health care, behaviours, or genetics. The diagram below **(figure 1)** shows what we mean when we talk about 'wider determinants' and how these factors interact.

Figure 1: The wider determinants of health



Source: The Dahlgren and Whitehead Health Determinants Model (1991)

These determinants are often experienced together and cumulatively over time. Particular groups can be affected by number of these determinants, which can be mutually reinforcing.

Education

Attainment

- The average Attainment 8 score in Wirral in 2019/20 was 51.5, which was one of the highest scores in the North-West overall and was the highest of the Liverpool City Region authorities. In Cheshire & Merseyside, only Warrington was higher at 51.7 and Wirral also scores higher than the average for England overall (50.2).

- This overall high scoring, however, hides large variations based on inequalities. For example, the average score of pupils classed as 'Disadvantaged' (see below for definition), was 39.5 in Wirral, compared to an average score of 56.8 for pupils classed as 'Non-Disadvantaged' (Source, LGInform, 2021).

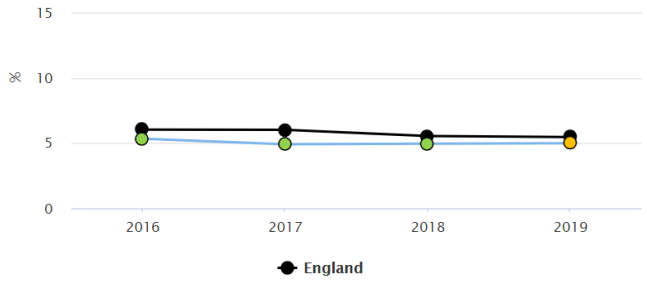
Definitions: Attainment 8 measures the average achievement of pupils in up to 8 qualifications including English and Maths. Points are allocated according to grades pupils achieve in all 8 subjects added together to give the Attainment 8 score, e.g., the maximum score for a pupil is 80, for a pupil who achieves eight A grades at GCSE in qualifying subjects. Disadvantaged pupils include pupils known to be eligible for Free School Meals (FSM) in any spring, autumn, summer, alternative provision, or pupil referral unit census from year 6 to year 11 or are looked after children for at least one day or are adopted from care.*

NEET (Not in Employment, Education and Training

Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression, or early parenthood (Public Health England, 2021). There is recognition that increasing the participation of young people in learning and employment not only makes a lasting difference to individual lives but is central to improving social mobility and economic growth.

To support more young people to study and gain the skills and qualifications that lead to sustainable jobs and reduce the risk of young people becoming NEET, legislation was introduced in 2013 to raise the participation age which required all young people remain in some form of education or training until the end of the academic year in which they turn 17.

Figure 2: Trend in young people NEET, 2016 to 2019, Wirral, North-West and England



		Wirral					
Period		Count	Value	95% Lower CI	95% Upper CI	North West	England
2016		390	5.3%	4.8%	5.9%	6.6%	6.0%
2017		350	4.9%	4.4%	5.4%	6.5%	6.0%
2018		340	4.9%	4.4%	5.4%	6.3%	5.5%
2019		350	5.0%	4.5%	5.5%	5.4%	5.5%

Source: Department for Education

Source: Public Health Outcomes Framework (2021)

See Wirral Statistical Compendium, for the inequality in NEET *within* Wirral (ward data).

Housing

Fuel poverty

The Department for Business, Energy and Industrial Strategy (DoBEIS) produce annual estimates on the number and proportion of households likely to be living in fuel poverty. Estimates for 2018 show that overall in England, 1 in 10 households (10.3% of households) are estimated to be living in fuel poverty; rising to 12.1% in the North-West overall and 12.2% in Wirral overall.

The overall proportion in Wirral, however, hides huge inequalities, with the proportions ranging from 1 in 4 households in some areas of Birkenhead (Birkenhead West LSOA has rates of 24.9% living in fuel poverty) to just 1 in 17 in other areas of Wirral (e.g. 6.3% in Caldy North LSOA).

Housing disrepair

The private rented sector is the only housing option available to some of the most vulnerable people in society. However, in some areas, properties in the private rented sector are more likely (than both privately owned and socially owned housing) to suffer from poor condition and poor management. In Wirral, 23% of private sector dwellings fail the Decent Homes Standard*, compared to 32% in the private rented sector. Where a household is on welfare benefits and living in the private rented sector, this rises to 36%.

In addition, the proportion of private rented properties in Wirral increased significantly between the 2001 Census and 2011 Census, from 11% to 16% - and most recently, was estimated to be 19% of all properties in 2019/20 English Housing Survey - with wide variation within Wirral, from 28% of all properties in Birkenhead & Tranmere ward, to 6% of all properties in Greasby, Frankby & Irby ward.

In order to ensure the safety and wellbeing of local residents, Local Authorities have the duty to ensure that remedial action is taken on private properties where there are serious hazards that affect the health, safety, and wellbeing of the occupiers. Given that a decision to enforce remedial action has financial implications for both the owner and the occupier (and such decisions may be subject to legal challenge and scrutiny), decisions to intervene are not undertaken lightly and as such, are a good indicator to areas where housing in a state of poor repair are concentrated.

There was a total of 774 interventions in the two years of 2017 and 2018, and 1 in 5 of these were concentrated in just two Wirral wards – Birkenhead & Tranmere and Seacombe wards. These two wards had the highest rate of interventions due to poor condition of all 22 Wirral wards – and both wards are among the most deprived wards in Wirral.

* The Decent Homes Standard is a national standard against which all homes can be measured. There are four criteria that a home is required to meet before being classified as 'decent'. These are: it meets the current statutory minimum standard for housing (currently the Housing Health & Safety Rating System); it is in a reasonable state of repair; it has reasonable modern facilities and service, and it provides a reasonable degree of thermal comfort.

Income and Employment

Unemployment

In March 2020, 20.6% of the working age population of Wirral were economically inactive (n=39,700); this was exactly the same proportion as in England overall (also 20.6% of the working age population).

By December 2020, this figure had increased to 26.1% (n=50,300) in Wirral, but in England overall, this figure had actually decreased (marginally) to 20.5% of working-age people being economically inactive – highlighting that the pandemic appears to have had a greater impact on employment locally than is the case nationally (Source: NOMIS, 2021).

Employment by sector/industry

The largest employers by sector/industry in Wirral are 'Health and Social Care' and 'Motor Trade, Wholesale and Retail' (Source: Business Register and Employment Survey, NOMIS and PCMD (2021). Both of these sectors are at higher risk of contracting COVID-19 according to Office for National Statistics (ONS) and Public Health England (PHE).

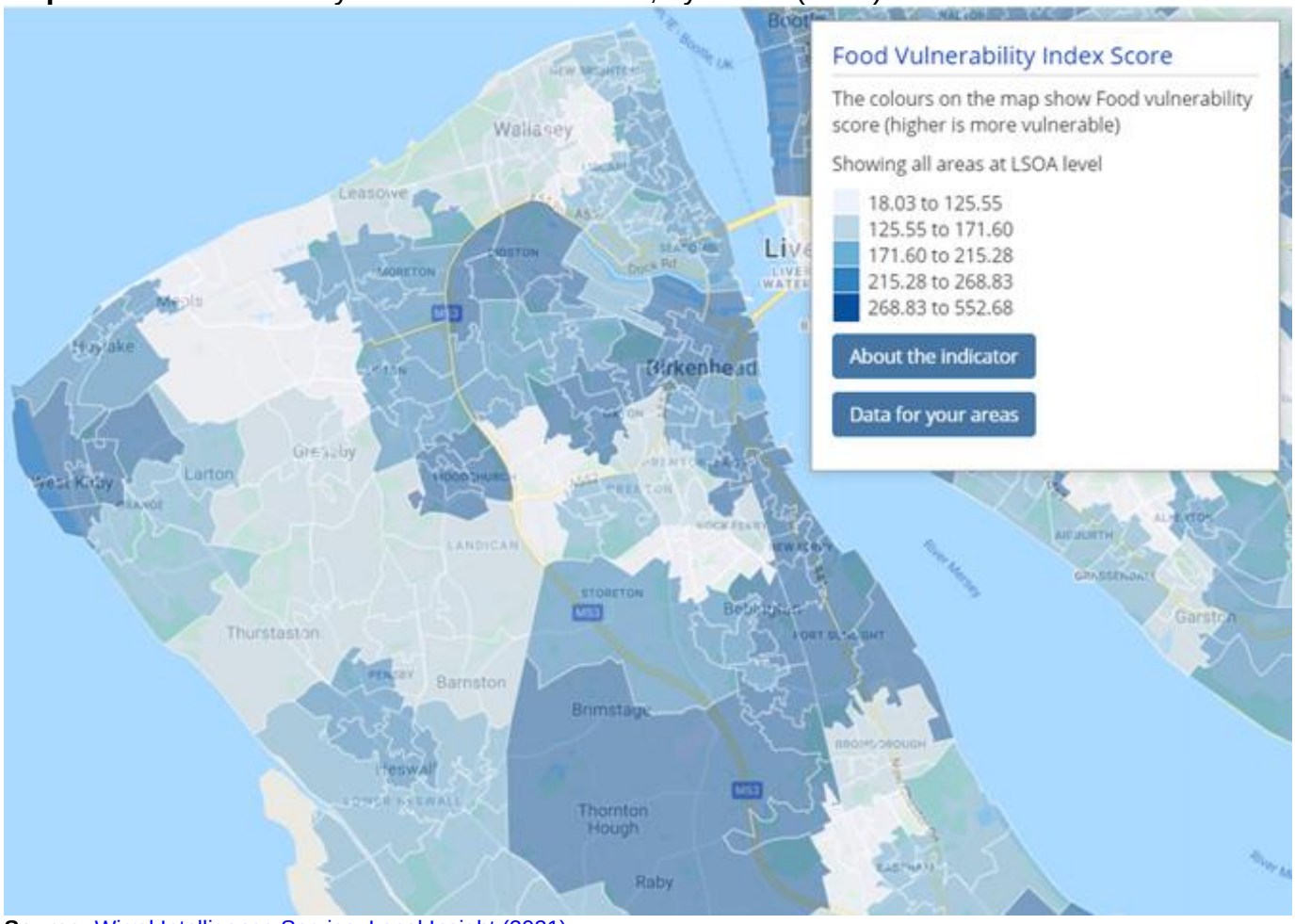
ONS has also reported that specifically, men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants, and men and women working in social care had significantly high rates of death from COVID-19 (Source: Wirral COVID-19 Mortality Report).

Food insecurity

The Food Vulnerability Index was calculated by the British Red Cross in 2020 (See Local Insight for full definition), a higher score on the shown in **Map 1**, indicates a higher level of vulnerability.

As **Map 1** shows, scores ranged from 132 in Greasby, Frankby & Irby ward, to 296 in Bidston & St. James ward. The average score for Wirral overall was 197

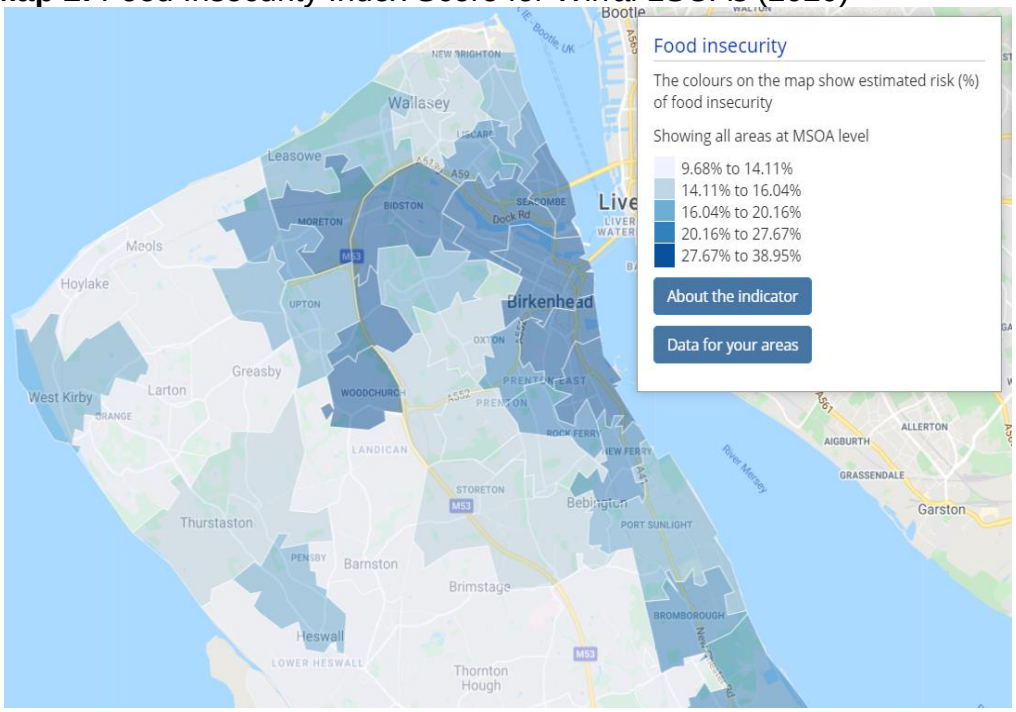
Map 1: Food Vulnerability Index Score for Wirral, by LSOA (2020)



Source: Wirral Intelligence Service: Local Insight (2021)

The estimated prevalence (%) of households at high risk of Food Insecurity (shown in **Map 2**) was calculated by the University of Southampton using two domains of economic characteristics: household composition and income-related benefit claimants.

Map 2: Food Insecurity Index Score for Wirral LSOAs (2020)



For Wirral, the overall proportion of the population estimated to be at risk of Food Insecurity is 16% of the population, however as **Map 2** shows, this varies widely across Wirral. It is as high as 32% (or 1 in 3) of the population of Bidston & St. James ward, to 12% (1 in 8) of people in Heswall.

Source: Wirral Intelligence Service: Local Insight (2021). Full methodology used by the University of Southampton is available at: https://doi.org/10.1016/j.apgeog.2017.12.

Environment

Air quality

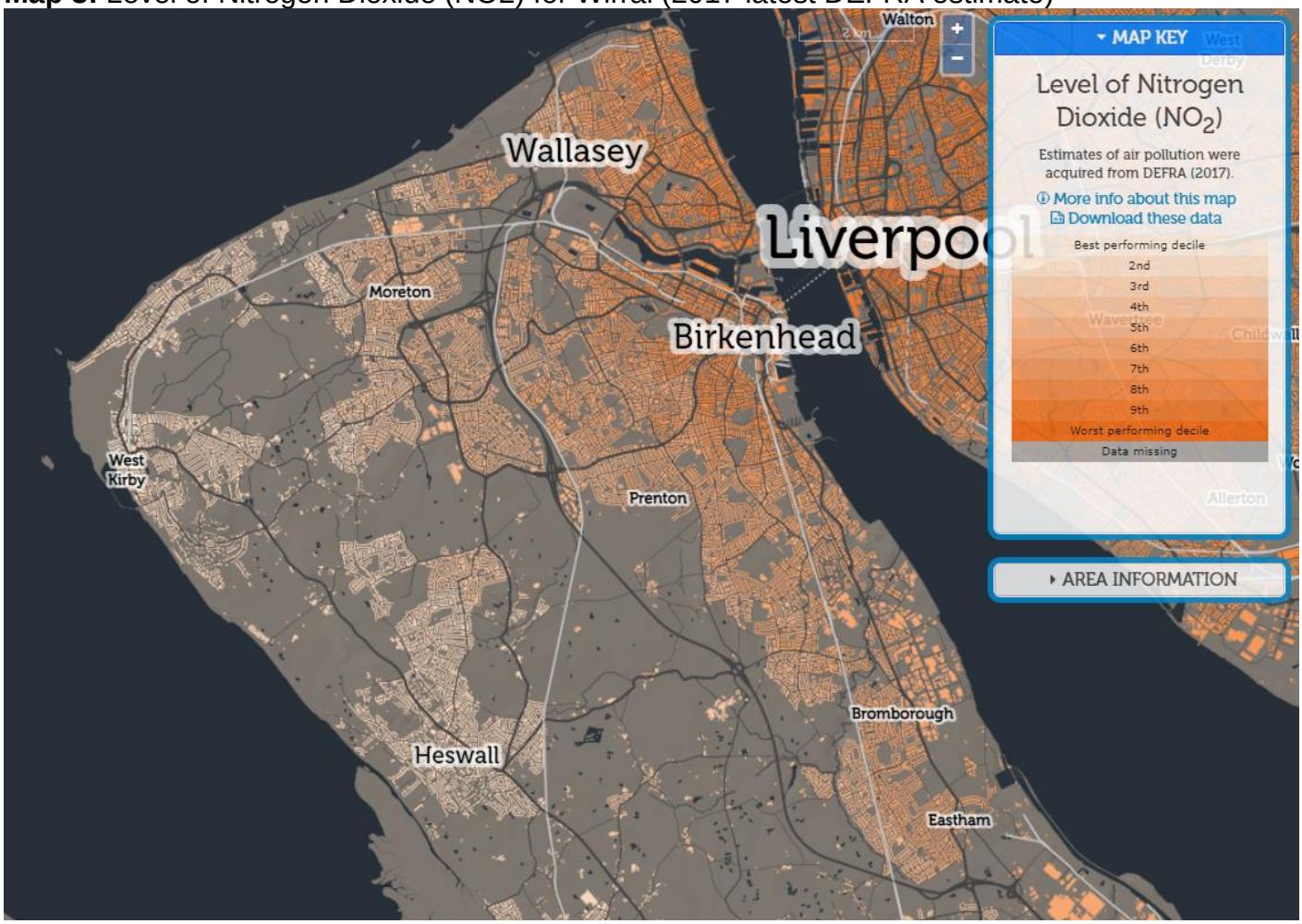
In September 2019, an audit of Wirral's local air quality actions (using Public Health England recommendations) was undertaken. Following this audit, a list of recommended local actions was formulated and outlined in a report to the Health and Wellbeing Board in November 2019. The recommendations included continued monitoring of air pollutants (specifically NO2 and PM2.5) to identify long term trends and areas for action locally.

Results of monitoring have found that Nitrogen Dioxide has reduced between 2015/2016 and 2019 (data obtained from two monitoring units located in Wirral); there was a 20% reduction in annual mean concentrations of Nitrogen Dioxide at Tranmere between 2015 to 2019 and a 15% reduction in annual mean concentrations of Nitrogen Dioxide at Birkenhead between 2016 to 2019 - data for 2015 is not available as the Birkenhead was installed in 2016).

The monitoring data for PM2.5 showed that background levels stayed the same between 2015–2019, with no change in the levels monitored (Source: 2020 Air Quality Annual Status Report (ASR) In fulfilment of Part IV of the Environment Act 1995 Local Air Quality Management, Wirral Council, June 2020, and Wirral JSNA Air Quality Chapter).

Data from the Consumer Data Research Centre shows that despite recent falls, the worst performing areas in Wirral on NO2 levels, were in the more deprived areas of Wirral in the east of the borough, see **Map 3**.

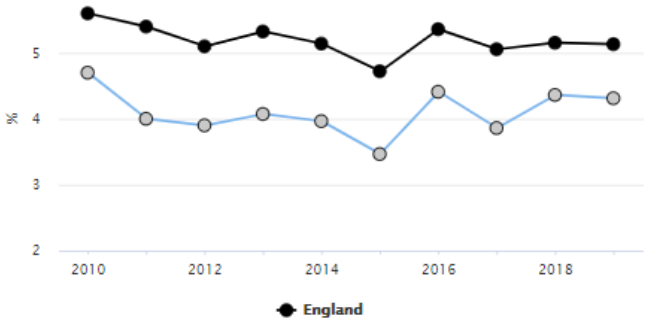
Map 3: Level of Nitrogen Dioxide (NO2) for Wirral (2017 latest DEFRA estimate)



Source: Consumer Data Research Centre, 2021

The Public Health England Outcomes Framework has published data (currently up to 2019), showing that Wirral has lower proportion of mortality which can be attributed to particulate air pollution than both England and the North-West overall (4.3% versus 5.1% in England overall and 4.% in the North West overall – see **figure 3** below).

Figure 3: Trend in fraction of mortality attributable to particulate air pollution for Wirral (2010 to 2020)



Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2010	○	-	4.7%	-	-	5.1%	5.6%
2011	○	-	4.0%	-	-	4.6%	5.4%
2012	○	-	3.9%	-	-	4.4%	5.1%
2013	○	-	4.1%	-	-	4.6%	5.3%
2014	○	-	4.0%	-	-	4.4%	5.1%
2015	○	-	3.5%	-	-	4.1%	4.7%
2016	○	-	4.4%	-	-	4.6%	5.4%
2017	○	-	3.9%	-	-	4.1%	5.1%
2018	○	-	4.4%	-	-	4.3%	5.2%
2019	○	-	4.3%	-	-	4.5%	5.1%

Source: Public Health Outcomes Framework (2021)

Green space

Wirral has a range of fantastic natural leisure assets, many of which can be enjoyed for free. Wirral has 25 miles of stunning coastline and over 1,500 hectares of parks and open spaces which provide endless leisure opportunities for walking, cycling, and enjoying time with friends and family **(Wirral Leisure Strategy: A 2020 Plan).**

Wirral saw an increase in the number of parks awarded Green Flag status in Wirral in 2020 (the largest number in the North-West for the third year running). In 2019, Wirral had 27 sites awarded Green Flag status (all were maintained in 2020, and a further 3 were added). Sites are awarded Green Flag status in recognition of good environmental standards, being well maintained, and providing clean and safe visitor facilities. (see **Map 4** for range of green space options in Wirral).

Map 4: Nearby Green Space for Wirral (2017)

Source: Consumer Data Research Centre, 2021

Green space positively influences health and wellbeing; however, inequalities in use of green space are prevalent. A UK study carried out (between 30 April and 1 May 2020) which aimed to explore how movement restrictions had changed during the COVID-19 pandemic, measured time spent visiting green space and experience of green space and how this differed by demographic characteristics.

Overall, 63% of respondents reported a decrease in time spent visiting green space following movement restrictions. Lower social grade respondents were less likely to visit green space both before and after restrictions were enforced (OR: 0.35 (95% CI 0.24 to 0.51); OR: 0.77 (95% CI 0.63 to 0.95)).

Female respondents were more likely than male respondents to agree that green space benefited their mental health more following restrictions (PP: 0.70 vs 0.59). Older (65+ years) respondents were less likely than middle-aged (25–64 years) respondents to have visited green space following the restrictions (OR: 0.79 (95% CI 0.63 to 0.98)).

The conclusions of the study were that inequalities in green space use were sustained, and possibly exacerbated, during movement restrictions (**Source: BMJ Open 2021;11:e044067. doi:10.1136/ bmjopen-2020-044067).**

ONS found something slightly different in that the proportion of people leaving home for exercise increased during the early lockdown period (Spring 2020), as restrictions limited other leisure activities, but that the rise in exercise was at least partly driven by people working from home, who have been more likely to leave the house for exercise than those who travel to work each day (Source: ONS, 2021).

In July 2020, 46% of people surveyed by Natural England also said they had spent more time outside than usual during the coronavirus (COVID-19) pandemic, with the analysis indicating that some people turned to nature to cope with feelings such as increased anxiety (41% of people saying that visits to natural spaces were more important to their wellbeing in May 2020 compared with before the pandemic) (Source: ONS, 2021 How has lockdown changed our relationship with nature?)

Connectedness and social/community networks

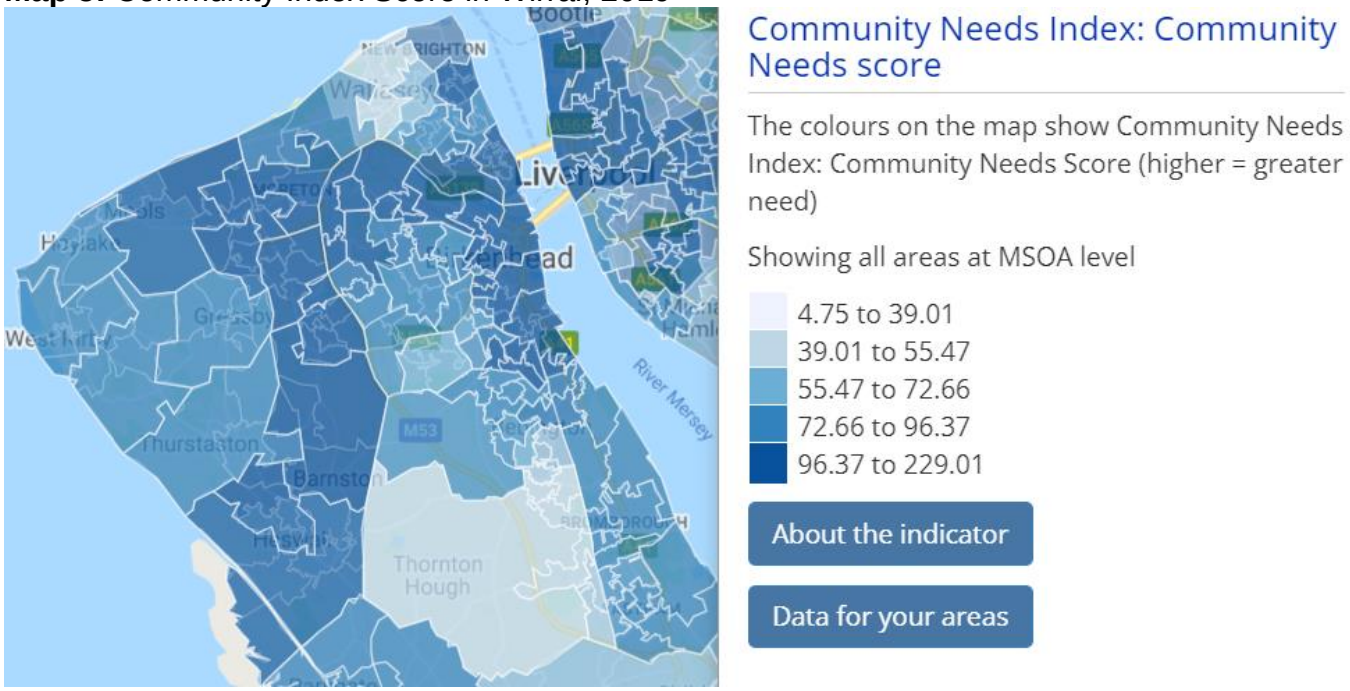
Community index score

The Community Needs Index was developed to identify areas experiencing poor community and civic infrastructure, relative isolation, and low levels of participation in community life.

The index was created by combining a series of 19 indicators (conceptualised under three domains: Civic Assets, Connectedness and Active and Engaged Community).

A higher score indicates that an area has higher levels of community need. The overall scoring for Wirral indicated a higher level of need compared to England overall (68 in England, compared to 96 in Wirral), but also that there were significant inequalities within Wirral; for example, scoring by ward varied from 130 in Seacombe and 122 in Bidston & St. James ward, to 41 in Clatterbridge and 42 in Wallasey). See **Map 5**.

Map 5: Community Index Score in Wirral, 2019



Source: Local Insight Wirral, 2021

Transport/car access

Access to a vehicle is very much linked to deprivation and as such, varies widely across Wirral. Although Census data is now several years old, it remains the definite source of information on vehicle access and the overall trend (that those in areas of deprivation have lower likelihood of having access to a vehicle) is a longstanding one and is unlikely to have shifted. The 2011 Census (see **table 1**) indicated that in Wirral overall, 28% of households (39,000 out of 140,000 households) had no access to a vehicle; this varied from 55.6% of households in Birkenhead & Tranmere to 10% of households in Heswall.

Table 1: Households with no access to a vehicle by area, 2011

Area	Households	No cars or vans in household	Percentage of area (%)
Bebington	6,645	1,439	21.7
Bidston & St James	6,889	3,488	50.6
Birkenhead & Tranmere	7,747	4,309	55.6
Bromborough	6,690	1,927	28.8
Clatterbridge	5,924	662	11.2
Claughton	6,285	1,719	27.4
Eastham	5,955	1,199	20.1
Greasby, Frankby & Irby	5,978	721	12.1
Heswall	5,808	579	10.0
Hoylake & Meols	5,713	1,034	18.1
Leasowe & Moreton East	6,390	2,021	31.6
Liscard	6,891	2,420	35.1
Moreton West & Saughall Massie	6,176	1,243	20.1
New Brighton	6,784	2,115	31.2
Oxton	6,592	1,458	22.1
Pensby & Thingwall	5,803	962	16.6
Prenton	6,051	1,510	25.0
Rock Ferry	6,465	3,010	46.6
Seacombe	6,871	3,156	45.9
Upton	7,127	2,283	32.0
Wallasey	6,313	1,226	19.4
West Kirby & Thurstaston	5,486	910	16.6
Birkenhead Constituency	**40,029**	**15,494**	**38.7**
Wallasey Constituency	**39,425**	**12,181**	**30.9**
Wirral South Constituency	**31,022**	**5,806**	**18.7**
Wirral West Constituency	**30,107**	**5,910**	**19.6**
Wirral	**140,583**	**39,391**	**28.0**

Source: Census, 2011

Digital exclusion

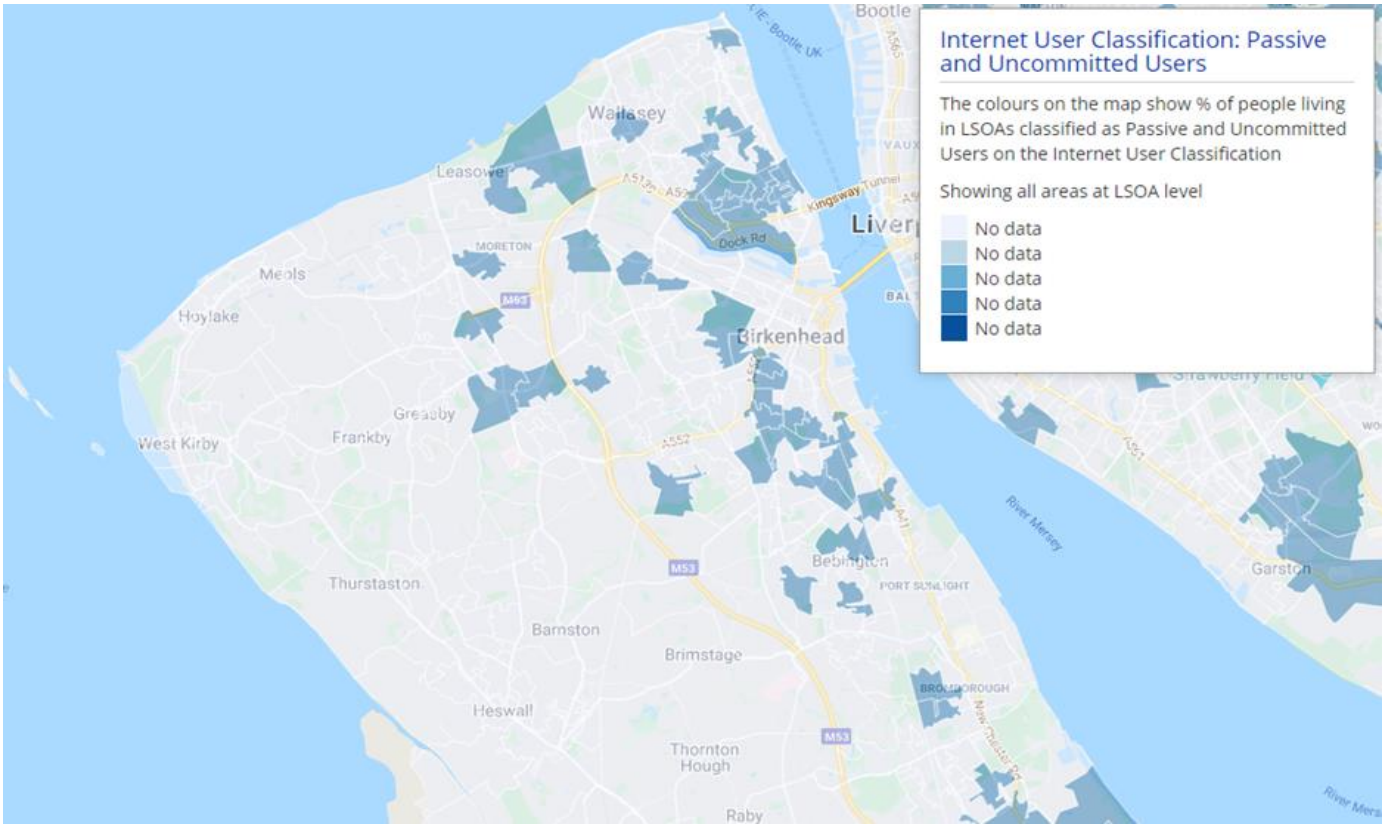
In 2018, the University of Liverpool, in association with the Consumer Data Research Centre (CDRC), produced an Internet User Classification (IUC) by Lower Super Output Area (LSOA). The IUC is a bespoke classification that describes how people in different parts of Great Britain interact with the internet. There are 10 different categorisations which are listed below, with the number in the brackets indicating how many LSOA's in Wirral are categorised as that classification:

- Digital Seniors (n = 24)
- **Passive and Uncommitted Users (n = 48)**
- Settled Offline Communities (n = 7)
- Youthful Urban Fringe (n = 0)
- E-Cultural Creators (n = 0)
- E-Mainstream (n = 37)
- E-Rational Utilitarians (n = 53)
- E-Veterans (n = 9)
- **E-Withdrawn (n = 28)**
- E-Professionals (n = 0)

Passive and Uncommitted Users and e-Withdrawn appear to be the two groups for whom internet access is **least** likely; both have been detailed below, with maps showing where in Wirral these groups are most likely to live and how many people are classified as belonging to these groups.

Passive and Uncommitted Users

Map 6: Lower Super Outputs Areas (LSOA) in Wirral Classified as "Passive and Uncommitted Users"



Source: Wirral Intelligence Service: Local Insight (2021)

The Passive and Uncommitted Users classification is the 2nd most prevalent in Wirral (behind E-Rational Utilitarians). The definition of this classification is as follows:

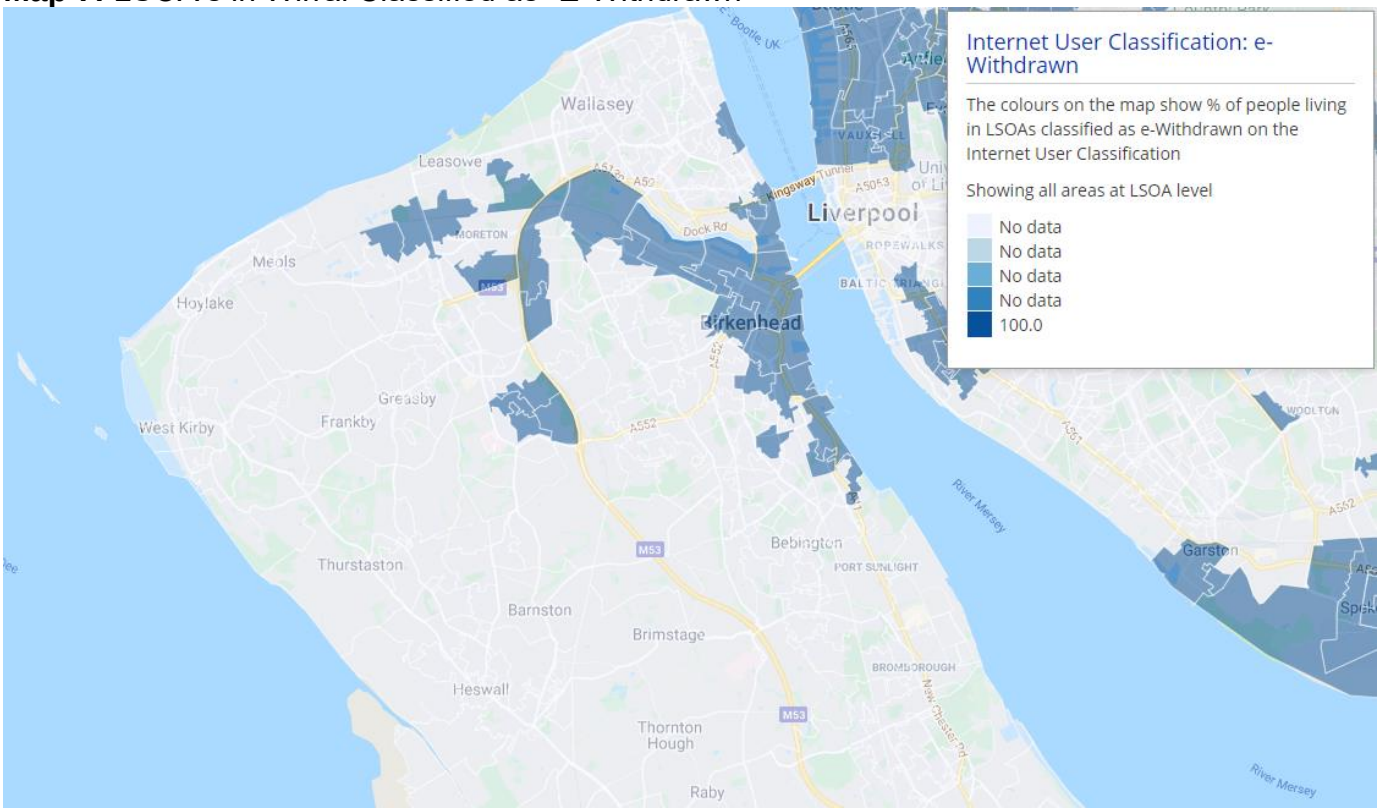
"The Passive and Uncommitted Users group comprises individuals with limited or no interaction with the Internet. They tend to reside outside city centres and close to the suburbs or semi-rural areas. Members of this Group have few distinctive characteristics in conventional socio-economic terms, albeit higher levels of employment in semi-skilled and blue-collar occupations. Individuals are rarely online, and most commonly report use once a week or less. Access to broadband is well below average, and for those online, there is mild preference for access via smartphones. The Internet is typically used for social networks, gaming, and some limited online shopping."

There are an estimated 76,200 people in Wirral classified as Passive and Uncommitted Users (or 24% of the Wirral population. The highest concentrations are in Wallasey Constituency (n=28,982 or 32% of the population of the Constituency)**.** On the other hand, 1 in 5 people in Wirral South Constituency and just 1 in 12 Wirral West Constituency are classified as Passive and Uncommitted Users. See **Map 6** above for an indication of where this group live in Wirral.

E-Withdrawn

"The E-Withdrawn Group is mainly characterised by individuals who are the least engaged with the Internet. Their geography is expressed by areas that are associated with those more deprived neighbourhoods of urban regions. The socio-economic profile of the population is characterised by less affluent white British individuals or areas of high ethnic diversity; and it has the highest rate of unemployment and social housing among all other Groups.
The E-Withdrawn Group appears to have the highest ratio of people that do not have access or have access but never engage with the Internet. It also expresses the lowest rates of engagement in terms of information seeking and financial services, as well as the lowest rate in terms of online access via a mobile device. Online shopping is also particularly low, except for Clothing on Credit, suggesting an opportunistic dimension to Internet usage.

Map 7: LSOA's in Wirral Classified as "E-Withdrawn"



Source: Wirral Intelligence Service: Local Insight (2021)

This is further reinforced by the higher than average access to Cable broadband by TV Provider, which may suggest that some individuals have opted into broadband mainly for the TV-

associated benefits. It is possible that many people within this Group have opted out of online engagement, either because it is considered unnecessary or because of economic reasons."

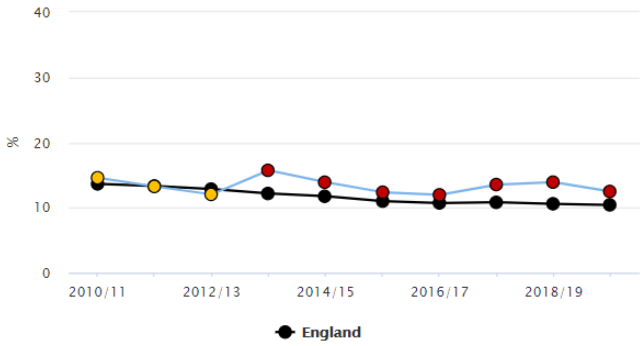
A map showing the location of the LSOA's classified as E-Withdrawn is shown above in **Map 7**. It shows that the large majority of those classified as E-Withdrawn reside in the Birkenhead area, with very few in Wirral South and Wirral West Constituencies. This reflects the Indices of Multiple Deprivation (IMD) – with a large majority of the LSOA's highlighted in **Map 7** being within the top 20% most deprived LSOA's nationally.

Nationally, only 8.8% of people are classified as E-Withdrawn, but this figure is 13.9% in Wirral (n=44,813 people). This overall proportion hides a large variation, with Birkenhead Constituency having 28.4% (or 25,752) of its population classified as E-Withdrawn, compared to just 2.3% of people in Wirral South (n=1,676).

Lifestyle and behaviour

Smoking

Figure 4: Trend in smoking Status at time of delivery (2010/11 to 2019/20)

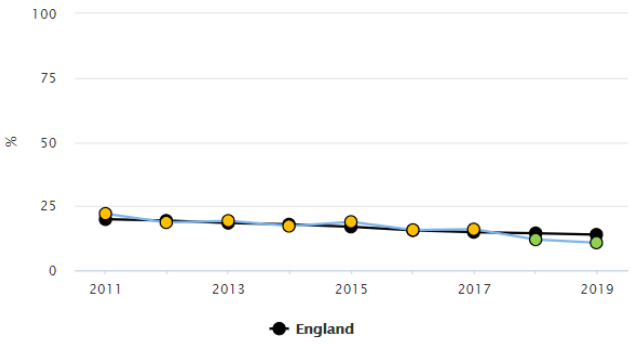


Recent trend: No significant change

Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2010/11		523	14.6%	13.5%	15.8%	17.8%	13.6%
2011/12		479	13.2%	12.2%	14.4%	17.1%	13.3%
2012/13		418	12.0%	11.0%	13.1%	16.5%	12.8%
2013/14		420	15.7%*	14.4%	17.1%	15.5%	12.2%
2014/15		364	13.9%*	12.6%	15.3%	14.8%	11.7%
2015/16		354	12.4%*	11.2%	13.6%	13.8%	11.0%
2016/17		348	12.0%*	10.8%	13.2%	13.4%	10.7%
2017/18		379	13.5%*	12.3%	14.9%	13.4%	10.8%
2018/19		422	13.9%	12.7%	15.2%	12.7%*	10.6%
2019/20		372	12.5%	11.3%	13.7%	12.2%*	10.4%

Source: Public Health Outcomes Framework (2021)

Figure 5: Trend in smoking Prevalence in adults (18+) – current smokers (2011 to 2019)



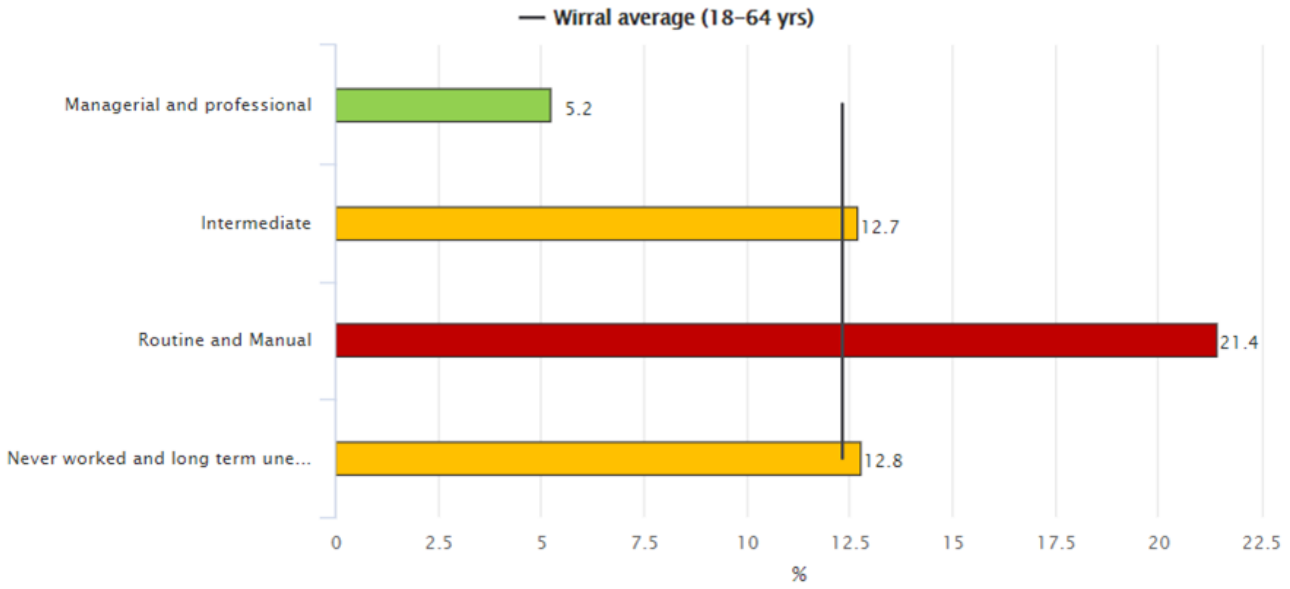
Recent trend: Could not be calculated

Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2011		55,552	22.0%	19.2%	24.9%	21.9%	19.8%
2012		47,100	18.6%	16.1%	21.1%	21.1%	19.3%
2013		48,818	19.3%	16.6%	22.0%	20.0%	18.4%
2014		43,775	17.2%	14.7%	19.8%	19.6%	17.8%
2015		47,945	18.9%	16.0%	21.7%	18.6%	16.9%
2016		39,952	15.7%	13.0%	18.4%	16.8%	15.5%
2017		40,667	15.9%	13.3%	18.6%	16.1%	14.9%
2018		30,556	12.0%	9.6%	14.3%	14.7%	14.4%
2019		27,545	10.7%	8.5%	13.0%	14.5%	13.9%

Source: Public Health Outcomes Framework (2021)

Although Wirral is lower than England (13.9%), the overall figure for Wirral of 10.7% **(figure 5)** hides wide inequalities, with prevalence ranging from 21.4% to 5.2% dependent on occupation, see **Figure 6**.

Figure 6: Smoking prevalence in adults aged 18+ by working status (2019)



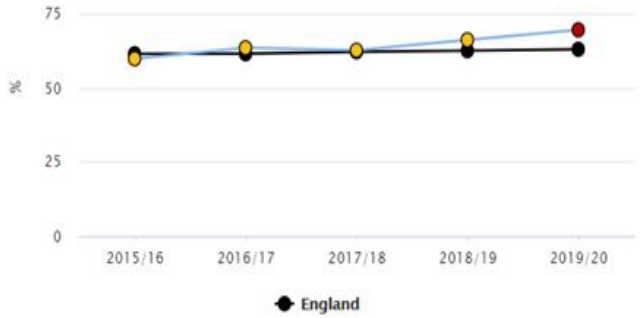
Source: Public Health Outcomes Framework (2021)

Unhealthy weight and diet (adults)

Data from PHE **(figure 7)**, shows that the proportion of adults who are classified as an unhealthy weight (either overweight or obese) has increased in Wirral since 2015/16 to 2019/20; from 59.6% to 69.3% - an increase of almost 10% in 5 years.

This means that more than 2 in 3 of all adults in Wirral are either overweight or obese and as of 2019/20, Wirral was significantly higher than England for the first time since this indicator has been recorded (although not as high as the NW).

Figure 7: Trend in percentage of adults classified as overweight or obese (2015/16 to 2019/20)



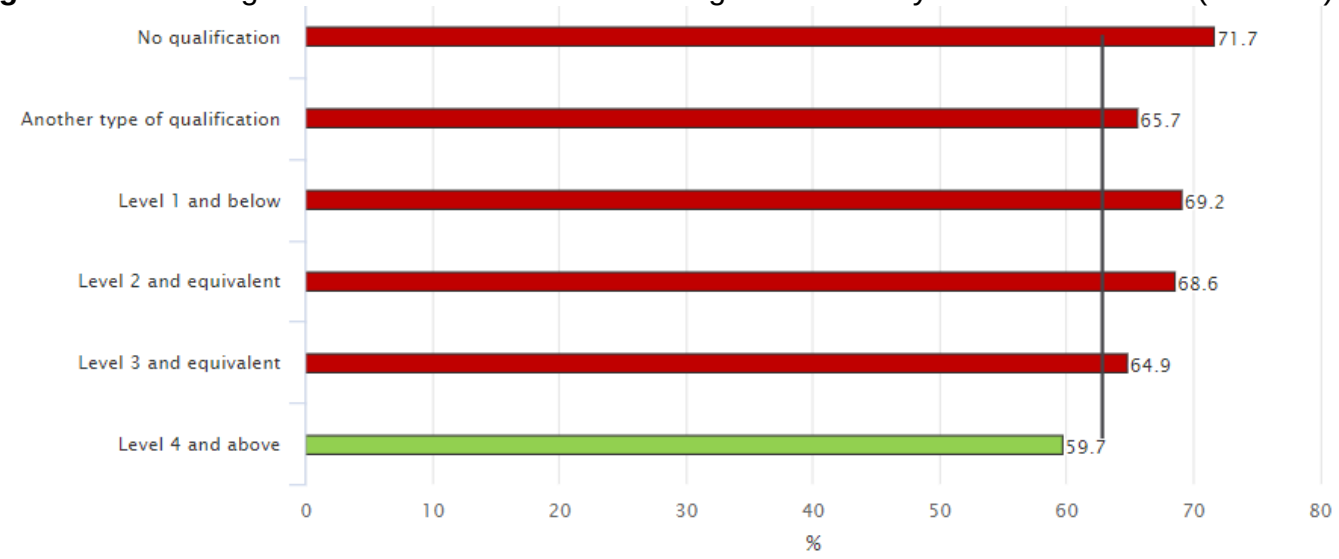
	Wirral						
Period		Count	Value	95% Lower CI	95% Upper CI	North West	England
2015/16		-	59.6%	54.7%	65.0%	63.0%	61.3%
2016/17		-	63.3%	58.1%	68.5%	63.3%	61.3%
2017/18		-	62.5%	57.8%	67.1%	64.3%	62.0%
2018/19		-	66.0%	61.4%	70.4%	64.9%	62.3%
2019/20		-	69.3%	65.1%	73.6%	65.9%	62.8%

Source: Public Health England (based on Active Lives survey, Sport England)

Source: Public Health Outcomes Framework (2021)

This overall figure of 69.3% (which is still more than 2 in 3 adults), also hides considerable inequalities however, with the proportion of adults classified as either overweight or obese varying from 71.7% of adults with no qualifications, to 59.7% of adults educated to Level 4 or above (Level 4 or above – Degree level or above; Other Higher Education below degree level). See **Figure 8**.

Figure 8: Percentage of adults classified as overweight or obese by level of education (2019/20)

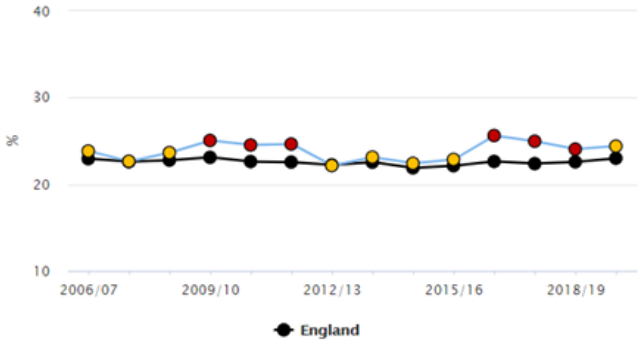


Source: Public Health Outcomes Framework (2021)

Unhealthy weight and diet (children)

As of 2019/20, almost 1 in 4 Reception aged children (aged 4-5) were either overweight or obese; this was higher than both England overall (24.4% in Wirral, vs 23.0% in England). There has been some fluctuation since 2006/07, but Wirral has generally always had a rate which is above England overall (see **figure 9** below).

Figure 9: Trend in prevalence of unhealthy weight (overweight and obese) in Reception age children, 2006/07 to 2019/20



Recent trend: ➡ No significant change

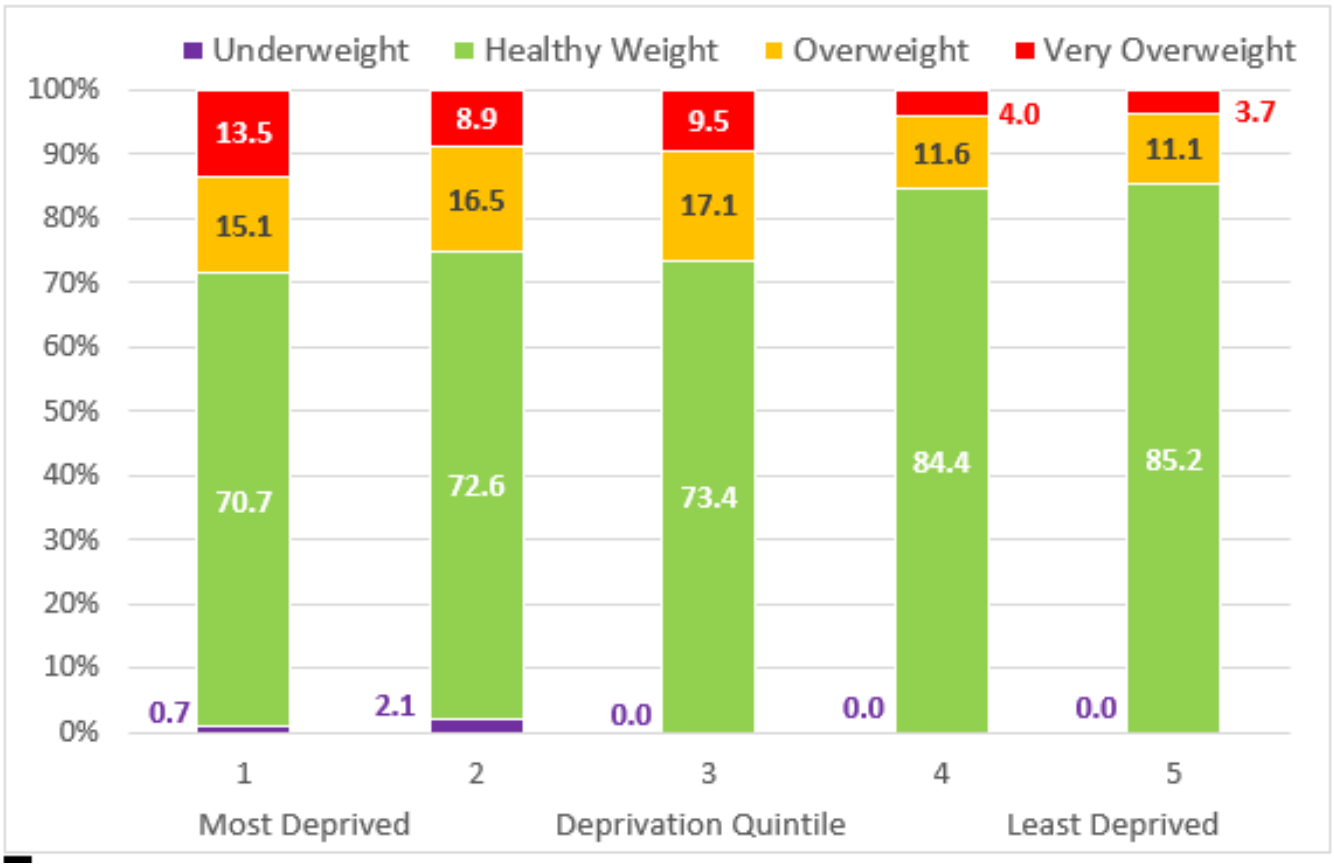
Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2006/07	●	612	23.8%	22.2%	25.5%	*	22.9%
2007/08	●	700	22.7%	21.2%	24.2%	23.1%	22.6%
2008/09	●	786	23.7%	22.2%	25.1%	23.1%	22.8%
2009/10	●	838	25.1%	23.6%	26.5%	23.6%	23.1%
2010/11	●	859	24.5%	23.1%	26.0%	23.3%	22.6%
2011/12	●	879	24.6%	23.3%	26.1%	23.2%	22.6%
2012/13	●	789	22.2%	20.8%	23.6%	23.2%	22.2%
2013/14	●	838	23.1%	21.8%	24.5%	23.6%	22.5%
2014/15	●	808	22.4%	21.1%	23.8%	22.9%	21.9%
2015/16	●	851	22.9%	21.5%	24.2%	23.2%	22.1%
2016/17	●	979	25.6%	24.3%	27.0%	23.9%	22.6%
2017/18	●	888	25.0%	23.6%	26.4%	23.9%	22.4%
2018/19	●	851	24.1%	22.7%	25.5%	24.4%	22.6%
2019/20	●	345	24.4%*	22.2%	26.7%	25.2%	23.0%

Source: Public Health Outcomes Framework (2021)

Within Wirral, there were wide inequalities in the proportion of Reception aged children classified as either overweight or very overweight (obese) in 2019/20. The chart below **(figure 10)** shows that in Quintile 1 (20% most deprived section of the population), 13.5% of children were very overweight (obese), compared to 3.7% in the least deprived 20% of the population.

In other words, the rate of obesity is more than 3 times higher in areas of deprivation than areas classed as least deprived (or most affluent).

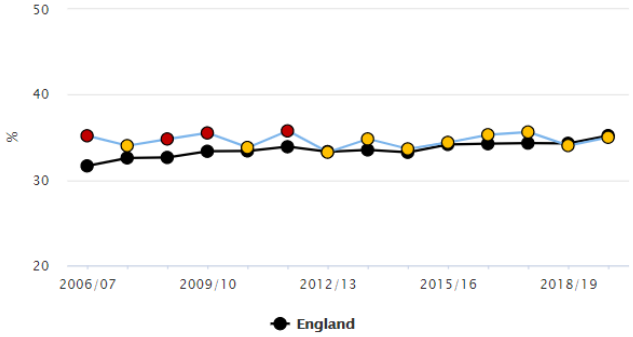
Figure 10: Prevalence of unhealthy weight (overweight and obese) in Reception age children, by deprivation quintile, 2019/20



Source: Public Health Outcomes Framework (2021)

By the time children reach Year 6 (age 10-11), a higher proportion are classified as either overweight or obese; in Wirral in 2019/20, this was 35% (**figure 11**). This was not significantly different to England (in fact, it was slightly lower than both the NW and England), but the fact remains that more than 1 in 3 children are overweight or obese by the age of 11 in Wirral; a proportion which has not changed significantly for the past 14 years.

Figure 11: Trend in prevalence of unhealthy weight (overweight and obese) in Year 6 age children, 2006/07 to 2019/20



Recent trend: ➡ No significant change

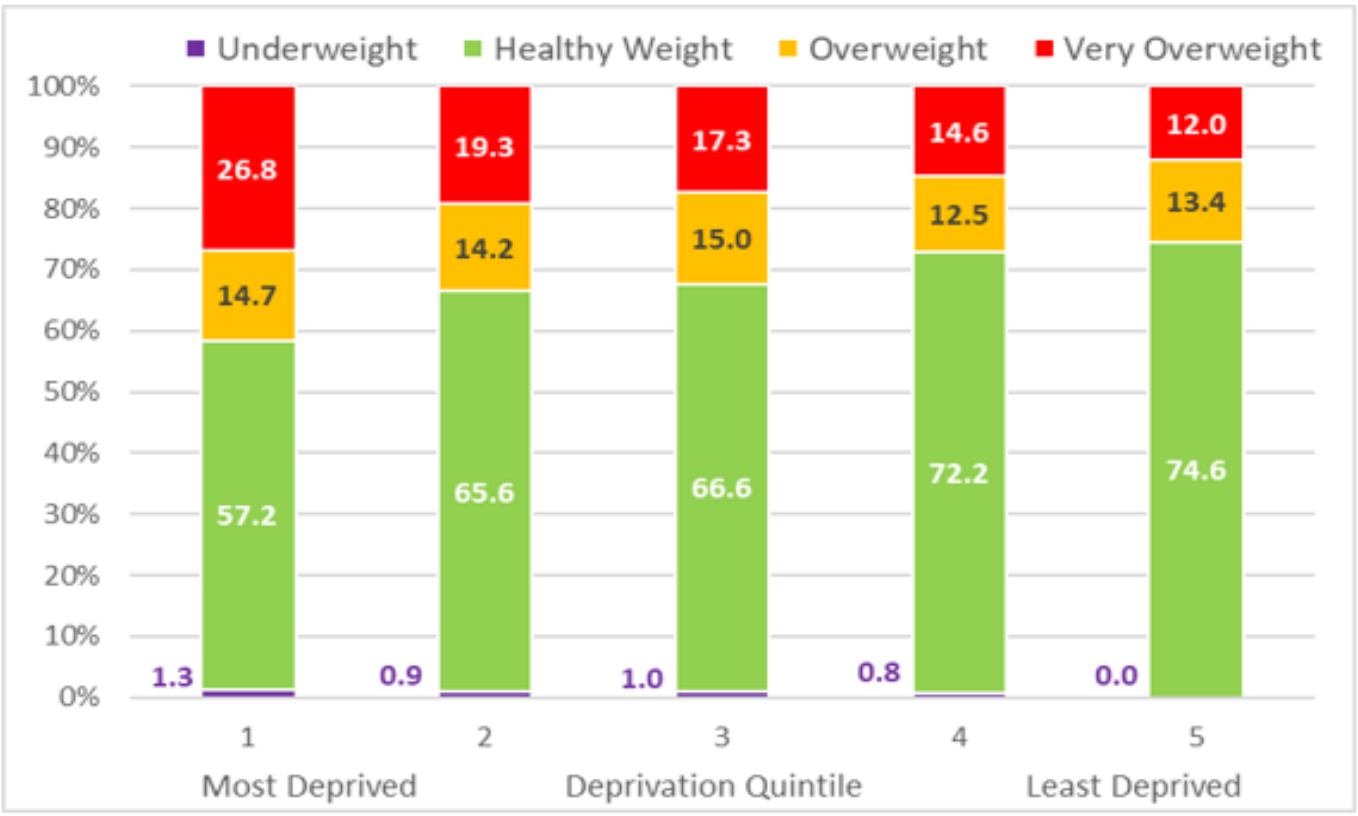
Period		Wirral Count	Wirral Value	Wirral 95% Lower CI	Wirral 95% Upper CI	North West	England
2006/07	●	998	35.2%	33.4%	37.0%	*	31.7%
2007/08	●	1,056	34.0%	32.4%	35.7%	32.7%	32.6%
2008/09	●	1,127	34.8%	33.2%	36.5%	33.0%	32.6%
2009/10	●	1,164	35.5%	33.9%	37.2%	34.1%	33.4%
2010/11	●	1,093	33.8%	32.2%	35.5%	34.3%	33.4%
2011/12	●	1,130	35.7%	34.1%	37.4%	34.7%	33.9%
2012/13	●	1,021	33.3%	31.6%	34.9%	34.2%	33.3%
2013/14	●	1,109	34.8%	33.2%	36.5%	34.4%	33.5%
2014/15	●	1,105	33.6%	32.0%	35.3%	33.8%	33.2%
2015/16	●	1,171	34.4%	32.8%	36.0%	35.2%	34.2%
2016/17	●	1,231	35.3%	33.7%	36.9%	35.2%	34.2%
2017/18	●	1,262	35.6%	34.1%	37.2%	35.5%	34.3%
2018/19	●	1,191	34.0%	32.5%	35.6%	35.9%	34.3%
2019/20	●	1,180	35.0%	33.3%	36.5%	37.4%	35.2%

Source: Public Health Outcomes Framework (2021)

As was the case for Reception aged children, there are stark inequalities in the proportions of children who are overweight and very overweight (obese) for Year 6 within Wirral also. In 2019/20, over a quarter, or 1 in 4 children from the most deprived areas (26.8%) were obese, compared to 12% (or 1 in 8) children from the least deprived areas (12.0%).

In other words, the rate of obesity in the most deprived areas of Wirral, is more than double that of the least deprived areas **(figure 12)**.

Figure 12: Prevalence of unhealthy weight (overweight and obese) in Year 6 children, by deprivation quintile, 2019/20

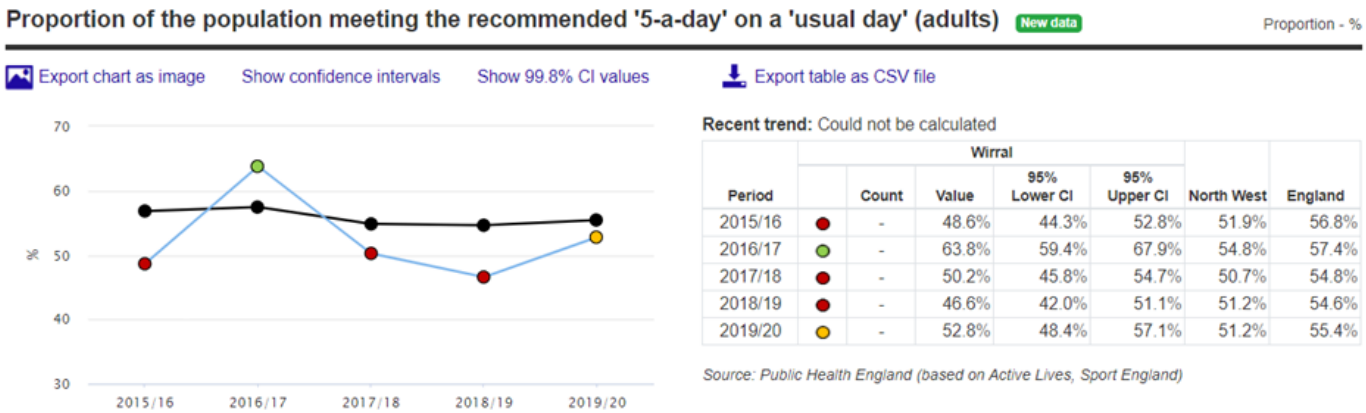


Source: Public Health Outcomes Framework (2021)

Diet

Wirral is currently just behind England on the proportion of the population meeting the recommendation (to eat at least 5 portions of fruit and veg per day) but not significantly so as seen in **figure 13** below. This is a slight improvement for Wirral, given that in the previous two time periods, Wirral has been significantly worse on this measure than England overall.

Figure 13: Trend in percentage of population meeting 5-a-day recommendations, 2015/16 to 2019/20



Source: Public Health Outcomes Framework (2021)

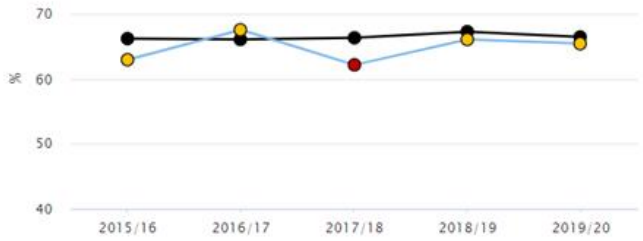
Physical activity

Physical inactivity is the 4th leading risk factor for global mortality accounting for 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis, and colon/breast cancer and with improved mental health. In older adults physical activity is associated with increased functional capacities.

The estimated direct cost of physical inactivity to the NHS across the UK is over £0.9 billion per year. The Chief Medical Officer for England (CMO) currently recommends that adults undertake a minimum of 150 minutes (2.5 hours) of moderate physical activity per week, or 75 minutes of vigorous physical activity per week or an equivalent combination of the two (MVPA), in bouts of 10 minutes or more. The overall amount of activity is more important than the type, intensity, or frequency.

Figure 14 suggests that just under 2 in 3 adults reported being physically active enough to benefit their health* in Wirral in 2019/20 – meaning 1 in 3 are ***not*** physically active enough to benefit their health (a proportion which is not significantly different to England or the North-West overall and improving over time).

Figure 14: Trend in percentage of physically active adults, 2015/16 to 2019/20



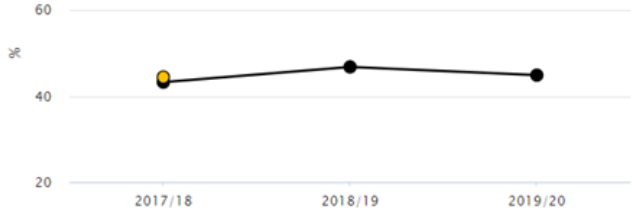
		Wirral					
Period		Count	Value	95% Lower CI	95% Upper CI	North West	England
2015/16		-	62.9%	58.7%	66.9%	64.6%	66.1%
2016/17		-	67.5%	63.3%	71.4%	65.1%	66.0%
2017/18		-	62.1%	57.7%	66.3%	64.7%	66.3%
2018/19		-	66.0%	61.7%	70.1%	65.6%	67.2%
2019/20		-	65.4%	61.1%	69.4%	63.9%	66.4%

Source: Public Health England (based on the Active Lives Adult Survey, Sport England)

Source: Public Health Outcomes Framework (2021)
Notes: *Weighted number of respondents aged 19 and over, with valid responses to questions on physical activity, doing at least 150 MIE minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days.

The picture for children is worse than that for adults, in 2017/18 (figures are not available for more recent years as they are for adults), less than half reported being physically active enough to benefit their health (44.4% in Wirral, vs 43.3% in England). While Wirral was slightly ahead of England, this was not significant and is still a concerningly low proportion (see **figure 15**).

Figure 15: Percentage of physically active children and young people, 2017/18



		Wirral					
Period		Count	Value	95% Lower CI	95% Upper CI	North West	England
2017/18		-	44.4%	37.9%	51.2%	42.3%	43.3%
2018/19		-	*	-	-	45.3%	46.8%
2019/20		-	*	-	-	43.3%	44.9%

Source: Public Health England (based on Active Lives Children and Young People Survey, Sport England)

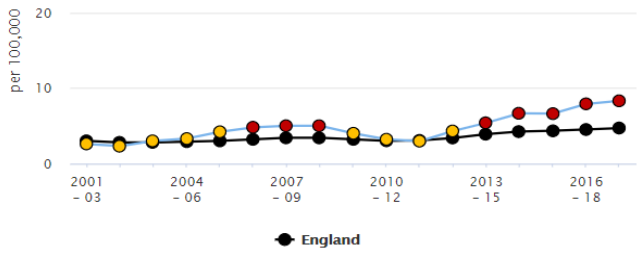
Source: Public Health Outcomes Framework (2021)
Notes: *Percentage of children aged 5-16 that meet the UK Chief Medical Officers' (CMOs') recommendations for physical activity (an average of at least 60 minutes moderate-vigorous intensity activity per day across the week)

Drugs

Wirral Drug Misuse JSNA chapter gives an in-depth analysis of the impact of drugs misuse on the residents of Wirral, compared to regional and national comparators. The JSNA chapter details how issues such as the rate of client seeking treatment for drug issues and admissions

due to drug misuse are higher in the more deprived areas of Wirral. A summary of some of the information is below, but users are directed to the full chapter for more information.

Figure 16: Trend in Drug Misuse deaths 2001-2019



Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2001 - 03		24	2.6	1.7	3.9	3.7	3.0
2002 - 04		21	2.3	1.4	3.6	3.3	2.8
2003 - 05		27	3.0	2.0	4.3	3.3	2.8
2004 - 06		30	3.3	2.2	4.7	3.6	2.9
2005 - 07		38	4.2	3.0	5.8	3.8	3.0
2006 - 08		43	4.8	3.4	6.4	4.3	3.2
2007 - 09		46	5.0	3.7	6.7	4.6	3.4
2008 - 10		46	5.0	3.7	6.7	4.8	3.4
2009 - 11		37	4.0	2.8	5.5	4.7	3.2
2010 - 12		30	3.2	2.2	4.6	4.5	3.0
2011 - 13		28	3.0	2.0	4.3	4.6	3.1
2012 - 14		40	4.3	3.1	5.9	5.1	3.4
2013 - 15		49	5.4	4.0	7.1	5.6	3.9
2014 - 16		61	6.6	5.1	8.5	6.1	4.2
2015 - 17		61	6.6	5.0	8.5	6.2	4.3
2016 - 18		73	7.9	6.2	10.0	6.5	4.5
2017 - 19		75	8.3	6.5	10.4	6.8	4.7

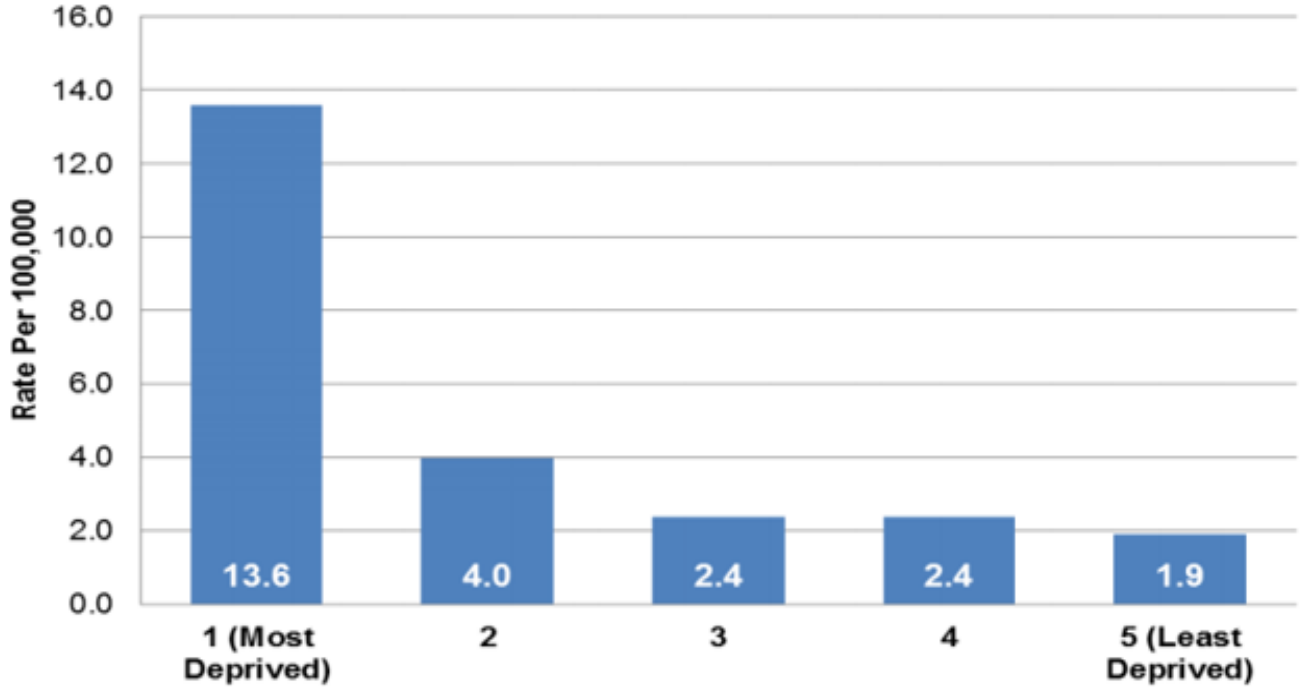
Source: Public Health Outcomes Framework (2021)

ONS have published the following information which provides some context for the increase in drug-related deaths, which has occurred nationally and internationally, as well as in Wirral:

- Drug-related deaths have been on an upward trend for the past decade. The reasons behind this are complex and differ by drug type. The overall trend is driven primarily by deaths involving opiates, but also by an increase in deaths involving other substances like cocaine
- Across Europe, rates of deaths involving heroin or morphine have been increasing, while the number of new heroin and morphine users has fallen. This indicates higher rates of death among existing long-term drug users. Possible explanations include:
  - there is an ageing cohort of drug users, likely to be suffering from the effects of long-term drug use and becoming increasingly susceptible to a fatal overdose
  - new trends in taking specific drugs, including gabapentinoids and benzodiazepines, alongside heroin or morphine, may increase the risk of an overdose
  - disengagement or non-compliance with opiate substitute therapy (OST)
  - The rise in deaths involving cocaine is likely to be a direct consequence of the increasing prevalence in cocaine use. This increase in cocaine use is also seen across Europe
  - Both cocaine and heroin have been reported to have high availability in recent years, with low prices and high purity levels.

There are wide inequalities in the rate of drug misuse deaths in Wirral and these are shown in **Figure 17** below. It highlights that the rate of drug related deaths in Quintile 1 (most deprived), is 7 times higher than the in Quintile 5 (least deprived).

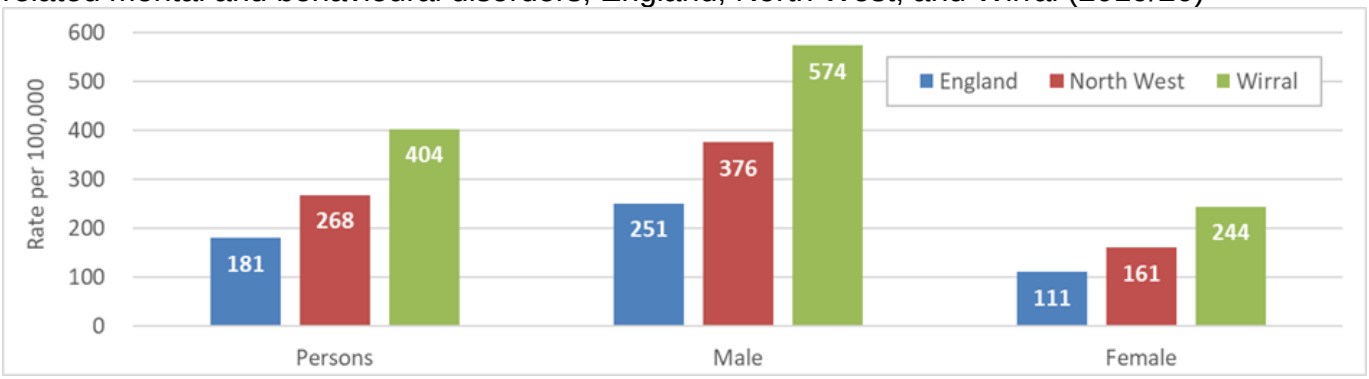
Figure 17: Drug Misuse Deaths by Indices of Multiple Deprivation quintile (rate per 100,000), Wirral, 2015-2017



Source: Primary Care Mortality Database (PCMD, 2020)

The number of NHS hospital admissions for drug-related mental and behavioural disorders (primary diagnosis of a drug-related mental and behavioural disorder), is shown in **Figure 18**.

Figure 18: Rate of hospital admissions episodes with a primary or secondary diagnosis of drug related mental and behavioural disorders, England, North West, and Wirral (2019/20)

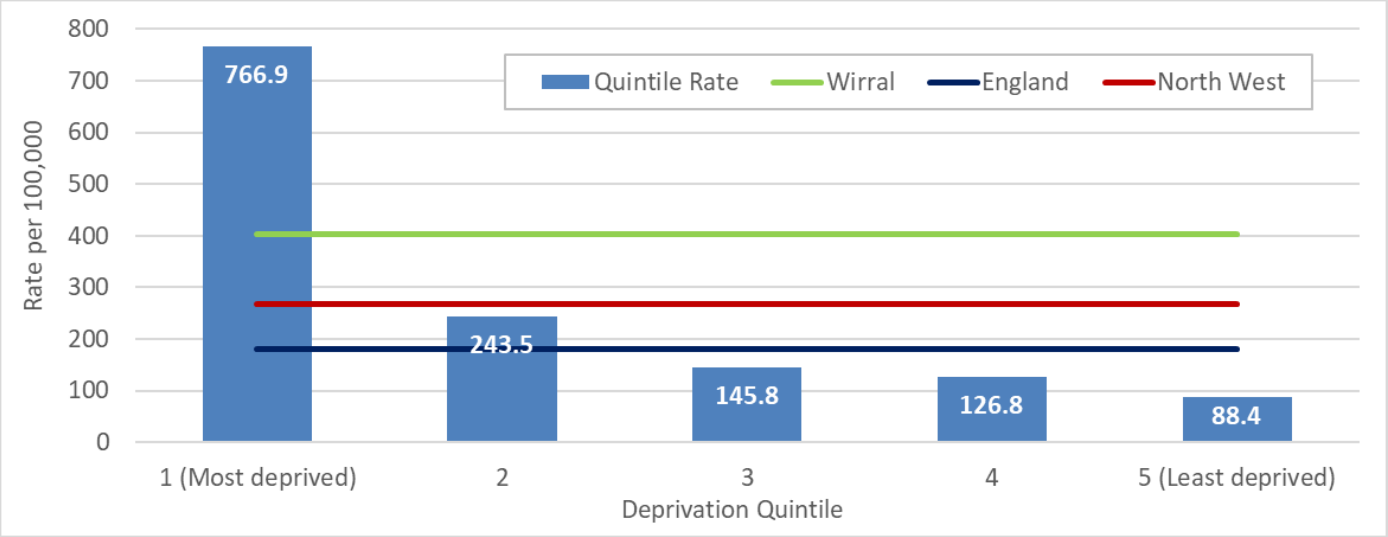


Source: NHS Digital, 2021

There was a total of 1,325 admissions where the primary or secondary diagnosis was drug-related mental and/or behavioural disorders in Wirral in 2019/20; giving an admission rate per 100,000 for Wirral of 404 (more than double the England rate of 181 per 100,000).

As the above chart also shows, rates in males were more than double those for females and for both males and females in Wirral, admission rates were more than double the rates in England overall and were also higher than the North-West overall. Within Wirral, there were also significant inequalities, as **Figure 19** shows

Figure 19: Rate of hospital admissions episodes with a primary or secondary diagnosis of drug related mental and behavioural disorders, by Wirral deprivation quintile and with national and regional comparators (2019/20)



Source: NHS Digital, 2021

Alcohol

On every key alcohol indicator measured by Public Health England, Wirral performs significantly worse than England, see **Figure 20**.

Figure 20: Public Health England key alcohol indicators, Wirral outcomes

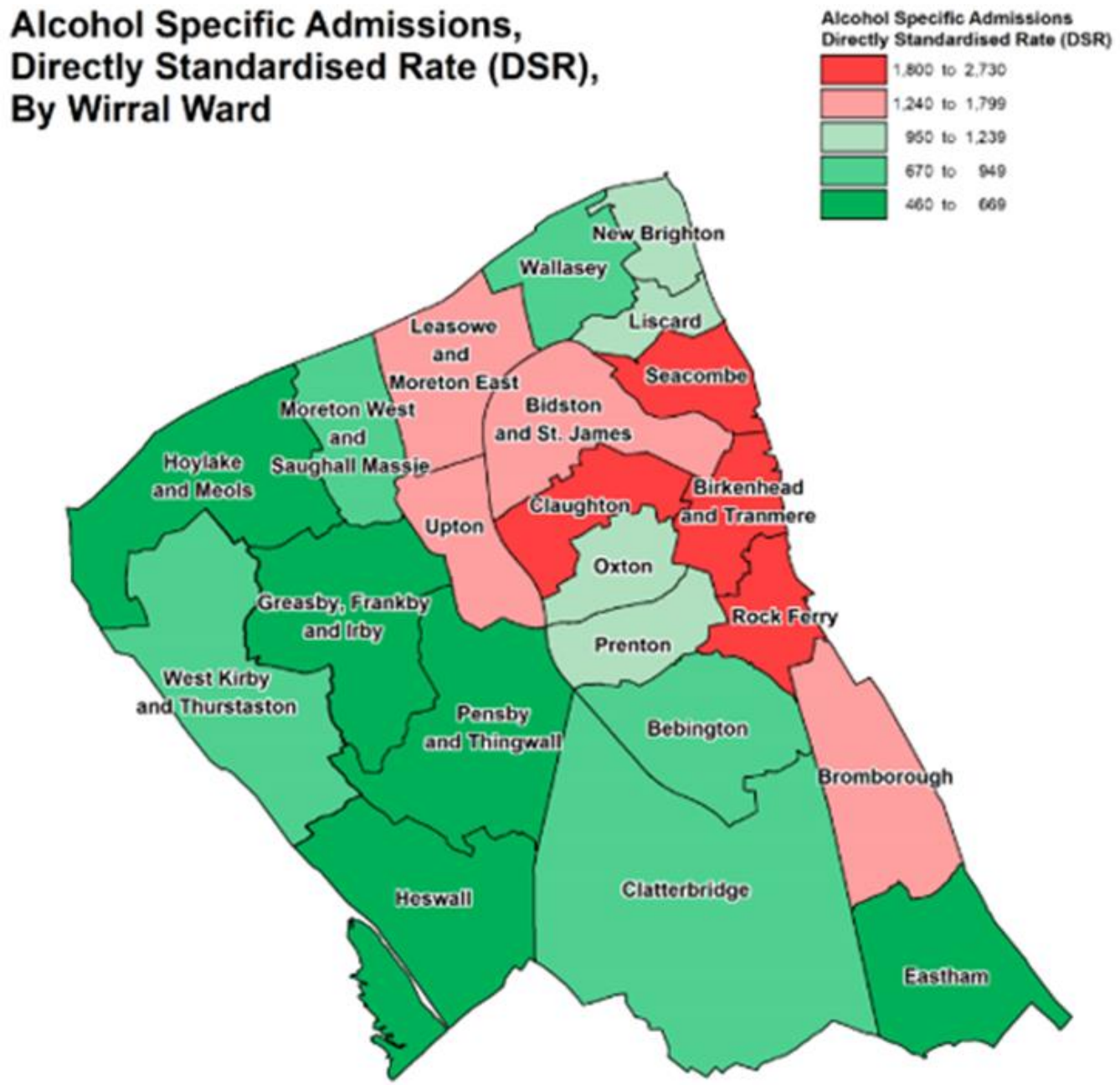
Indicator	Period	Wirral			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Admission episodes for alcohol-related conditions (Narrow)	2018/19	→	2,858	895	742	664	1,127		389
Admission episodes for alcohol-related conditions (Broad)	2018/19	↑	10,534	3,162	2736	2367	4,022		1,329
Admission episodes for alcohol-specific conditions	2019/20	↑	3,960	1,231	891	644	2,590		331
Admission episodes for alcohol-specific conditions - Under 18s	2017/18 - 19/20	–	95	46.9	43.6	30.7	111.5		7.7
Alcohol-related mortality	2018	→	201	58.9	54.9	46.5	86.1		26.9
Alcohol-specific mortality	2017 - 19	–	168	17.0	14.6	10.9	27.3		3.9

Source: Public Health Outcomes Framework (2021)

There was a total of 3,960 alcohol-specific admissions in Wirral in 2019/20 and they were strongly correlated with deprivation. The most deprived wards in Wirral had the highest admission rates, while the most affluent had the lowest rates. The Wirral overall rate (DSR or Directly Standardised Rate) was 1,140.

Heswall (the most affluent ward in Wirral) had a DSR of 461, while Birkenhead & Tranmere ward (the most deprived ward in Wirral) had a DSR of 2,726. This is a long-standing trend in Wirral. See **Map 8** below.

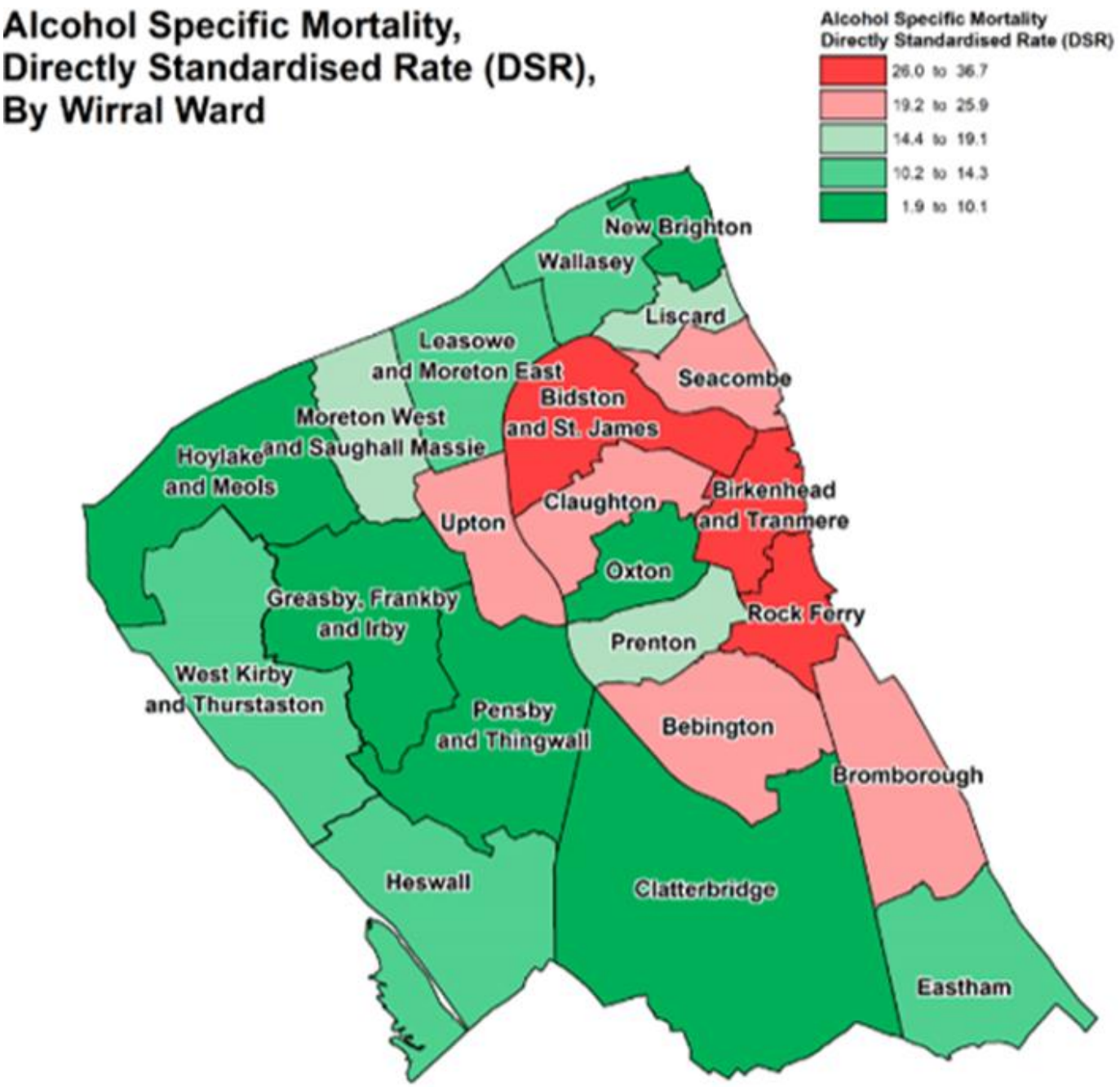
Map 8: Alcohol Specific Admissions (DSRs) by Wirral ward, 2019/20



Source: SUS, 2020 (2015-19, 5 pooled years)

The same pattern (areas of deprivation having a greater burden of morbidity and mortality related to alcohol) is observable for Alcohol-Specific Mortality rates in Wirral in 2019/20, see **Map 9**

Map 9: Alcohol Specific Mortality (DSRs) by Wirral ward, 2019/20

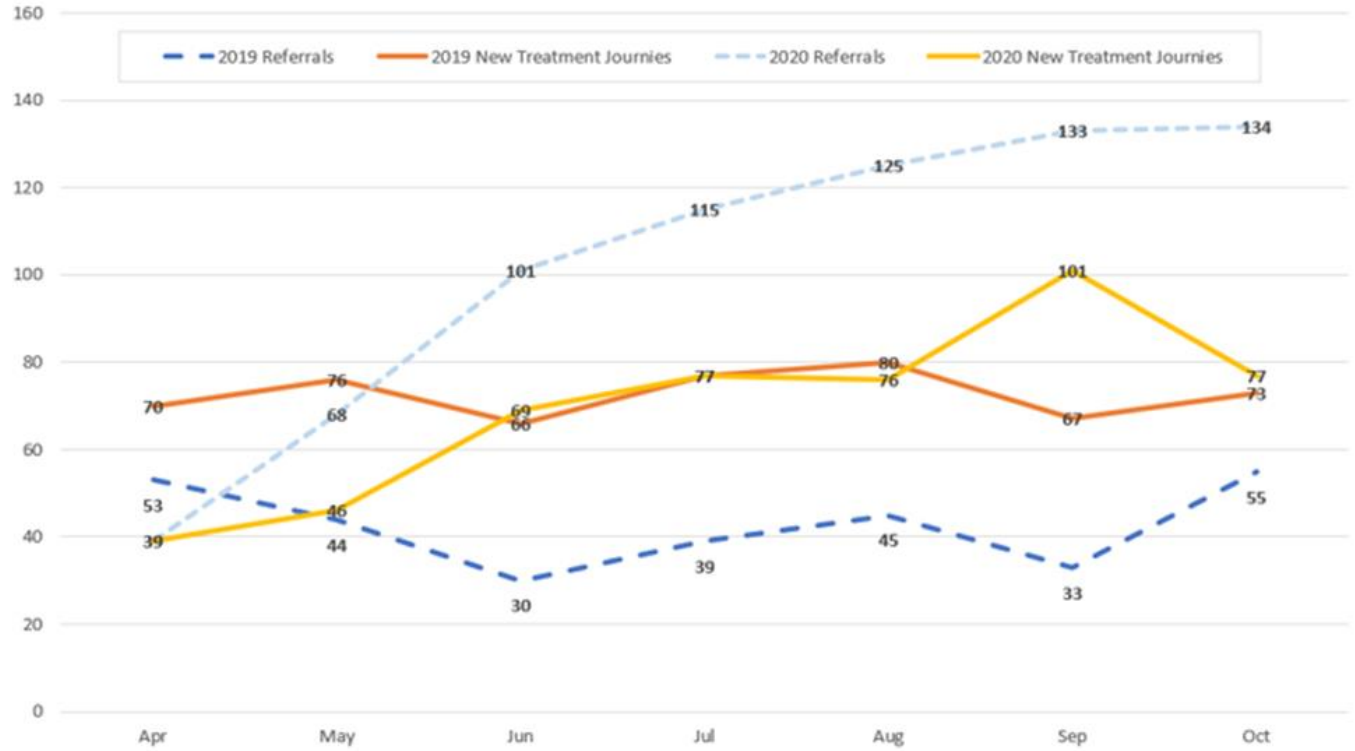


Source: SUS, 2020 (2015-19, 5 pooled years)

Referrals to alcohol treatment

- **Figure 21** below shows number of alcohol referrals (broken lines) and new treatment journeys (solid lines) for 6 month period April to October 2020, compared to same period in 2019 (to CGL – Change, Grow, Live – Wirral's main provider of Drug and Alcohol services)
- 299 total referrals for 2019, vs 715 for 2020 (a 139% increase)
- 508 new treatment journeys in 2019, vs 485 for 2020 (a 5% decrease to October)
- The largest increase was in self-referrals (317 in 2020 vs 94 during same 6 month period in 2019)

Figure 21: Referrals for alcohol treatment in Wirral: 2019 and 2020 comparison



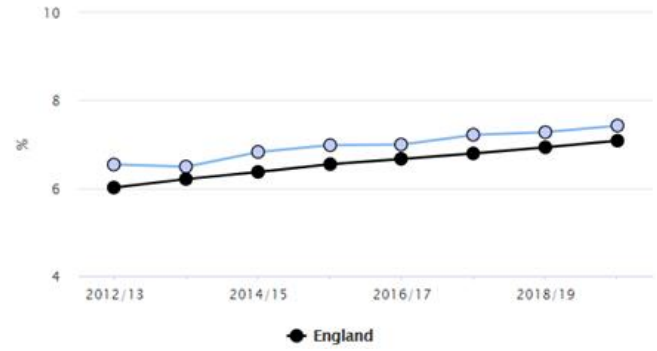
Source: CGL (Change, Grow, Live), 2021

Long Term Conditions

Diabetes

Prevalence of diabetes in Wirral in 2019/20 is higher than both the Cheshire & Merseyside area and England overall (7.4% versus 7.1% in Cheshire & Merseyside and England overall) – **figure 22**. Prevalence of diabetes has been steadily increasing in recent years, from 17,504 people in 2012/13 to 20,392 people in 2019/20; an increase of 16.5% in 7 years.

Figure 22: Trend in prevalence of diabetes in those aged 17+ (2012/13 to 2019/20)



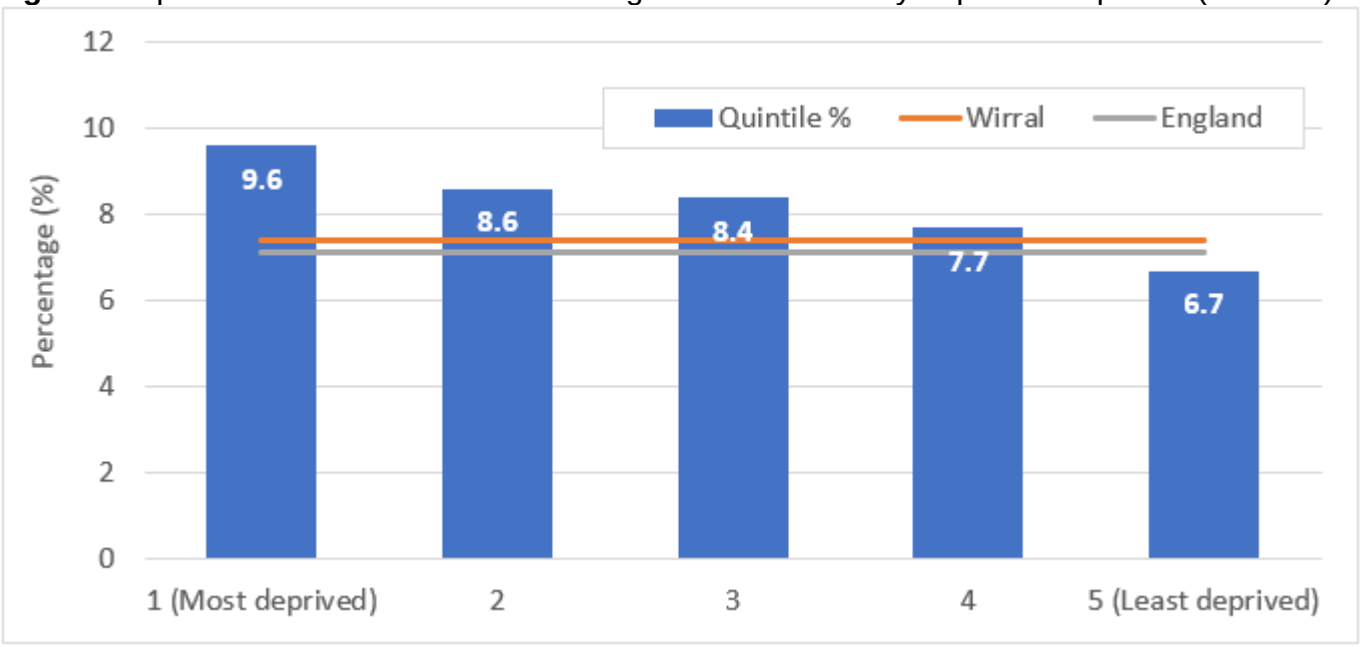
		NHS Wirral CCG				Cheshire and Merseyside	England
Period		Count	Value	95% Lower CI	95% Upper CI		
2012/13		17,504	6.5%	6.4%	6.6%	6.2%*	6.0%
2013/14		17,450	6.5%	6.4%	6.6%	6.3%*	6.2%
2014/15		18,399	6.8%	6.7%	6.9%	6.5%	6.4%
2015/16		18,889	7.0%	6.9%	7.1%	6.7%	6.5%
2016/17		19,428	7.0%	6.9%	7.1%	6.8%	6.7%
2017/18		19,658	7.2%	7.1%	7.3%	6.9%	6.8%
2018/19		19,893	7.3%	7.2%	7.4%	7.0%	6.9%*
2019/20		20,392	7.4%	7.3%	7.5%	7.1%*	7.1%

Source: Quality and Outcomes Framework (QOF), NHS Digital

Source: Public Health Outcomes Framework (2021)

Diabetes prevalence by deprivation quintile in Wirral in 2019/20 is shown in **Figure 23** and is 43% higher in the most deprived quintile of the population (9.6%% of the population in the most deprived quintile compared to 6.7% in Quintile 5, the least deprived quintile).

Figure 23: prevalence of diabetes in those aged 17+ in Wirral by deprivation quintile (2019/20)

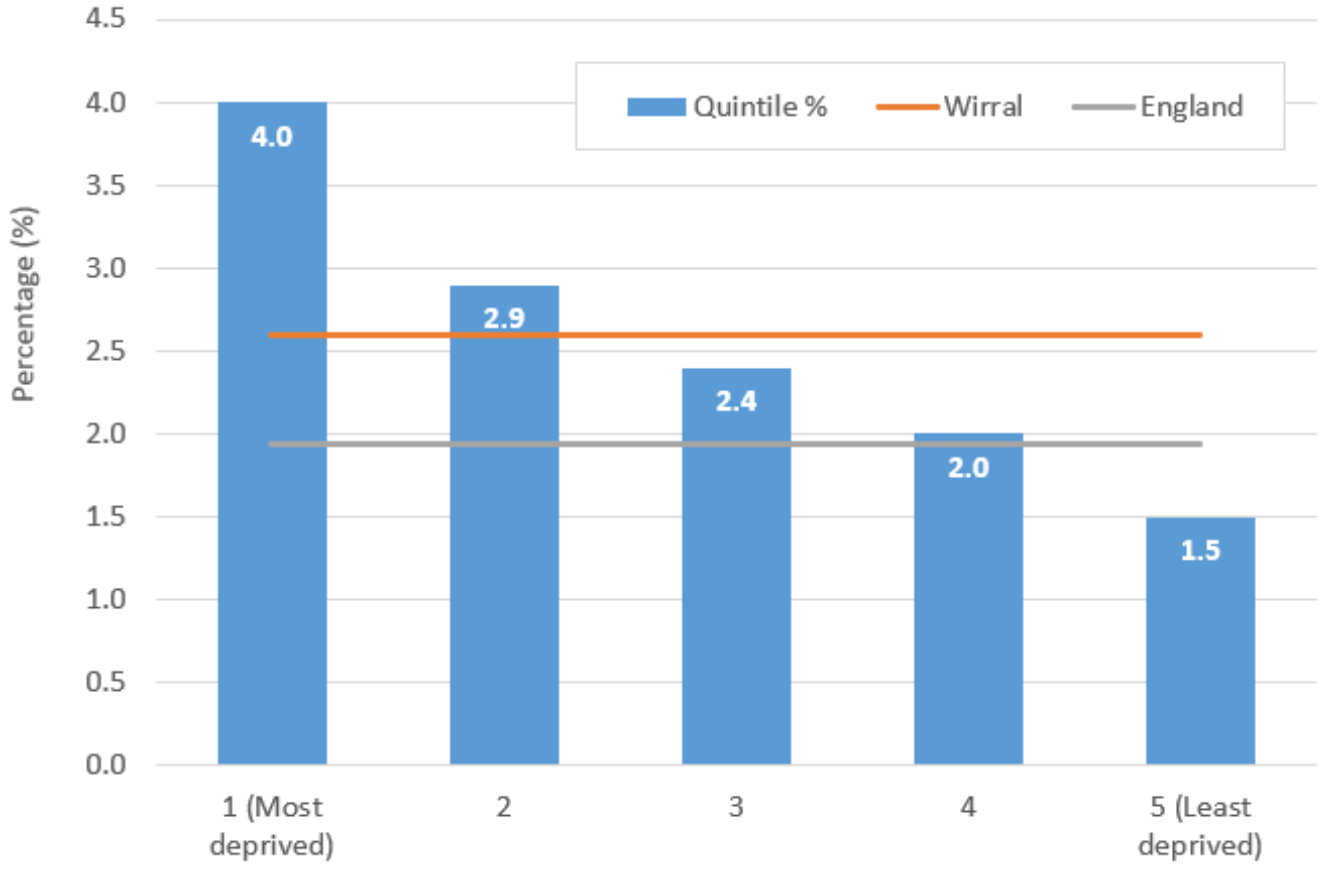


Source: QOF (Quality & Outcomes Framework), NHS England

Chronic Obstructive Pulmonary Disease (COPD)

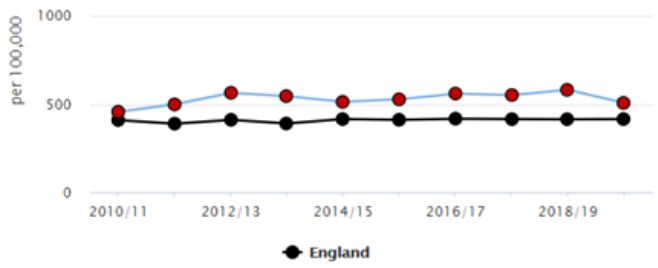
Prevalence of COPD in Wirral in 2019/20 is higher than both the NW and England overall (2.6% versus 2.5% in the NW and 1.9 in England overall). Prevalence of COPD has been steadily increasing in recent years, from 7,814 people in 2012/13 to 8,821 people in 2019/20; an increase of 13% in 7 years. COPD shows a clear association with deprivation, with those in the most deprived quintile, having a rate of COPD which is more than double that of the least deprived quintile (4.0% population in the most deprived quintile versus 1.5% population in the least deprived quintile) see **figure 24 and figure 25**.

Figure 24: prevalence of COPD in those aged 17+ in Wirral by deprivation quintile (2019/20)



Source: QOF (Quality & Outcomes Framework), NHS England

Figure 25: Trend in emergency admissions for COPD, 2010/11 to 2019/20



Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2010/11		873	457	427	488	568	410
2011/12		966	499	467	531	526	389
2012/13		1,104	564	531	599	549	411
2013/14		1,077	545	513	579	508	390
2014/15		1,026	513	482	545	553	415
2015/16		1,058	527	496	560	534	411
2016/17		1,148	560	528	594	532	417
2017/18		1,144	552	520	585	532	415
2018/19		1,210	581	549	615	530	414
2019/20		1,075	507	477	538	536	415

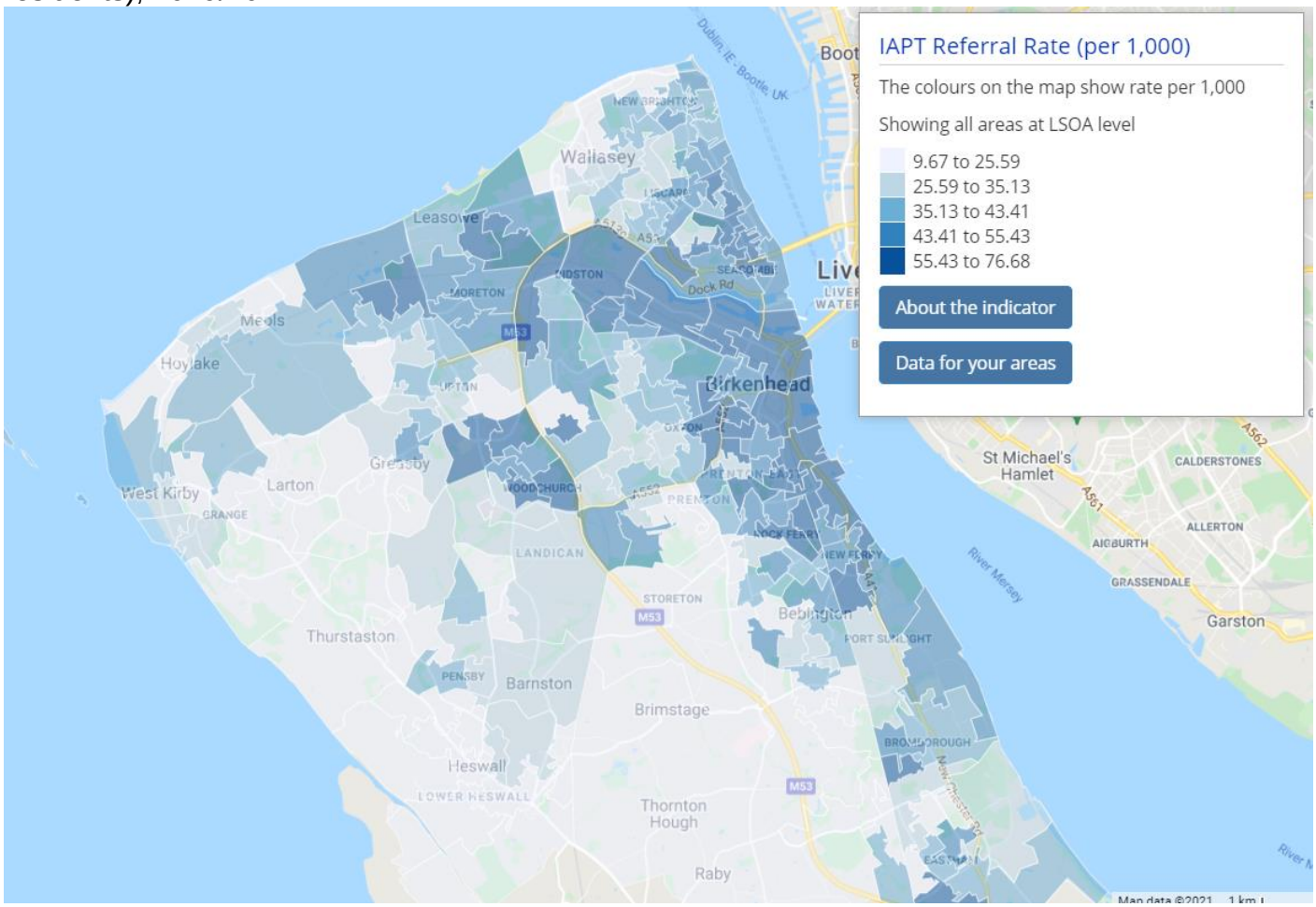
Source: Public Health Outcomes Framework (2021)

Mental health

Referral rates for psychological therapy

Map 10 below shows referrals to IAPT (Improving Access to Psychological Therapy) Service per 1,000 patients registered to GP practices within Wirral CCG in 2019/20. Although not all referrals will enter treatment, it is a fairly good indicator of mental health need

Map 10: IAPT (Improving the access to Psychological Therapies), referral rate (per 1,000 residents), 2019/20



Source: Wirral CCG BI Team

As **Map 10** above shows, referral rates vary considerably by ward; the overall rate of referral was 42 per 1,000 residents, but this varied from 61 per 1,000 in Birkenhead & Tranmere ward, to 20 per 1,000 in Heswall ward. In other words, the rate of referral was 3 times higher in areas of deprivation in Wirral, compared to more affluent areas.

Self-harm

Self-harm events severe enough to warrant hospital admission are shown on the PHOF as a proxy of the prevalence of severe self-harm, these are only the most acute manifestation of poor mental health in relation to the burden of self-harm. Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent. However, following an episode of self-harm, there is a significant and persistent risk of suicide which varies markedly between genders and age groups [PHOF, PHE].

In contrast to the trends in completed suicide, the incidence of self-harm has continued to rise in the UK over the past 20 years and, for young people at least, is said to be among the highest in Europe [PHOF, PHE]. Data on self-harm trends using HES data may be somewhat misleading and the large rise they suggest probably reflects improved data collection. Suicide risk is raised 49-fold in the year after self-harm, and the risk is higher with increasing age at initial self-harm [PHOF, PHE].

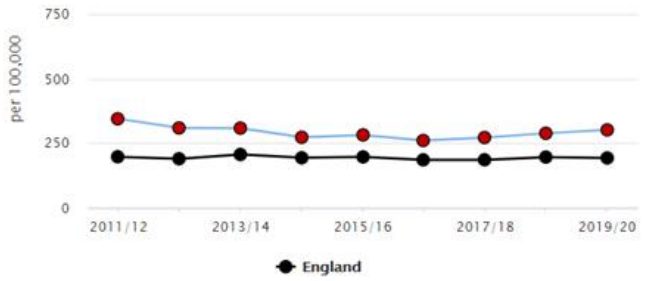
Self-harm is still often poorly understood and people who harm themselves are subject to stigma and hostility; those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year. One study of people presenting at Accident & Emergency (A&E) showed a subsequent suicide rate of 0.7% in the first year - 66 times the suicide rate in the general population. After 15 years, 4.8% of males and 1.8% of females had died by suicide.[3] Aside from the obvious danger of death, self-harm and suicide attempts can be seriously detrimental to an individual's long-term physical health if they survive. Paracetamol poisoning is a major cause of acute liver failure. Self-cutting can result in permanent damage to tendons and nerves, not to mention scarring and other disfigurements. The NICE guidelines on self-harm note that people who have survived a medically serious suicide attempt are more likely to have poorer outcomes in terms of life expectancy [PHOF, PHE].

Those at greater risk include [PHOF, PHE]:

- Women - rates of deliberate self-injury are two to three times higher in women than men
- Young people - Self-harming in young people is not uncommon (10-13% of 15-16-year-olds have self-harmed in their lifetime
- Older people who harm themselves are more likely to do so in an attempt to end their life
- People who have or are recovering from drug and alcohol problems
- Self-harm in prisons is associated with subsequent suicide in this setting, suggesting the prevention and treatment of self-harm is an essential component of suicide prevention in prison
- People who are lesbian, gay, bisexual or gender reassigned
- Socially deprived people living in urban areas
- Women of South-Asian ethnicity
- Individual elements including personality traits, family experiences, life events, exposure to trauma, cultural beliefs, social isolation, and income
- Other factors such as education, housing, and wider macro-socioeconomic trends such as unemployment rates may also contribute directly, or by influencing a person's susceptibility to mental health problems

Admissions for self-harm are significantly higher in Wirral than in England overall (301.0 per 100,000 locally, versus 192.6 nationally – or 915 in actual numbers) (**figure 26**) and have been since information on this indicator has been made available. As further breakdown (**figure 27**) shows, these overall numbers show that women are far more likely than men to be admitted as a result of self-harm.

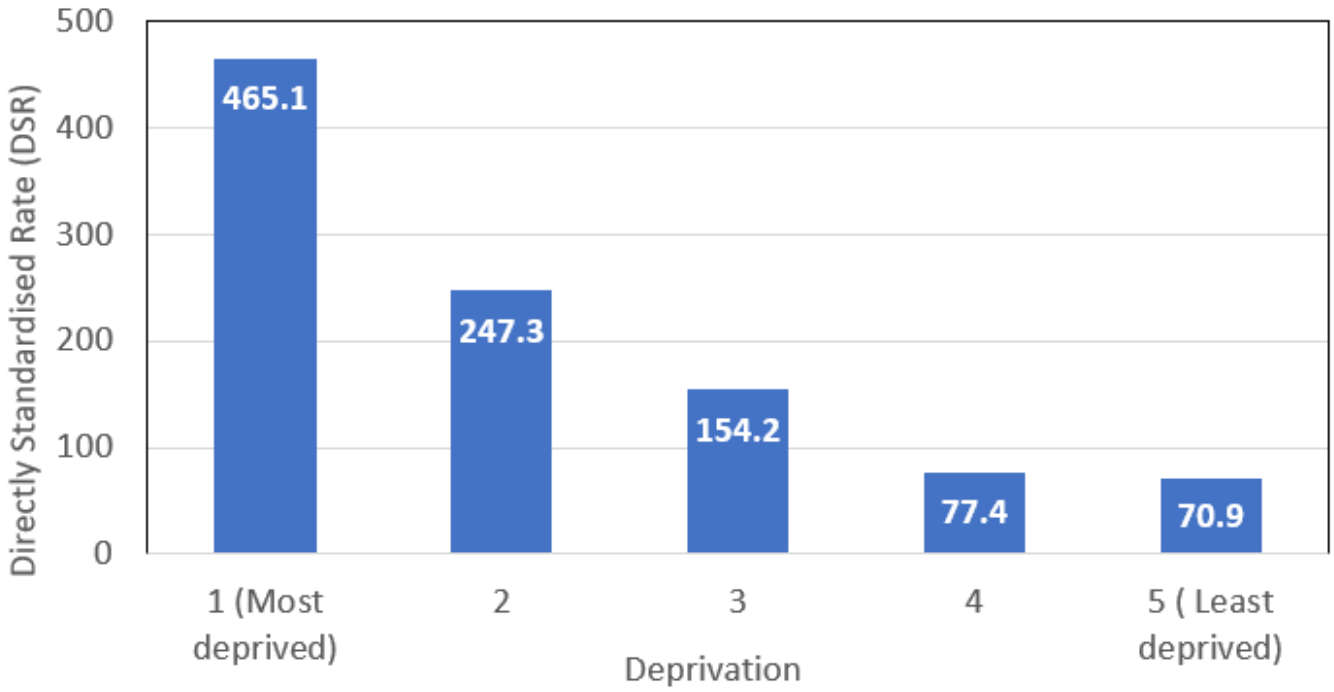
Figure 26: Rate (DSR) of Emergency Hospital Admissions for intentional self-harm in Wirral with comparators England, North West (2011/12 – 2019/20)



Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2011/12	●	1,076	343.9	323.5	365.2	254.2	197.2
2012/13	●	964	308.6	289.3	328.8	244.6	189.6
2013/14	●	959	307.9	288.6	328.1	270.6	205.9
2014/15	●	846	272.6	254.4	291.7	256.6	193.2
2015/16	●	866	281.6	263.0	301.1	250.4	196.5
2016/17	●	794	260.1	242.2	278.9	231.0	185.3
2017/18	●	823	271.5	253.2	290.9	234.5	185.5
2018/19	●	870	288.0	269.0	307.9	246.1	196.0*
2019/20	●	915	301.0	281.7	321.3	237.6	192.6

Source: Public Health Outcomes Framework (2021)

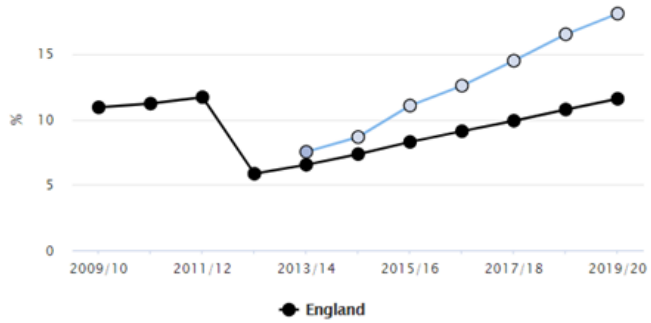
Figure 27: Rate of admissions for Self-harm in Wirral by Deprivation Quintile, 2019/20



Depression

The recorded depression prevalence (**figure 28**) is the number of people with depression recorded on GP practice registers, as a proportion of the practice list size of the CCG aged 18 years or over.

Figure 28: Recorded prevalence of Depression (%) (aged 18+) for Wirral with comparators England, North West (2009/10 – 2019/20)



Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2009/10		-	-	-	-	-	10.9%
2010/11		-	-	-	-	-	11.2%
2011/12		-	-	-	-	-	11.7%
2012/13		-	-	-	-	-	5.8%
2013/14	●	19,880	7.5%	7.4%	7.6%	7.3%*	6.5%
2014/15	●	22,949	8.6%	8.5%	8.7%	8.3%	7.3%
2015/16	●	29,453	11.0%	10.9%	11.2%	9.6%	8.3%
2016/17	●	34,413	12.6%	12.4%	12.7%	10.7%	9.1%
2017/18	●	38,881	14.5%	14.3%	14.6%	11.7%	9.9%
2018/19	●	44,503	16.5%	16.4%	16.6%	12.9%*	10.7%*
2019/20	●	48,973	18.1%	17.9%	18.2%	14.0%	11.6%

Source: Quality and Outcomes Framework (QOF), NHS Digital

Source: Public Health Outcomes Framework (2021)

The prevalence of those recorded as having ever had depression on GP records in Wirral is much higher than England, at 18.1% of the population aged 18+ overall, compared to 11.6% in England. This figure has increased considerably in recent years, in 2013/14 the overall prevalence in Wirral was 7.5% compared to 6.5% in England – meaning prevalence has more than doubled in 6 years.

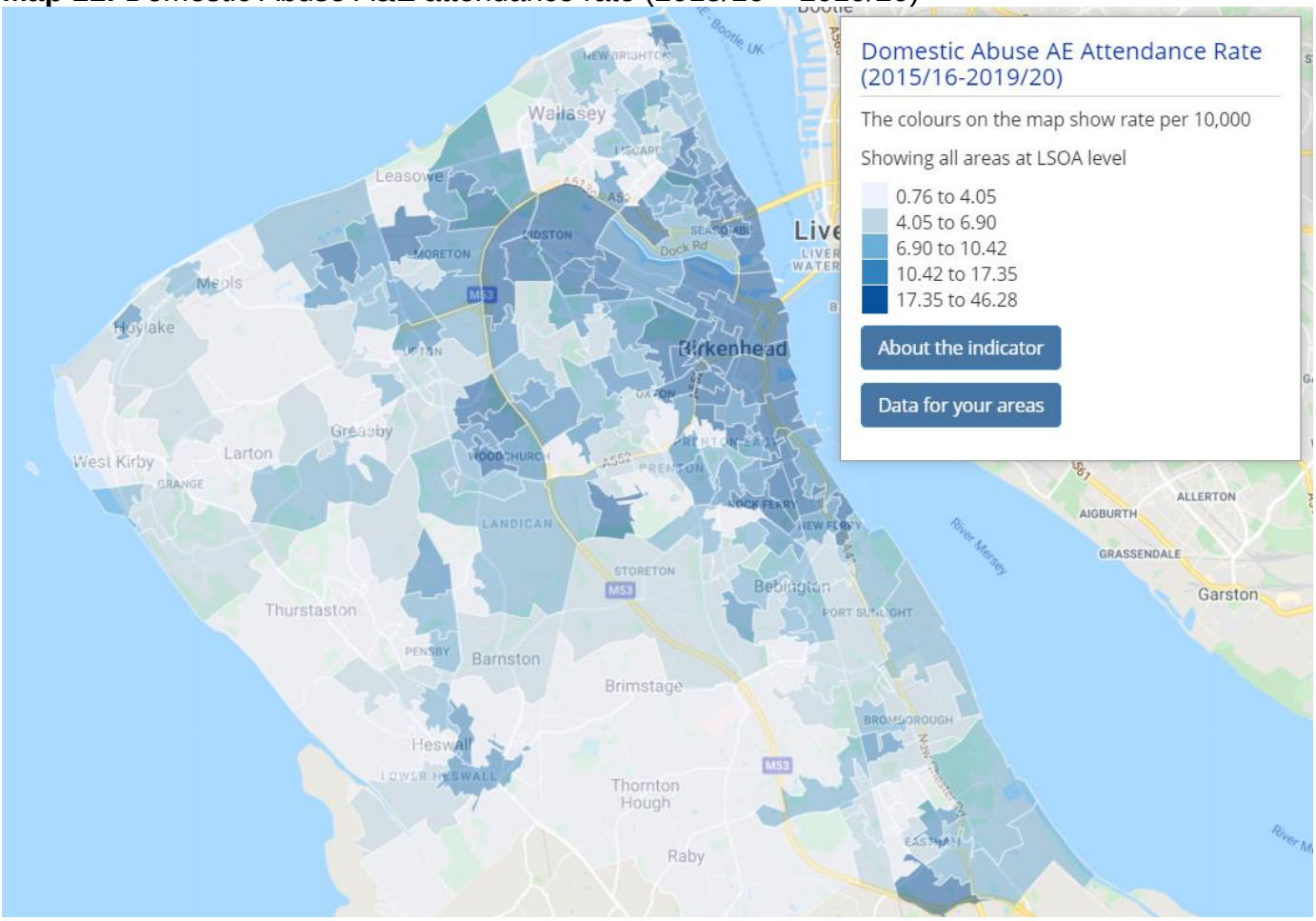
Even this large overall figure, however, hides large inequalities, with some practices with populations in areas of deprivation having as many as 1 in 3 (or 33.6%) of their populations recorded as having depression. In more affluent areas, the equivalent is around 1 in 14 (or 7.7%) of their practice population recorded as having had depression in 2019/20 (**Source:** Public Health Outcomes Framework (2021)).

Crime

Anti-social behaviour

Map 11 shows the rate of attendances for domestic abuse (5 pooled years); it shows that rate of attendances mirrors the areas of deprivation in Wirral – with rates varying from 26.5 per 10,000 in Birkenhead & Tranmere ward, to 3.7 in West Kirby & Thurstaston ward (overall Wirral rate of 11.2 per 10,000).

Map 11: Domestic Abuse A&E attendance rate (2015/16 – 2019/20)



Source: Local Insight Wirral, 2021 (data from Trauma, Injury Intelligence Group (Liverpool John Moores University, 2021)

Attendances at Arrowe Park A&E for injuries and assaults reported as being carried out by somebody known to the attendee are compiled by TIIG (Trauma, Injury & Intelligence Group) of LJMU.

Reported incidents of anti-social behaviour (ASB), were located to the point at which they occurred and allocated to the appropriate Constituency; ASB is defined as 'behaviour by a person which causes, or is likely to cause, harassment, alarm or distress to persons not of the same household as the person'. The data in **Table 2** below is reported incidents and shows the two calendar years of 2019 and 2020.

Table 2: Reported incidents of anti-social behaviour in Wirral, by Constituency, 2019 and 2020 (calendar years)

	2019		2020		Change	
Area	**Number**	**Rate per 1,000**	**Number**	**Rate per 1,000**	**Number**	**%**
Birkenhead	2,283	25.2	3,439	37.9	1,156	50.6
Wallasey	1,433	15.8	2,444	27.0	1,011	70.6
Wirral South	775	10.6	1,409	19.2	634	81.8
Wirral West	797	11.5	1,600	23.0	803	100.8
Wirral	**5,288**	**16.3**	**8,892**	**27.4**	**3,604**	**68.2**

Source: https://data.police.uk/data/

As **Table 2** shows, there has been a 68% increase in ASB in Wirral between 2019 and 2020 when a large number of months were spent in lockdown. The overall increase hides large variation between Constituencies, which ranged from 50.6% in Birkenhead (lowest increase, but still the highest number of reported incidents), to 100.8% increase in Wirral West.

Domestic Abuse

As **Table 3** shows, the number of crimes and incidences of domestic abuse have been increasing in recent years. This may not necessarily be due to increased incidence, but due to increased awareness and willingness to report to the police. It is clear that Wirral has a higher rate than Merseyside, the North West and England overall and this appears to be a long-standing trend.

Table 3: Trend in Domestic abuse crimes and incidences in Wirral and comparators, 2010/11 to 2019/20

Year	Wirral		Merseyside	North West	England
	Crimes and Incidences	Rate per 1,000			
2010/11	9,214	*	27.6	22.2	18.4
2011/12	9,416	*	28.8	21.1	18
2012/13	9,591	36.8	29.3	21.4	18.1
2013/14	9,589	36.8	28.4	21.4	19.4
2014/15	9,806	37.5	27.6	20.5	20.4
2015/16	10,308	39.4	26.2	23.5	23.7
2016/17	9,965	38.1	24.6	24.1	24.0
2017/18	10,189	38.9	23.6	25.1	25.1
2018/19	11,942	45.5	25.8	28.6	27.4
2019/20	12,795	48.7	28.8	25.7	28.0

Source: Wirral Intelligence Service Annual Statistical Compendium, 2021

Notes and definitions for Table 3

1. Domestic abuse is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members. It can include psychological, physical, sexual, financial and/or emotional abuse (Home Office, 2013)

2. Figures from 2015/16 include the new methodology which captures data relating to the new categories of all domestic abuse related crimes and domestic abuse related incidents. Figures from 2015/16 onwards are therefore not comparable with data released in previous years.

3. An incident is an occurrence reported to the police where circumstances are considered as domestic by the call the call handler. An incident may or may not result in a crime record being created

4. A crime is controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality

5. Offences have been recorded as a crime, whereas the number of incidents refers to those that were not recorded as a crime, so the two categories are mutually exclusive of each other

6. Rates have been calculated using the preceding calendar years mid-year population estimated sourced from the Office for National Statistics (ONS)

7. * notes that data is not available at the time of publishing

Source: Public Health Outcomes Framework, Public Health England (PHE) and Merseyside Police Information Management Systems

Life expectancy

Life expectancy is an important marker for the underlying health of the population. Consequently, it is calculated regularly (annually). Life expectancy at birth in England showed dramatic increases throughout the twentieth century as health and living conditions improved.

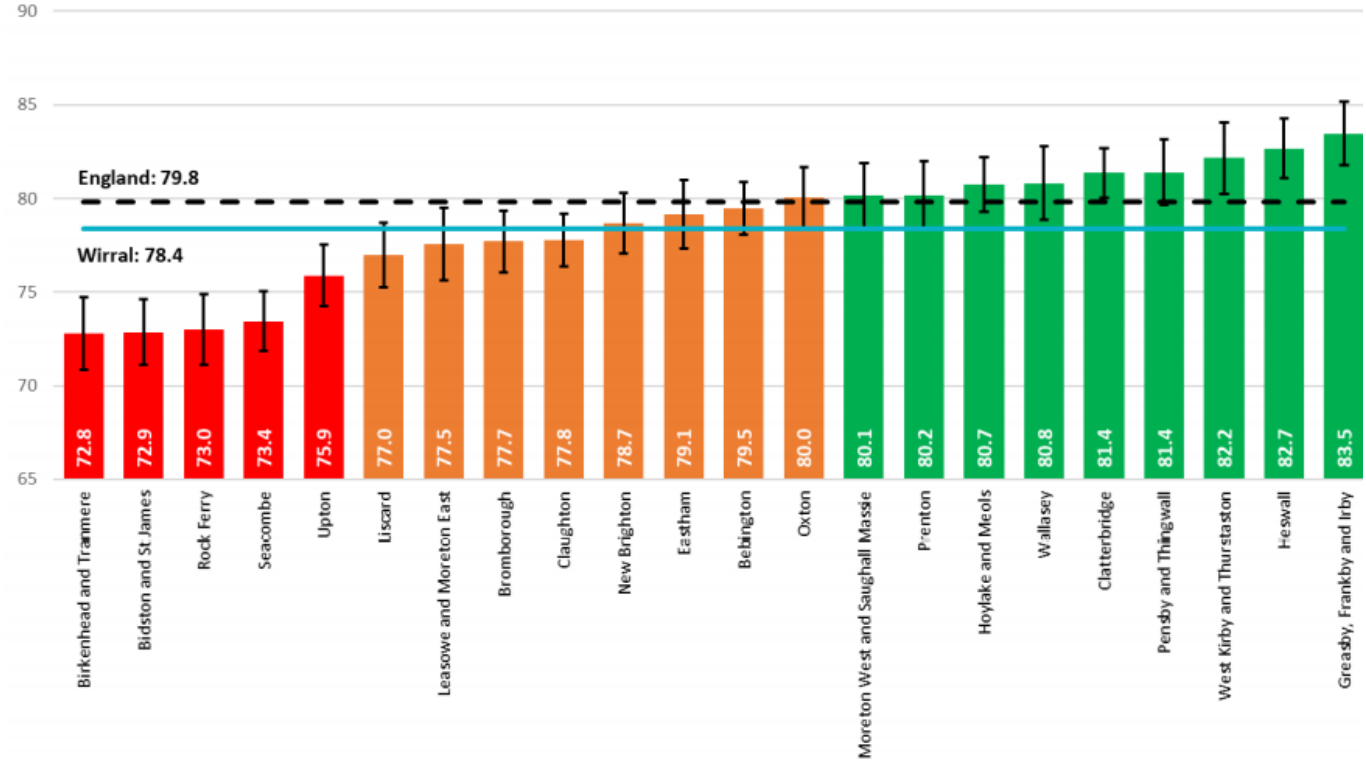
It increased from 46 for males and 50 for females in 1900, to 76 for males and 80 for females in 2000 and has continued to increase since.

However, increases in life expectancy have not been uniform across all social groups and the inequality in life expectancy between those from more deprived areas and those from more affluent areas has continued to increase. A full report on Life Expectancy in Wirral updated for 2017-19 is available here. This report also highlights the causes of the gap between Wirral and England (e.g. showing that the largest cause of the gap was respiratory disease, for both males and females). This analysis on the gap, was originally carried out by Public Health England and more information is available on the Segment Tool section of the Public Health Outcomes Framework website.

As **Figure 29** shows, there is a gap of 10.7 years between the wards with the highest and lowest male LEx in Wirral for 2017-19 (Birkenhead and Tranmere and Greasby, Frankby and Irby). The average Wirral LEx for males was 78.4 years, whilst the England average was 79.8 for the same time period (1.4 years higher).

The four wards with the lowest LEx are also the four most deprived wards in Wirral according to the IMD 2019: Birkenhead & Tranmere, Bidston & St James, Rock Ferry and Seacombe.

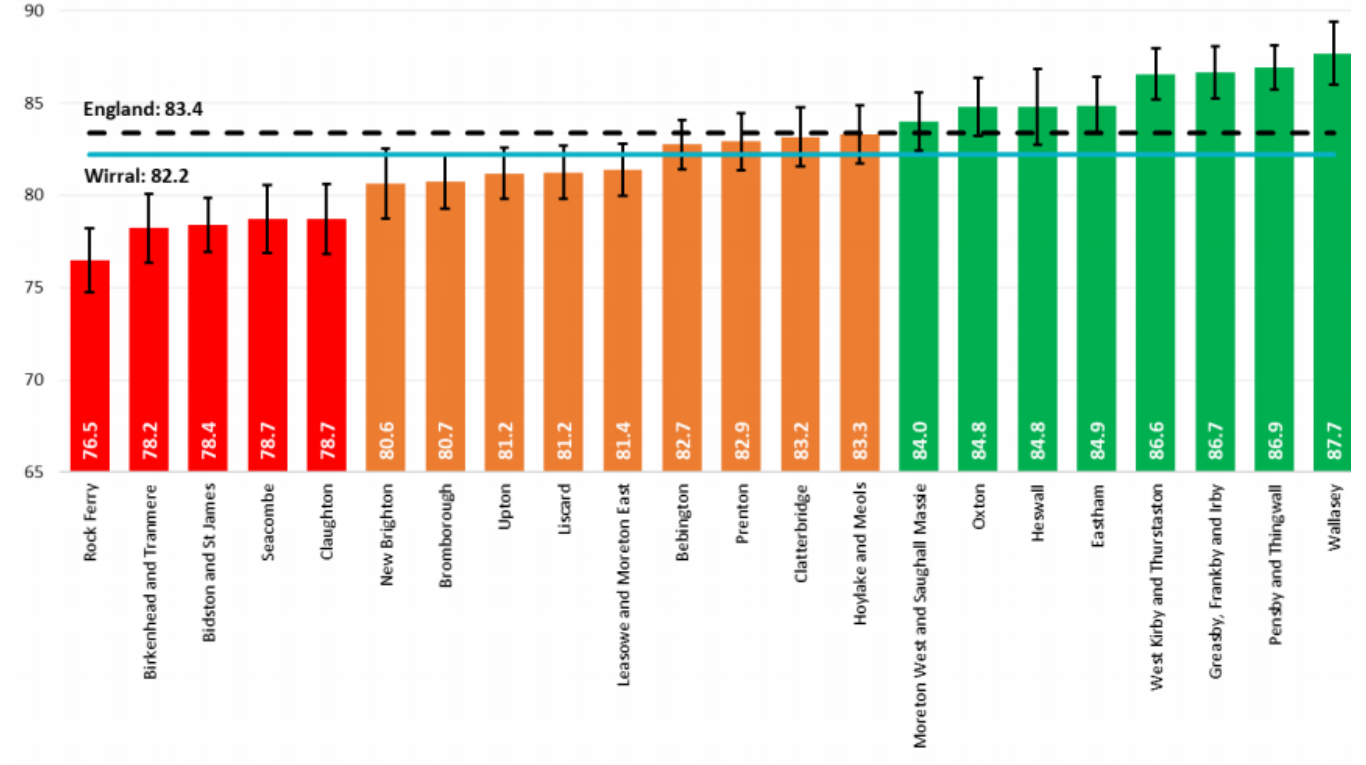
Figure 29: Male life expectancy at birth, by Wirral Ward, 2017-19



Source: Public Health Intelligence Team, Wirral Intelligence Service, 2021

As **Figure 30** below shows, in 2017-19, the gap between the Wirral wards with the highest and lowest female LEx was 11.2 years (Rock Ferry and Wallasey). As was the case with males, the four wards with the lowest female LEx are the four most deprived wards in Wirral: Rock Ferry, Birkenhead & Tranmere, Bidston & St. James and Seacombe.

Figure 30: Female life expectancy at birth, by Wirral Ward, 2017-19



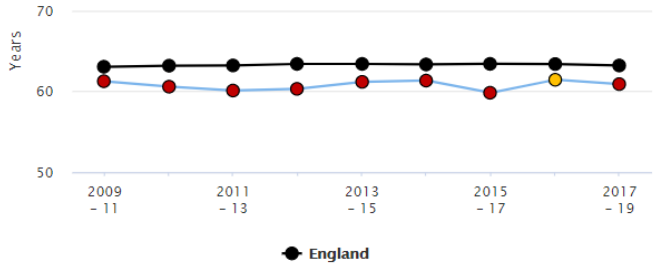
Source: Public Health Intelligence Team, Wirral Intelligence Service, 2021

Healthy life expectancy

In addition to life expectancy, we also monitor healthy life expectancy (HLE), or the number of years people can expect to live in 'good' health. Increases in HLE have not matched the gains in life expectancy, meaning that although people are living longer, their later years are spent in poorer health, creating greater demands on health and social care services.

In 2017-19, HLE in Wirral was 60.9 years for men compared to 63.2 years for men in England (significantly worse than England, as shown by **figure 31** below). On comparing HLE to LEx, this measure shows that, in Wirral, a male is likely to spend approximately only three-quarters (or 77.6%) of their life in 'good' health and the remainder (22.4% or 17.6 years) in poorer health.

Figure 31: Trend in male Healthy Life Expectancy for Wirral and comparators, 2009/11 to 2017/19)

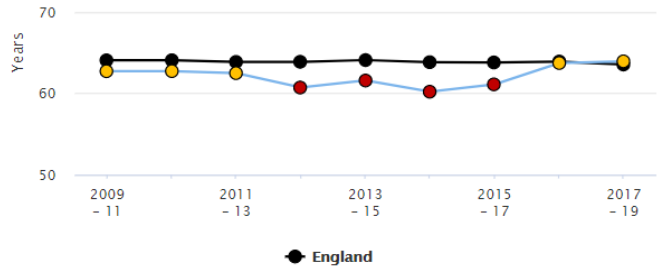


	Wirral						
Period		Count	Value	95% Lower CI	95% Upper CI	North West	England
2009 - 11	●	-	61.2	59.7	62.8	60.8	63.0
2010 - 12	●	-	60.6	58.9	62.2	61.0	63.2
2011 - 13	●	-	60.1	58.3	61.8	61.2	63.2
2012 - 14	●	-	60.3	58.5	62.1	61.0	63.4
2013 - 15	●	-	61.2	59.3	63.0	61.1	63.4
2014 - 16	●	-	61.3	59.6	63.0	60.9	63.3
2015 - 17	●	-	59.8	57.7	61.9	61.2	63.4
2016 - 18	●	-	61.4	59.5	63.4	61.6	63.4
2017 - 19	●	-	60.9	59.0	62.8	61.7	63.2

Source: Public Health Outcomes Framework (2021)

Women in Wirral are estimated to spend 77.6% of their life (or 63.9 years) in 'good' health and 22.4% (or 18.4 years) in poorer health. See **figure 32** below. This is marginally higher than women in England overall (but not significantly so).

Figure 32: Trend in female Healthy Life Expectancy for Wirral and comparators, 2009/11 to 2017/19)



	Wirral						
Period		Count	Value	95% Lower CI	95% Upper CI	North West	England
2009 - 11	●	-	62.7	61.1	64.3	61.6	64.0
2010 - 12	●	-	62.7	61.1	64.4	61.7	64.0
2011 - 13	●	-	62.5	60.8	64.1	62.0	63.8
2012 - 14	●	-	60.7	58.9	62.5	61.7	63.9
2013 - 15	●	-	61.6	59.7	63.5	61.9	64.1
2014 - 16	●	-	60.2	58.3	62.1	61.9	63.8
2015 - 17	●	-	61.1	59.2	63.0	62.3	63.8
2016 - 18	●	-	63.7	61.9	65.5	62.5	63.9
2017 - 19	●	-	63.9	62.1	65.7	62.2	63.5

Source: Public Health Outcomes Framework (2021)

Mortality

Avoidable mortality

Avoidable mortality is deaths from causes for which all or most deaths are considered avoidable through timely and effective healthcare and public health interventions, specifically:

- Preventable mortality - deaths that can be mainly avoided through effective public health and primary prevention interventions
- Treatable mortality - deaths that can be mainly avoided through timely and effective healthcare interventions, including secondary prevention and treatment

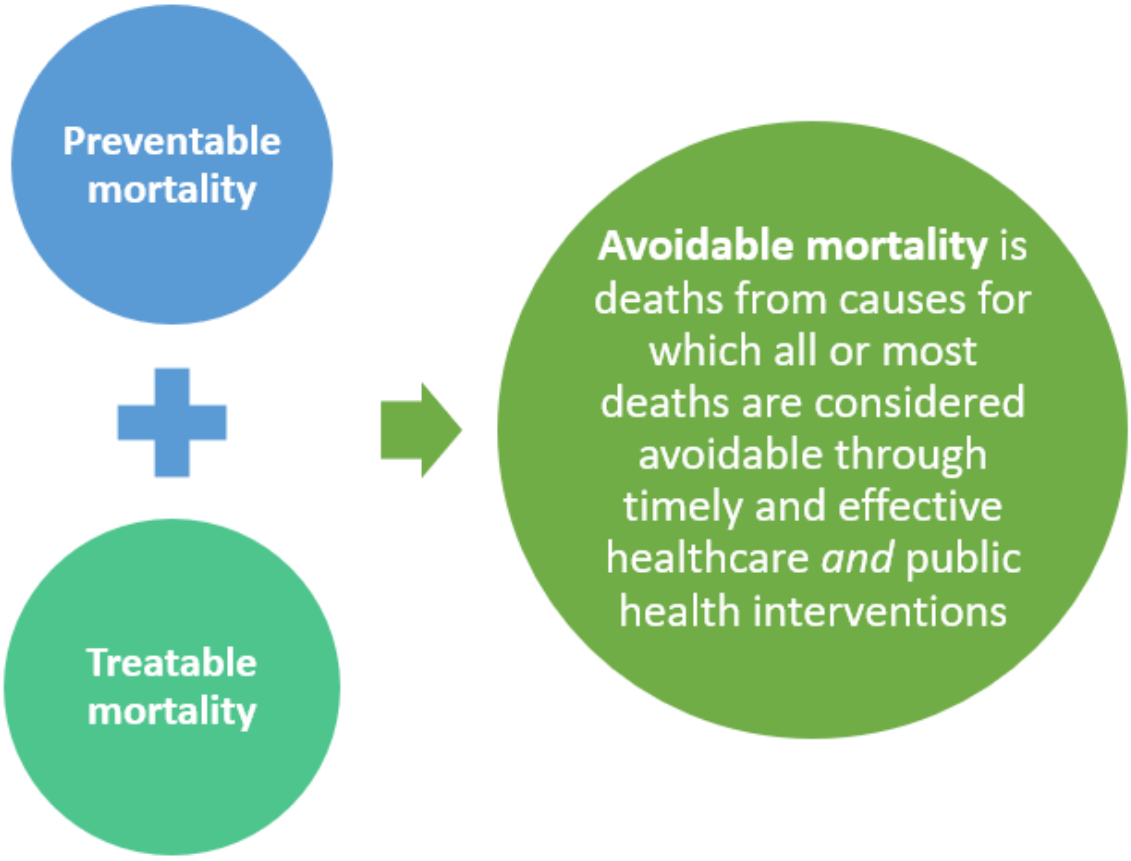
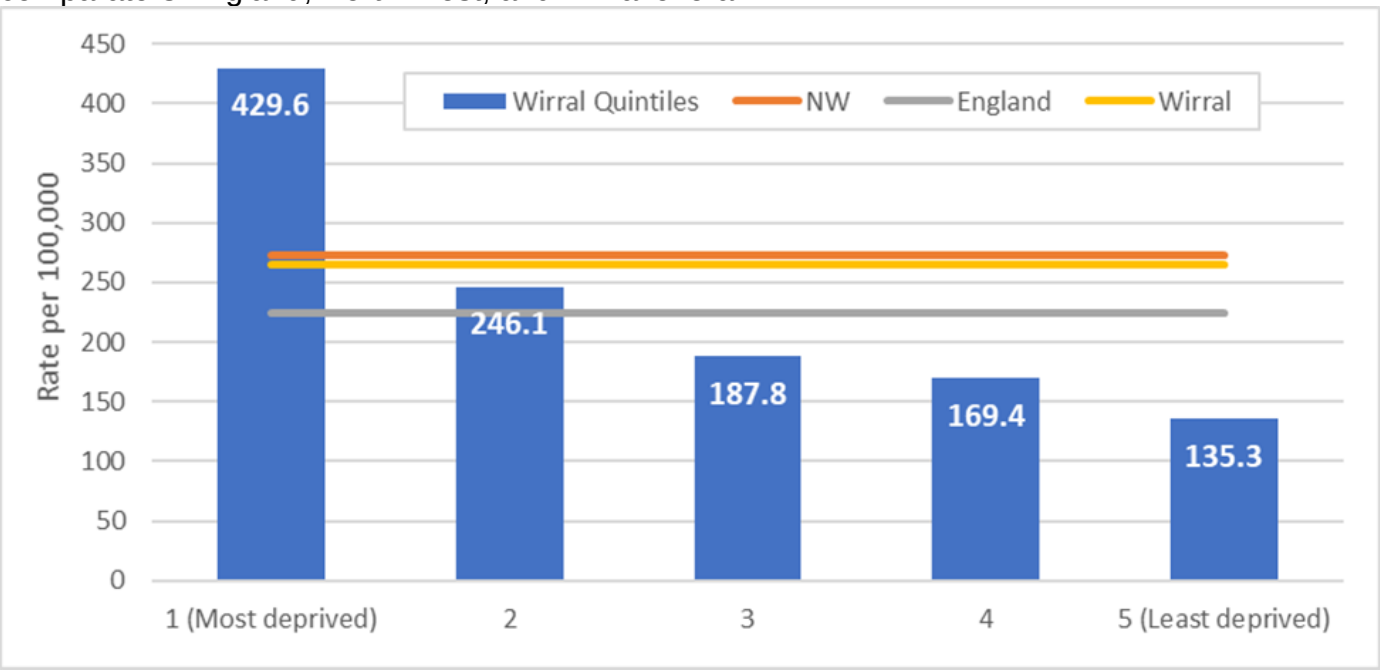


Figure 33 below shows the rate (per 100,000) of avoidable deaths in Wirral by deprivation quintile in 2017-19 (with comparators of England, the North West and Wirral overall as comparator lines).

Figure 33: Rate of Avoidable Mortality by Deprivation Quintile in Wirral in 2017-19, with comparators England, North West, and Wirral overall



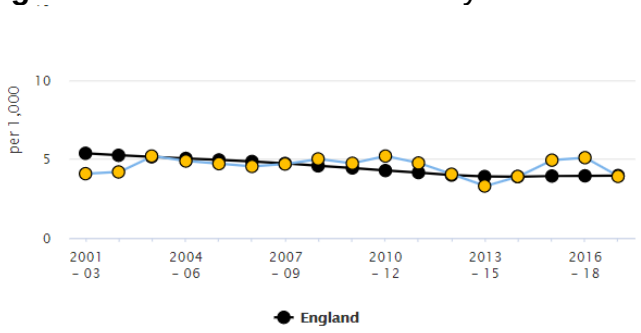
Source: PCMD (Primary Care Mortality Database), 2021

As **Figure 33** shows, the rate of Avoidable Mortality in Wirral in 2017 varied widely by deprivation quintile, with the rate more than 3x higher in the most deprived quintile of the population, compared to the least deprived quintile (429.6 vs 135.3 per 100,000).

Infant mortality

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social, and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn (see **Figure 34 below).**

Figure 34: Trend in Infant Mortality rate for Wirral and comparators, 2001/03 to 2017/19)

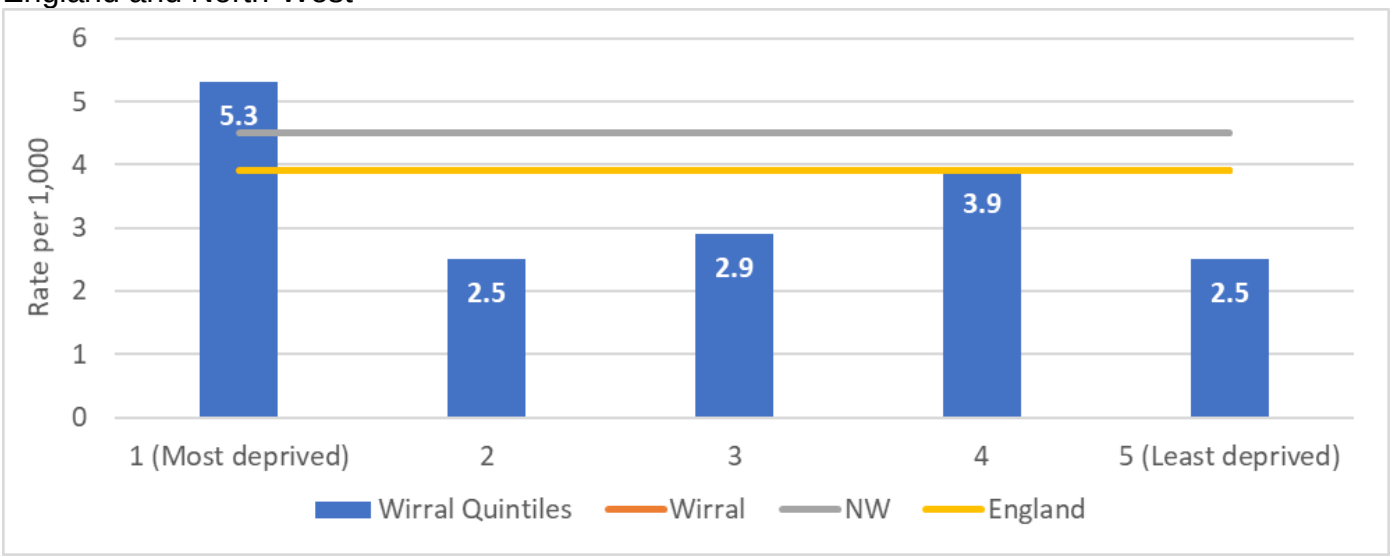


Period		Wirral Count	Value	95% Lower CI	95% Upper CI	North West	England
2001 - 03		41	4.1	2.9	5.5	5.7	5.4
2002 - 04		43	4.2	3.0	5.6	5.6	5.2
2003 - 05		55	5.2	3.9	6.7	5.7	5.1
2004 - 06		52	4.9	3.6	6.4	5.6	5.0
2005 - 07		51	4.7	3.5	6.2	5.5	4.9
2006 - 08		50	4.5	3.4	6.0	5.3	4.8
2007 - 09		52	4.7	3.5	6.1	5.0	4.7
2008 - 10		56	5.0	3.8	6.5	4.9	4.6
2009 - 11		53	4.7	3.5	6.2	4.7	4.4
2010 - 12		59	5.2	3.9	6.7	4.6	4.3
2011 - 13		53	4.7	3.6	6.2	4.4	4.1
2012 - 14		44	4.0	2.9	5.4	4.3	4.0
2013 - 15		35	3.3	2.3	4.6	4.2	3.9
2014 - 16		41	3.9	2.8	5.3	4.5	3.9
2015 - 17		51	4.9	3.7	6.5	4.6	3.9
2016 - 18		51	5.1	3.8	6.7	4.6	3.9
2017 - 19		38	3.9	2.8	5.3	4.5	3.9

Source: Public Health Outcomes Framework (2021)

In 2017-19, Wirral overall had an infant mortality rate that was exactly the same as England (3.9 per 1,000) and was lower than the North-West overall (4.5 per 1,000). As with so many health issues however, the overall rate hides large inequalities, shown in the **Figure 35** below.

Figure 35: Infant mortality in 2017-19 by deprivation quintile in Wirral, with comparators of England and North-West



Source: PCMD, 2021 (Primary Care Mortality Database)
Note: Wirral line is hidden by the England line, as both rates are exactly 3.9

As **Figure 35** shows, the most deprived quintile had an infant mortality rate that was more than double the rate of the least deprived quintile.

Although quintile 4 (for reasons that are unclear but are possibly a product of fairly low numbers (n=38 for the 3 pooled years of 2017-19), has the 2nd highest rate, that Quintile 1 has by far and away the highest rates.

Access to health care and services

Geographical access

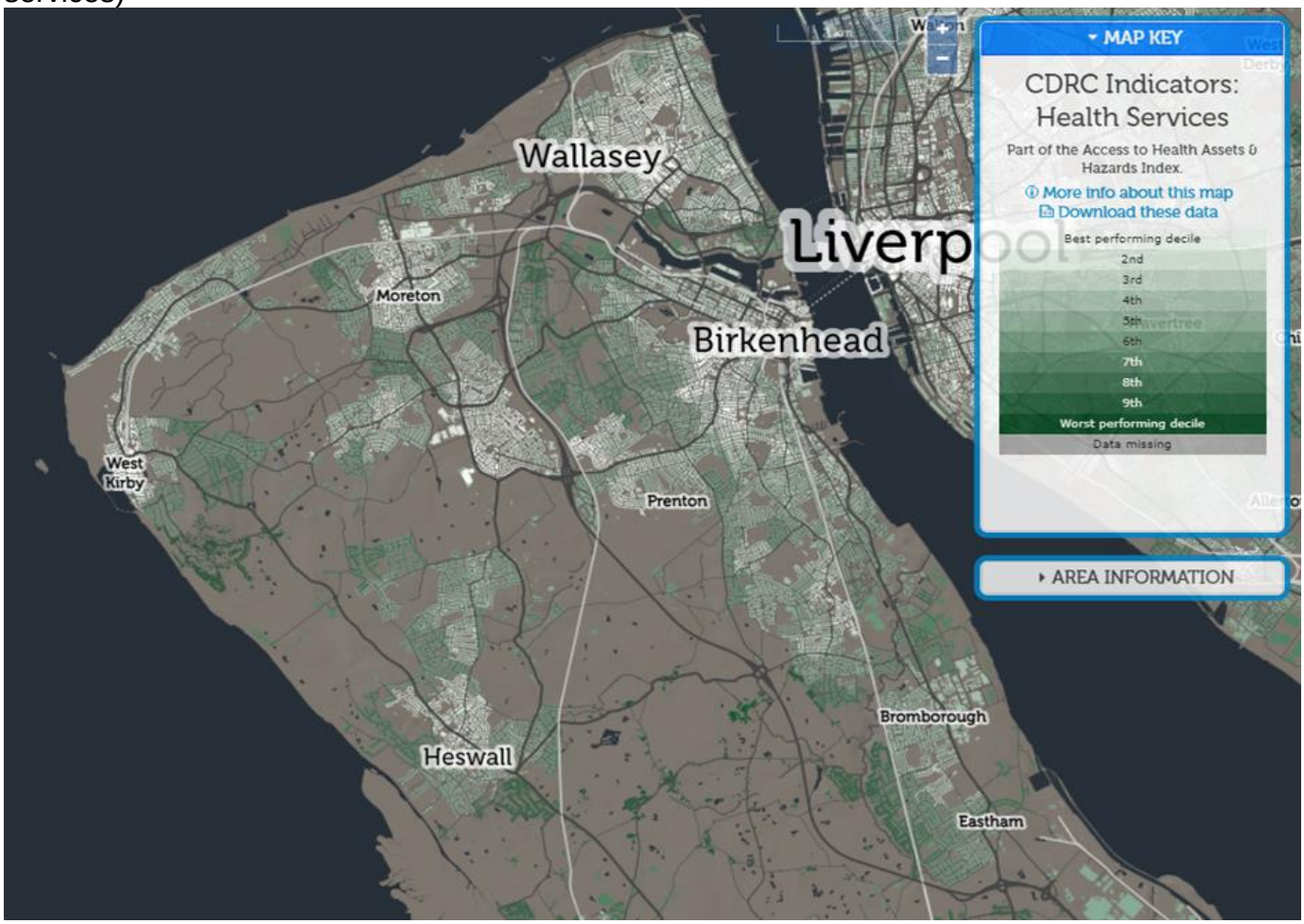
Geographic accessibility to health services has been demonstrated to be associated with use of services. As part of the Index of 'Access to Healthy Assets and Hazards' (AHAH) developed by the University of Liverpool and the CDRC (Consumer Data Research Centre), accessibility to three 'domains' has been calculated and mapped; the 'domains' are:

1) Retail environment
2) Health services
3) Physical environment

The accessibility to health-related services included distance (km) to: GP surgeries; A&E Hospitals; Pharmacies; Dentists and Leisure Centre's and the **map 12** below shows Wirral's performance on this domain.

Map 12 below shows a mixed picture in Wirral, with accessibility being poor in both in some areas of deprivation (Bidston, Beechwood, parts of Seacombe, Poulton and Moreton for example), but also in some affluent areas (such as Caldy, Spital, Dibbinsdale, Irby and Thornton Hough), although the much higher likelihood of having access to a vehicle in more affluent areas is likely to mean longer distances to health services is likely to be less of an issue (see **Table 1**).

Map 12: Access to health services in Wirral (GPs, hospitals, pharmacies, dentists, leisure services)



Source: Consumer Data Research Centre, 2021

Waiting times

The NHS England waiting time for non-urgent treatments and procedures is 18 weeks (from the day an appointment is booked, or when the hospital or service receives a referral letter), to the time of treatment. In March 2020, the average waiting time in Wirral (WUTH), was 9.3 weeks (across all specialties), by March 2021, this had increased to 9.4 weeks. The percentage of people seen within the 18 week target in March 2020 was 76.4%; by March 2021 this has reduced to 70.0% of people.

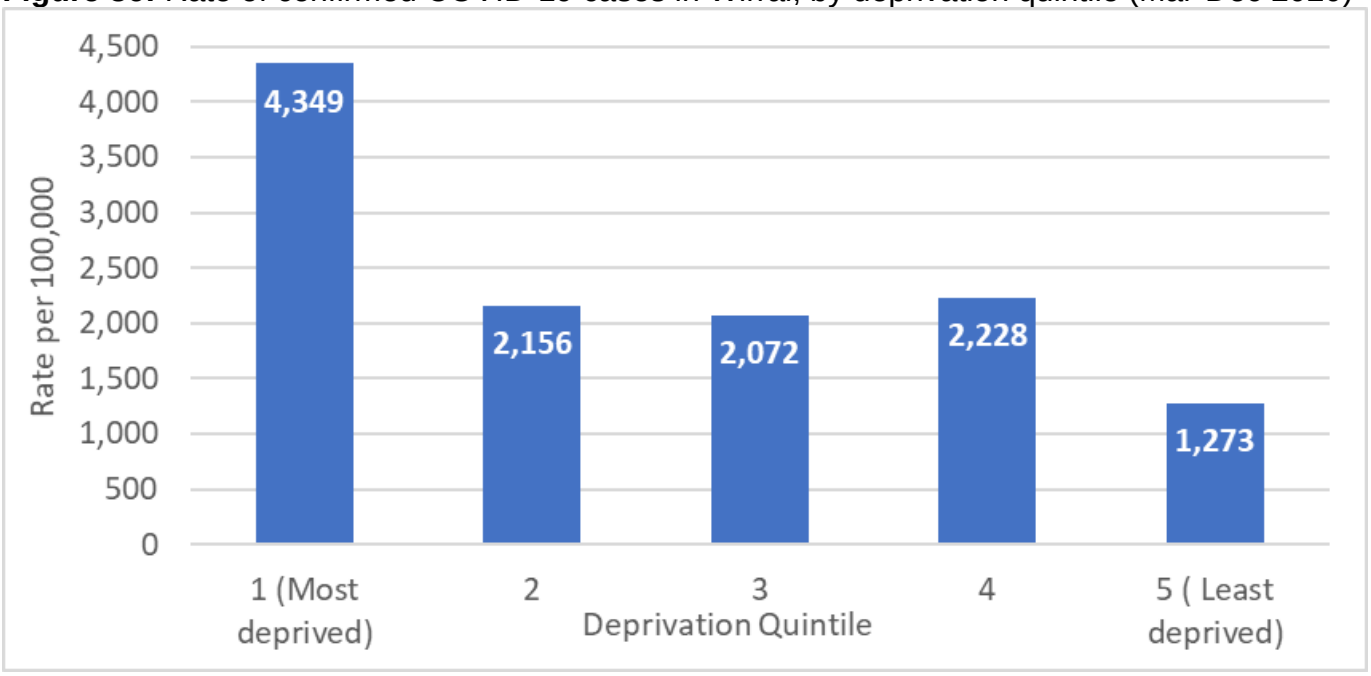
The largest increase in waiting times has been in the Geriatric Medicine specialty, which has gone from 94.1% of people seen within 18 weeks in March 2020, to 61.5% in March 2021 (average waiting time has increased from 4 weeks to 14 weeks).

COVID-19

COVID-19 Cases

COVID-19 cases were widely predicted to have a disproportionate impact on the most deprived at the beginning of the pandemic in early 2020 (by organisations such as Red Cross*, Centre for Progressive Policy etc…) and this turned out to be the case both locally and nationally.

Figure 36: Rate of confirmed COVID-19 cases in Wirral, by deprivation quintile (Mar-Dec 2020)



Source: Situational Explorer, Public Health England, 2021

Figure 36 shows that the rate of COVID-19 infections (March to December 2020) was more than triple the rate in the most deprived quintile, than was the case in the least deprived quintile.

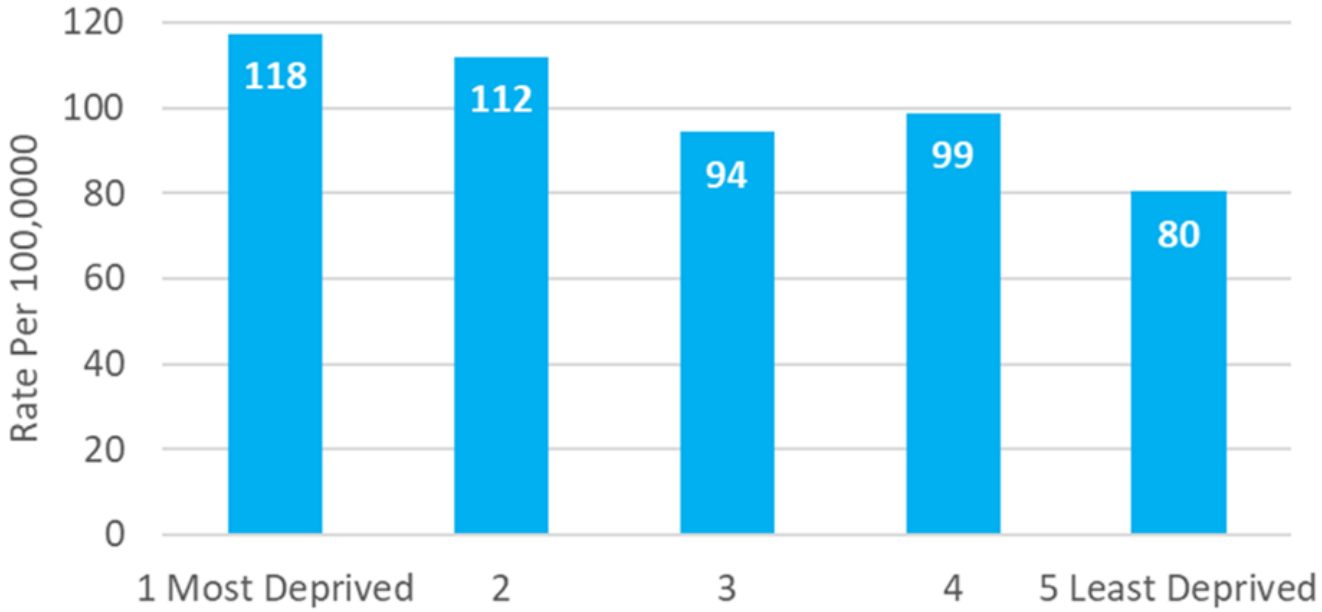
COVID-19 Mortality

Nationally, PHE has reported that mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females (Source: Disparities in the risk and outcomes of COVID-19. Public Health England, June 2020).

Locally however, the relationship between deaths and deprivation initially appeared less clear, with rates highest in Quintile 4 (second least deprived quintile); A large contributory factor to this, however, was the location of Care Homes in Wirral, as the majority of COVID-19 deaths in Quintile 4 occurred in Care Home residents. When deaths in non-Care Home residents were

analysed separately, the pattern was much more comparable with national findings (i.e., death rates highest in Quintile 1 and lowest in Quintile 5). See **Figure 37**.

Figure 37: Rate of COVID-19 deaths (rate per 100,000) in Wirral, in non-Care Home residents by IMD Quintile in 2020



Source: Situational Explorer, Public Health England, 2021

As **Figure 37** above shows, when deaths which occurred *outside* of care homes are calculated separately as a rate per 10,000 deaths (for each quintile), the highest rates are seen in Quintile 1 and the lowest seen in Quintile 5.

- Nationally, PHE report that men working as security guards, transport workers, chefs, sales/retail assistants, lower skilled workers in construction and processing plants and social care workers of both genders had significantly high rates of death from COVID-19.

- In Wirral, just 68 out of a total of 616 COVID-19 deaths (to 31/12/2020) were of working age (aged 16-67); almost one in five of those deaths (19%) had a blank field for occupation.

- With the caveat that numbers locally are small, the largest categories of occupational field for deaths from COVID-19 in Wirral were Health & Social Work (13%), Construction (12%) and Motor Trade, Wholesale & Retail (10%).

- The presence of Health & Social Work and Motor Trade, Wholesale & Retail in the top 3 is not surprising, as they are the two largest employment fields in Wirral, employing respectively, 22.8% and 16.6% (almost 40% in total) of the total working population of Wirral.

- In fact, given that 22.8% of Wirral work in Health & Social Work, plus a potential level of exposure to COVID-19 which is higher than the public at large, it is perhaps surprising that the number of deaths is not larger in this group (16.4% of all deaths from COVID-19).

- The most over-represented occupational group in Wirral was Construction, which employs only 4.0% of the Wirral population, but accounted for 14.5% of deaths (caveat of small numbers)

Local Data

Indirect impact of COVID on population outcomes

This short report and its themes, provided by various departments in Wirral Council outline the emerging and evolving evidence about the indirect impacts of COVID-19 across a range of themes that impact upon health.

These themes are based on research evidence nationally, regionally, and locally exploring the impact of the pandemic on health and wellbeing. As validated intelligence systems often have substantial time lag, this information is based on locally collated intelligence. It will need to be regularly reviewed, updated, and validated to better understand the wider impact of the pandemic in order to deliver strategies, services, and programmes relevant to Wirral and our residents.

Short Report: Indirect impact of COVID on population outcomes (July 2021)

Background reports

Life Expectancy in Wirral 2017-19
https://www.wirralintelligenceservice.org/this-is-wirral/wirral-population/life-expectancy/

Wirral Council Health & Wellbeing Board (2021) Tackling Health Inequalities through Regeneration: Health & Employment, 16th June 2021

Wirral Council, Place & Investment Team, Interim Economic Strategy Evidence Base, March 2021

JSNA: Children & Young People Population & Demographics, January 2020
https://www.wirralintelligenceservice.org/this-is-wirral/children-young-people/

This is Wirral: Crime and Safety, December 2019 https://www.wirralintelligenceservice.org/this-is-wirral/crime-and-safety/

This is Wirral: Housing, December 2019 https://www.wirralintelligenceservice.org/this-is-wirral/housing/

Adult Care & Health Overview and Scrutiny Committee: Public Health and Housing, 27th February 2020

Public Health Outcomes Framework, 2021
Public Health Outcomes Framework - Data - PHE

Community Needs Index – measuring social and cultural factors, OCSI 2021
https://ocsi.uk/2019/10/21/community-needs-index-measuring-social-and-cultural-factors/

Wirral Community Insight, OCSI 2021 https://wirral.communityinsight.org

This is Wirral: Health & Wellbeing, December 2019 Health & Wellbeing - Wirral Intelligence Service

Coronavirus (COVID-19) in the UK https://coronavirus.data.gov.uk/

CQC (2021) COVID-19 INSIGHT, Issue 12
https://www.cqc.org.uk/sites/default/files/20210721%20COVID%20IV%20Insight%20issue%2012%20slides.pdf

COVID-19 Mortality in Wirral, March 2021 COVID-19: The impacts - Wirral Intelligence Service

Contact details

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Embracing optimism

living with COVID-19

rector of Public Health for Wirral

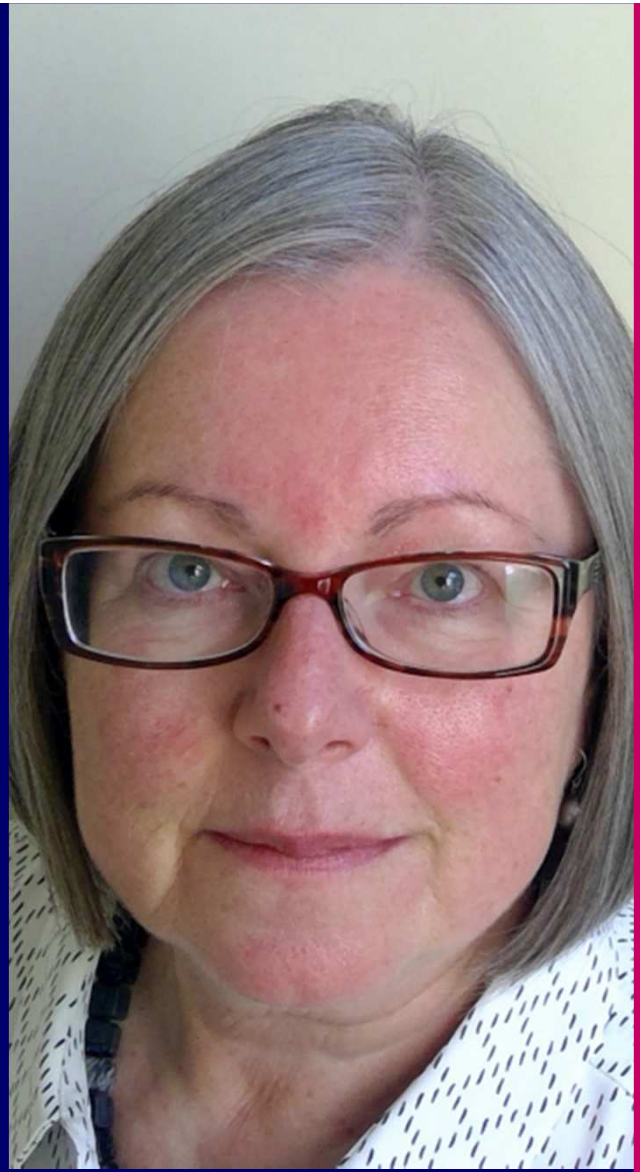
nual Report 2020-2021

What a year it's been…

In January 2020 Wirral became one of the first places in the world to respond to COVID-19 when we hosted British residents repatriated from Wuhan, China. Since then, we have all worked hard together to Keep Wirral Well.

Although COVID-19 has been the biggest health challenge to affect us all for generations, many of the enduring health problems we faced before the pandemic have worsened as a result.

Whilst the pandemic has touched us all, some people have felt the impact of the virus and the measures to control it more than others. It has also showed us how valuable our health is and how staying healthy protects us all.



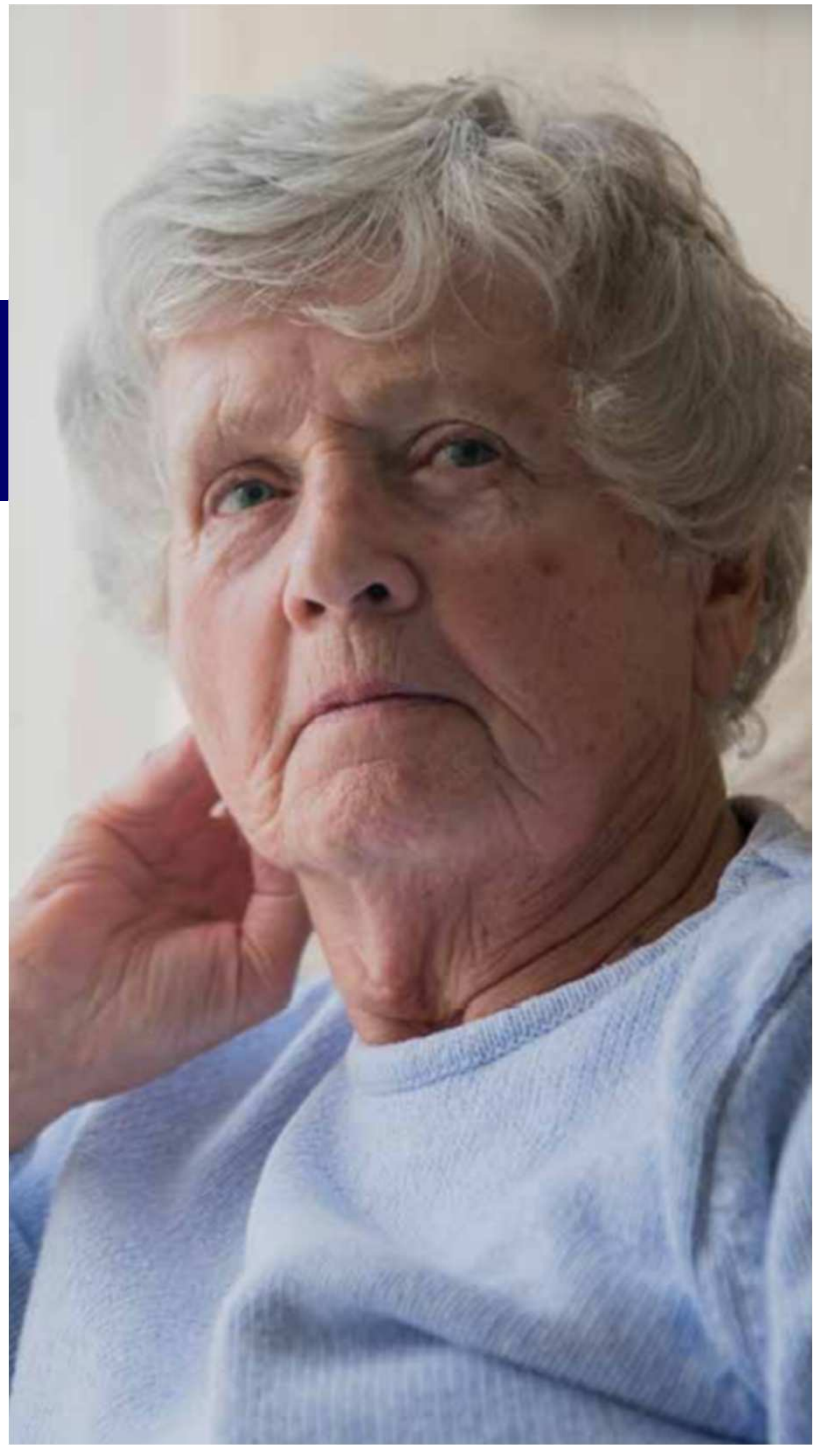
Julie Webster
Director of Public Health

Same Virus
Different Struggles

The pandemic held up a mirror to the existing health, economic and social inequalities in our borough.

COVID-19 has made these differences worse, and the heaviest impacts have fallen on the lives of people who are already experiencing health, economic and social inequalities.

These differences are the most significant health challenge in Wirral. They impact on the quality of people's lives; the way residents use services and how individuals and the economy prosper.

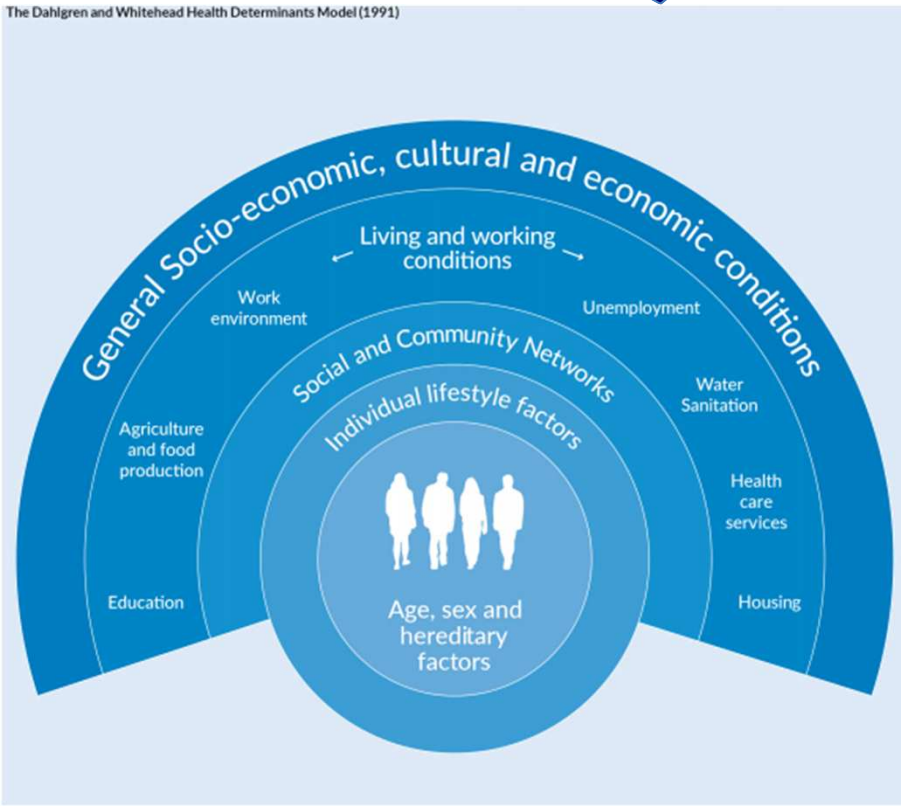


Health inequalities in Wirral

Health inequalities are ultimately about differences in the status of people's health. They occur due to factors often outside of people's direct control and as a result people can experience systematic, unfair, and avoidable differences in their health, the care they receive and the opportunities they have to lead healthy lives.

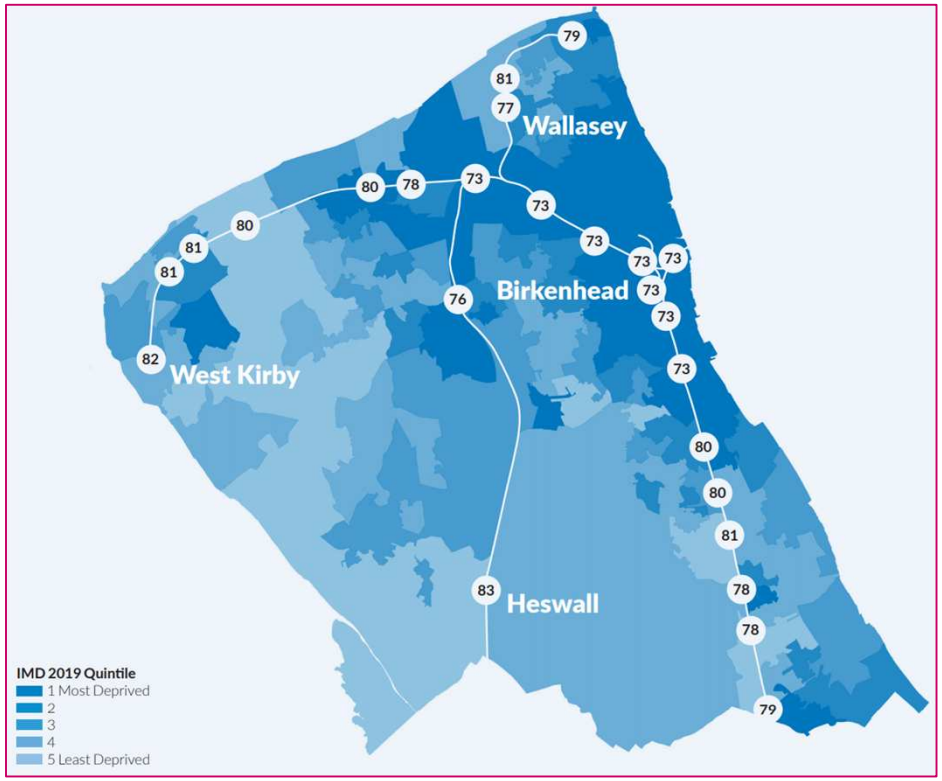
Research has shown that health inequalities occur because of the different conditions into which we are born, grow, live, work and age.

This diagram shows how these factors interact.

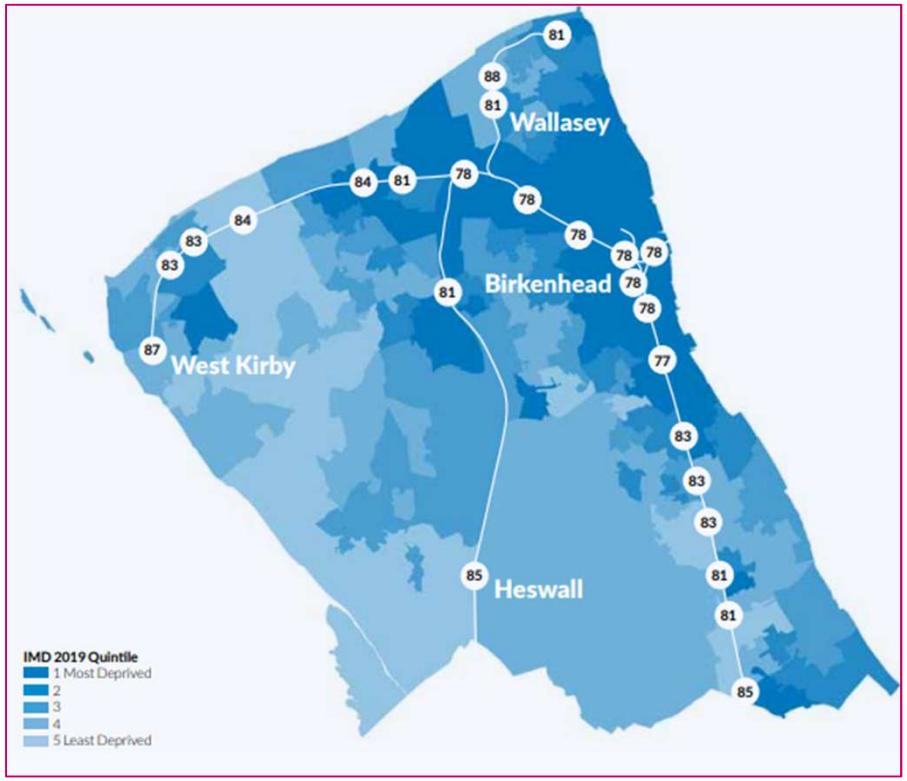


Life Expectancy by Ward

Health inequalities can be measured in many different ways. As a key measure of a population's health status life expectancy is one of the foremost measures of health inequality



Male Life Expectancy at Birth



Female Life Expectancy at Birth

Data Source: Life Expectancy at Birth by Wirral Railway Station 2017-2019 (3 Years Pooled) Underlaid with IMD 2019 Deprivation Quintile
Station life expectancy is based on the Wirral ward life expectancy that the station is located in.

Wirral life course statistics 2021

A comparison to England

There are many reasons why people do not have the same experience of health as others. The places we live and work, the people we know and how we live all affect our health and wellbeing.

This diagram details how some of these factors affect the health of Wirral residents throughout their life.

What do we do about it?

We have made great progress in supporting people to live healthier lives. However, health inequalities are stubbornly persistent.

Crucially we are presented with the opportunity to reduce the gap in health between our communities and the rest of England or face the possibility that failure to act together, and at pace, increases poor health in Wirral.

Tackling health inequalities will benefit every resident of Wirral. The pandemic has shown us what we can achieve when we all work together and the speed at which we can make change happen.

Recommendations

The following recommendations have been made to improve the health and wellbeing of residents, and reduce health inequalities in Wirral

1

Prioritise economic regeneration and a strong local economy

2

Safeguard a healthy standard of living for all

3

Increase support for children, young people and families

4

Strengthen action to address differences in health outcomes and prevention

5

Residents and partners continue to work together

1. Prioritise economic regeneration and a strong local economy

I recommend that:

- Economic development plans are reviewed to ensure that they respond to the impact of the pandemic on residents and communities.

- Economic Regeneration and Development Committee, working with the Health and Wellbeing Board, should consider the development of an Economic Inequalities Strategy for Wirral.

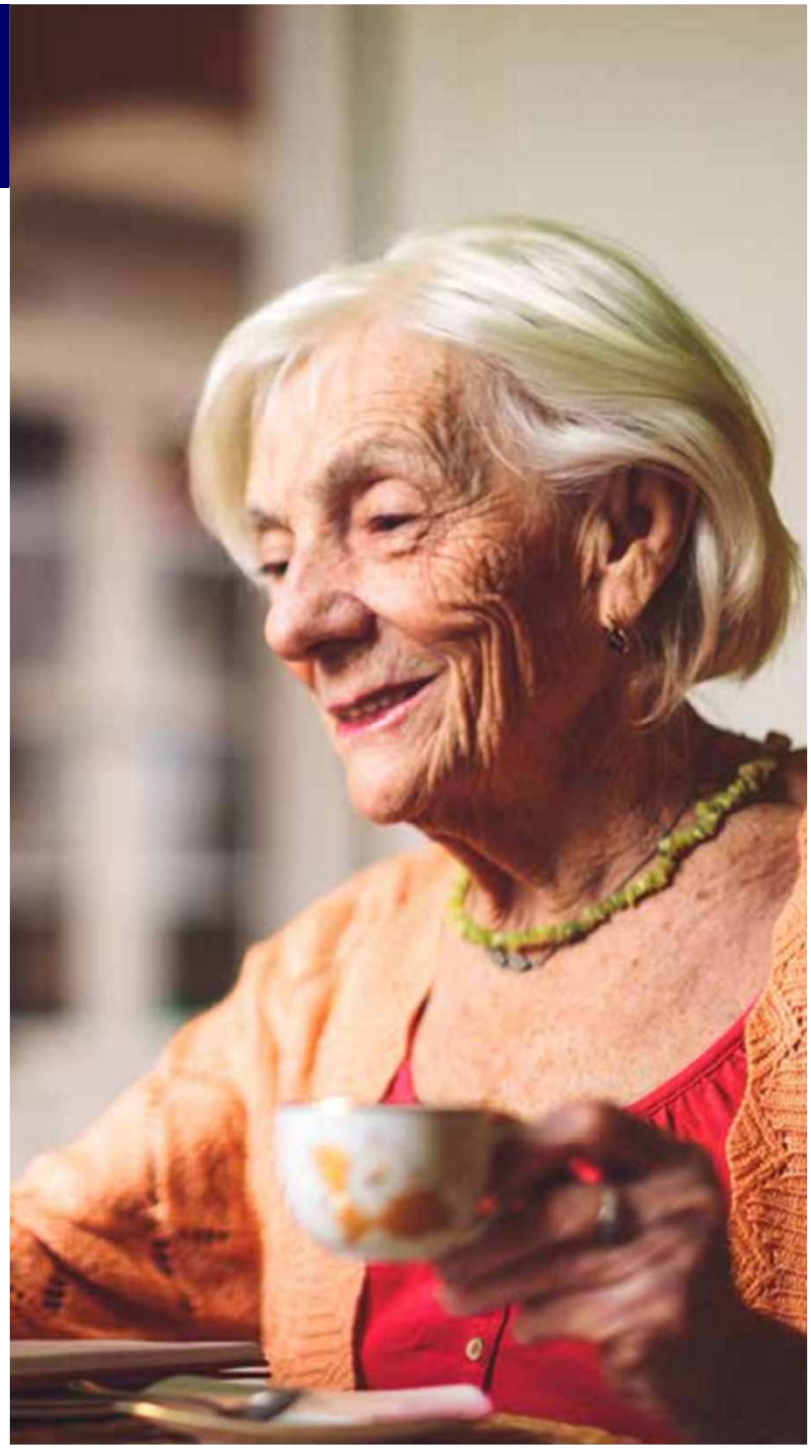
- Employment support services and skills development programmes are available, accessible and sustainable to ensure income maximisation and support those most susceptible to job loss and job insecurity.

- Partners embed a ‘Health in All’ policies approach to regeneration planning. We can use this approach to ensure that the wide breadth of health impacts of the pandemic is part of routine decision making and to reduce health inequalities.

2. Safeguard a healthy standard of living for all

I recommend that:

- Wirral's Housing Strategy is reviewed to reflect the changing needs of residents and to address the challenges that have emerged during the pandemic.
- There is an integrated information and advice offer to enable people to access support when they need it.
- Build on the progress made during the pandemic to support people who are homeless.
- Define and streamline fuel poverty support pathways with partners across Wirral learning from COVID response.
- Relevant partners utilise Health Impact Assessment in spatial planning to identify risks to health and ways to mitigate them.



3. Increase support for children, young people and families

I recommend that:

- The impacts of the pandemic on our young people are examined to ensure that children and families have the support they need to predict future areas requiring support and inform the offer for early years support from the Council and other partners.
- Continue to develop the early help and intervention model underpinned by a prevention framework.
- Work with families, early years, schools, further and higher education sectors to ensure all children and young people fulfil their potential through a ‘cradle to career’ approach.
- Ensure that services are maximising opportunities to mitigate the impact of the pandemic on children, young people and families with a focus on physical and mental health.
- Review existing support and services for our most vulnerable children, young people and families to ensure they are resilient, accessible and driving progress.

4. Strengthen action to address differences in health outcomes and prevention

I recommend that:

- Local health and care partners focus on tackling inequalities in healthcare provision - this is their direct responsibility and must be the prime focus of their action.
- Local NHS partners ensure they can access high-quality data to measure performance on reducing health inequalities across services. This includes being able to breakdown outcome and performance data by deprivation and ethnicity.
- NHS partners use their role as local anchor institutions and the choices they make as an employer and a purchaser to reduce inequalities.
- Preventative programmes and proactive health management for groups at greatest risk of poor health outcomes are accelerated across key service areas as outlined within the NHS Long Term Plan.
- The developing integrated care system and local providers have a named executive board level lead for tackling health inequalities and access training made available by local and national partners.
- Local NHS partners engage with and play a supportive role in multi-agency action to improve the social, economic and environmental conditions in which people live.
- Health and care partners focus on good infection prevention control to ensure avoidable infections are prevented.

5. Residents and partners continue to work together

I recommend that:

- All partners should continue to build on the strong partnership work developed through our COVID-19 response by implementing the action emerging from the Health and Wellbeing Board Community and Voluntary Sector work.

- All partners fully engage local people to co-design services and initiatives to enable residents to recover and improve their health and wellbeing. We need to prioritise our more vulnerable residents who have been disproportionately affected by COVID-19 and use tailored communication methods.

- We undertake a resident listening exercise to learn from the experience of the pandemic to understand local people's experiences and aspirations for the future. This work should be a blueprint for developing a sustainable model for the use of insights gathered from local people.

Thank you

WIRRAL

COMMITTEE: HEALTH AND WELLBEING BOARD

Date: 29 SEPTEMBER 2021

REPORT TITLE:	**Wirral Pharmaceutical Needs Assessment (PNA) 2022 – 2025**
REPORT OF:	**DIRECTOR OF PUBLIC HEALTH**

REPORT SUMMARY
The Health and Wellbeing Board has the responsibility for the publication and update of the local Pharmaceutical Needs Assessment. The process for producing a new Pharmaceutical Needs Assessment for Wirral began in Spring 2020 with a view to its publication in March 2021. However, due to the COVID-19 pandemic the publication date was put back to September 2022 as per national direction.

This report details the proposed process to produce a new Pharmaceutical Needs Assessment for Wirral.

A further report will be brought forward when the draft Pharmaceutical Needs Assessment for 2022 – 2025 is ready for public consultation and ahead of signing off the final publication of a new Pharmaceutical Needs Assessment for Wirral on or before 30th September 2022.

The proposed actions affect all wards within the borough.

The decision requested is not a key decision.

RECOMMENDATIONS

The Health and Wellbeing Board is recommended to:

1. request the Director of Public Health to undertake the necessary steps to produce the next Pharmaceutical Needs Assessment on or before 30th September 2022.
2. request the Director of Public Health to produce a further report with the final draft Pharmaceutical Needs Assessment for sign-off prior to public consultation.
3. request the Director of Public Health to produce a final report in September 2022 prior to publication of the Pharmaceutical Needs Assessment.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1 The local Health & Wellbeing Board has the responsibility for the publication and update of the local Pharmaceutical Needs Assessment as a consequence of the 2013 Health & Social Care Act.

2 The Pharmaceutical Needs Assessment provides a detailed review of existing pharmacy provision, including current service provision and an assessment of population needs that can direct future provision.

2.0 OTHER OPTIONS CONSIDERED

2.1 Not applicable as this is a mandatory process as set out in The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. https://www.legislation.gov.uk/uksi/2013/349/contents/made

3.0 BACKGROUND INFORMATION

3.1 From April 2013, Health and Wellbeing Boards became responsible for the publication and update of the local Pharmaceutical Needs Assessment which provide a detailed review of existing pharmacy provision, including current service provision and opening hours as well as an assessment of population needs.

3.2 The Health and Social Care Act 2013 provides the legislation that requires the Health and Wellbeing Board to produce a new Pharmaceutical Needs Assessment every three years. To date Wirral has produced three Pharmaceutical Needs Assessments in 2011, 2015 to 2018 and the current version 2018 to 2021.

3.3 Since 2014 the approach has been led by Public Health, and since 2017 produced by Wirral Intelligence Service, with support from local and sub-regional partners. This approach will be repeated for the renewed Pharmaceutical Needs Assessment (2022-2025).

3.4 The Pharmaceutical Needs Assessment is used primarily by NHS England to inform their local commissioning decisions regarding community pharmacy services. It also informs councils and Clinical Commissioning Groups for planning purposes.

3.5 There is a legal requirement for the Wirral Health and Wellbeing Board to publish an updated Pharmaceutical Needs Assessment before the 30th September 2022.

3.6 Wirral's current Pharmaceutical Needs Assessment (see links in subject history below) was produced in 2018 and concluded that the borough is well served in terms of spread of community pharmacies. There was one pharmacy for every 3,402 residents, which compared favourably to the national average of one pharmacy for every 5,000 residents.

4.0 FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications for Wirral Council.

4.2 NHS England will use the Pharmaceutical Needs Assessment as the basis for future commissioning decisions in relation to community pharmacy services in Wirral.

5.0 LEGAL IMPLICATIONS

5.1 There is a statutory requirement for the local Health & Wellbeing Board to produce a Pharmaceutical Needs Assessment every three years. This has been extended by initially 12 months and then a further 6 months in recognition of the impact of the COVID-19 pandemic.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There are no additional resources to complete the Pharmaceutical Needs Assessment. The work is led by the Council's Intelligence Service and Public Health teams in collaboration with Cheshire and Merseyside Councils to ensure consistency in approach and production.

7.0 RELEVANT RISKS

7.1 The key risk is that the new Pharmaceutical Needs Assessment is not delivered within the required timeframe of on or before 30th September 2022. In order to mitigate this risk a detailed project timeline has been developed.

8.0 ENGAGEMENT/CONSULTATION

8.1 **Public Survey – Pharmacy Services**
A public survey will be conducted during November and December 2021.Responses will be collated and incorporated into the first final draft of the new Pharmaceutical Needs Assessment this will be reported in March 2022.

8.2 **Pharmacy Survey – Contractors and provision**
A Pharmacy Survey will also be conducted between June and August 2021. Responses will be collated and incorporated into the first final draft of the new Pharmaceutical Needs Assessment this will be reported in March 2022

8.3 **Formal consultation on a new draft Pharmaceutical Needs Assessment**
As part of the production of the new Pharmaceutical Needs Assessment, there is a statutory requirement to consult with a wide group of consultees including some mandated consultee groups (listed in Appendix one). This consultation is scheduled to be held for a minimum of 60 days between April and June 2022. Responses will be collated and reported to the board in September 2022.

9.0 EQUALITY IMPLICATIONS

9.1 There are no equality issues arising directly from this report.

9.2 Equality Impact Assessments will be produced where appropriate for surveys and consultations and will be used to inform any final decisions.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 Wirral Council is committed to carrying out its work in an environmentally responsible manner, and these principles will guide the development of the Pharmaceutical Needs Assessment.

REPORT AUTHOR: **Name: Julie Webster**
Title: Director of Public Health
email: juliewebster@wirral.gov.uk

APPENDICES

Appendix One

BACKGROUND PAPERS

Pharmaceutical Needs Analysis

WIRRAL PHARMACEUTICAL NEEDS ASSESSMENT (PNA) 2018-2021 - FOR INFORMATION

Wirral PNA 2018 to 2021 FINAL, item 41

Wirral HWBB PNA Appendix 13 Consultation Report FINAL March 2018, item 41

Link to final PNA 2018, item 41

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
HWBB briefing note on forthcoming PNA 2021 – 2024 development and publication	11/03/2020
14/03/2018 - Health and Wellbeing Board	14/03/2018
30/01/2018 - Adult Care and Health Overview and Scrutiny Committee	30/01/2018
19/07/2017 - Health and Wellbeing Board	19/07/2017

Appendix One

Consultation on pharmaceutical needs assessments (minimum requirements and extended list)

According to pharmaceutical regulations https://www.legislation.gov.uk/uksi/2013/349/regulation/8/made the draft document must be distributed for comment to:

- Local Pharmaceutical Committee (LPC)
- Local Medical Committee (LMC)
- Any persons on the pharmaceutical lists
- Dispensing doctors (if situated within Wirral boundary)
- Any Essential Small Pharmacies (known as LPS chemists) contracted under the Local Pharmaceutical Services provisions by NHS England
- Local Healthwatch
- Any consumer or community group that Wirral H&WBB consider having an interest in the provision of pharmaceutical services
- Any local NHS trust of NHS Foundation Trusts in the area
- NHS England/NHS Commissioning Board
- Neighbouring Health and Wellbeing Boards

The draft PNA will also be distributed for comment to:

- Councillors and Committees
- Wirral Partnership
- GPs, Practices and other Primary Care Staff
- Wirral Health and Care Commissioning (covering NHS Wirral Clinical Commissioning Group, Wirral Council Adult Social Care and Public Health)
- Neighbouring Local Authorities
- Neighbouring Local Pharmaceutical Committee
- Neighbouring Local Medical Committee
- Local Dental Committee
- Local Ophthalmic Committee

Patients and Public

- Patient Participation Groups
- Older People's Parliament
- Voluntary Sector Groups
- Community Sector Groups
- Faith Sector Groups

Other Methods considered:

- Press releases to variety of outlets
- Council and Partners websites
- Wirral Intelligence Service Website and Bulletin
- Council Engagement Contacts via email distribution

- Local Pharmaceutical Committee website and bulletin

Note: Four hard copies of the Draft Pharmaceutical Needs Assessment (2022-2025) will be placed in accessible main libraries/council buildings for the duration of the consultation period (one per constituency)

All other opportunities will be explored in this process to extend access wherever possible

WIRRAL

HEALTH AND WELLBEING BOARD
Wednesday, 29 September 2021

REPORT TITLE:	**INTEGRATED CARE SYSTEM AND INTEGRATED CARE PARTNERSHIP DEVELOPMENTS**
REPORT OF:	**GRAHAM HODKINSON, DIRECTOR OF CARE AND HEALTH**

REPORT SUMMARY

The purpose of this report is to update the Health and Wellbeing Board on the legislative changes that will lead to the establishment of the Cheshire and Merseyside Integrated Care Board.

This report sets out the updated policy context for the development of Integrated Care Systems and Integrated Care Partnerships and provides an update on the local governance arrangements, and developments for Wirral's Integrated Care Partnership at "place" level.

RECOMMENDATIONS

It is recommended that the Health and Wellbeing Board:

1. Note the legislative developments detailed in the Health and Care Bill that will lead to the establishment of the Cheshire and Merseyside Integrated Care Board (ICB).

2. Note the preferred model of place-based partnership governance arrangements that will be discussed further at the Adult Social Care and Public Health Committee on 13th October 2021, to develop a Joint Committee between the Council and the Cheshire and Merseyside Integrated Care Board, in which decision making at place level will be jointly carried out in partnership with ICB, local NHS Partners and the Council.

3. Receive regular committee reports relating to the developments of the Integrated Care Board and Integrated Care Partnership at system level, and local place-based partnership arrangements for Wirral.

4. Provide an oversight role in shaping local services through setting the vision, priorities and outcomes for population health and wellbeing in collaboration with Wirral's place-based partnership.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATIONS

1.1 Health and Wellbeing Board

1.2 The Health and Wellbeing Board has a key role in the development and oversight of the place-based partnership arrangements and activities. The Health and Care Bill refers to amendments to the Health and Social Care Act, however none that appear to change the function, role or purpose of the Health and Wellbeing Board. The legislation refers to the importance of the Integrated Care Board working with the Health and Wellbeing Board around planning arrangements, detailing that joint forward plans and revised plans for Integrated Care Board should be shared with the Health and Wellbeing Board.

1.3 The Health and Care Bill details that Integrated Care Board must involve/consult each relevant Health and Wellbeing Board in preparing or revising the plans and consult each relevant Health and Wellbeing Board on whether draft reports take proper account of the Wirral's local health and wellbeing strategy.

1.4 The Health and Wellbeing Board retains the statutory role for local population health. The Health and Wellbeing Board will have the oversight role for Wirral's place-based partnership and producing joint strategic needs assessments and joint health and wellbeing strategy, to which the Cheshire and Merseyside Integrated Care System will be required to have regard.

1.5 The Health and Wellbeing Board has a key role in the development of place-based partnerships necessary to deliver improved outcomes in population health and tackling health inequalities. It is recommended that the Health and Wellbeing Board receives regular written committee reports on the progress regional and place-based developments at future meetings.

2.0 OTHER OPTIONS CONSIDERED

2.1 The Cheshire and Merseyside Integrated Care Board could establish any of the following place-based governance arrangements with local authorities and other partners, to jointly drive and oversee local integration:

2.2 **Option 1 - Consultative forum** - Helpful for engaging the widest range of partners to discuss and agree shared strategic direction together. Consultative forum is a collaborative forum to inform and align decisions by relevant statutory bodies, such as the ICB or local authorities, in an advisory role. In this arrangement, the decisions of statutory bodies should be informed by the consultative forum.

2.3 **Option 2 - Committee of the ICB** - Helpful for making decisions of the ICB based on a range of views. This is a committee provided with delegated authority to make decisions about the use of NHS resources, including the agreement of contracts for relevant services. The terms of references and scope are set by the ICB and agreed to by the committee members. A delegated budget can be set by the ICS NHS body to describe the level of NHS resources available to cover the remit of the committee.

2.4 **Option 3** - **Joint committee** - A joint committee established between partner organisations, such as the ICB, local authorities, or statutory NHS providers. The relevant statutory bodies can agree to delegate defined decision-making functions to the joint committee in accordance with their respective schemes of delegation. A budget may be defined by the bodies delegating statutory functions to the joint committee, to provide visibility of the resources available to deliver the committee's remit.

2.5 **Option 4** - **Individual delegated authority** - Individual directors of the ICB having delegated authority, which they may choose to exercise through a committee.

2.6 **Option 5** - **Lead provider** - Lead provider managing resources and delivery at place-level under a contract with the ICB, having lead responsibility for delivering the agreed outcomes for the place.

2.7 There is a possibility that the Health and Care Bill could be amended as it is still going through the House of Commons and is at the committee stage.

2.8 A workshop was held with Councillors on 14th September 2021 to discuss the range of integrated place-based partnership governance options. Option 3 to develop a Joint committee is the preferred option of the Council to enable a partnership approach with local NHS partners, making joint decisions about Wirral's integrated place-based partnership arrangements.

2.9 Option 3 to develop a Joint committee for Wirral's integrated place-based partnership will be discussed further with the Adult Social Care and Public Health Committee on 13th October 2021. It is proposed that the Health and Wellbeing Board would oversee the work on the Joint Committee, and Wirral's Healthy Wirral Partnership will continue to play a key role for providers alliances and system partners working closely.

2.10 The place-based governance arrangements will continue to evolve and require further discussions at Cheshire and Merseyside Integrated Care System Development Advisory Group, the Council's Adult Social Care and Public Health Committee and Health and Wellbeing Board, and the system partnership meetings such as Healthy Wirral Partnership, CEO Integrated Care Partnership Development Group and Wirral's Integrated Care Partnership Delivery Group.

2.11 The place-based partnership will align the commissioning of NHS and local government services around shared objectives and outcomes, involving relevant partners, people and communities. The Council and local NHS organisations will work in partnership to develop measures of success for Wirral's Integrated Care Partnership, so that the local system can track the benefits to be achieved from implementing the new legislation and policy guidance creating new ways of working.

3.0 BACKGROUND INFORMATION

3.1 Health and Care Bill

3.2 The Health and Care Bill was introduced in the House of Commons on 6th July 2021 and is still at committee stage. The Health and Care Bill introduces statutory Integrated Care Boards (ICBs) and statutory Integrated Care Partnerships (ICPs) from April 2022.

3.3 The purpose of the Health and Care Bill is to give effect to the policies that were set out as part of the NHS's recommendations for legislative reform following the Long-Term Plan and in the White Paper 'Integration and Innovation: Working together to improve Health and Social Care for all' published in February 2021.

3.4 The Health and Care Bill aims to support Government in doing the following:

- Promoting local collaboration.
- Reforming the NHS Provider Selection Regime.
- Improving accountability and enhancing public confidence in the health and care
- system; and
- Delivering a range of targeted measures to support people at all stages of life.

3.5 The Health and Care Bill sets out two key components to enable Integrated Care Systems to deliver their core purpose, including:

- **strong place-based partnerships** between the NHS, local councils and voluntary organisations, local residents, people who access services, leading the detailed design and delivery of integrated services within specific localities, incorporating a number of neighbourhoods.
- **provider collaboratives**, bringing NHS providers together, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.

3.6 Integrated Care Systems (ICSs)

3.7 Integrated Care Systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area. Integrated Care Systems will play a critical role in aligning action between partners to achieve their shared purpose, to improve

outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities. The ICS will be assuming the commissioning functions of CCGs in Cheshire and Merseyside and will be working with those CCGs to manage the transition to the new statutory body. The ICS, CCGs and local authorities are working together on the future models for the discharge of these commissioning functions from April 2022.

3.8 Integrated Care Systems (ICSs) exist to achieve four aims:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

3.9 Subject to the passage of legislation, the statutory Integrated Care Systems arrangements will comprise:

- **an ICS Partnership**, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- **an ICS NHS body**, bringing the NHS together locally to improve population health and care.

3.10 Collaborating as Integrated Care System will help health and care organisations tackle complex challenges including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

3.11 **Integrated Care Boards – System Level**

3.12 Integrated Care Boards (ICB) will be statutory organisations that bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnerships across the ICS. ICBs will be established as new statutory organisations from April 2022, to lead integration within the NHS. The ICB will have a unitary board, responsible for ensuring the body plays its role in achieving the four purposes. Each board will be required to establish an audit committee and remuneration committee. Each ICB will need to align its constitution and governance with the Integrated Care Partnership.

3.13 All Integrated Care Boards will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. The Integrated Care Board will take on the commissioning functions of the CCGs as well as some of NHS England's commissioning functions. It will have the ability to exercise its functions

through place-based committees (while remaining accountable for them) and it will also be directly accountable for NHS spend and performance within the system. The ICB will have a key role in establishing the membership of the ICS Partnership (jointly with local authorities).

3.14 **Integrated Care Partnership – System Level**

3.15 Each Integrated Care System will have an Integrated Care Partnership established by the Integrated Care Board and relevant local authorities as equal partners and bringing together organisations and representatives concerned with improving the care, health and wellbeing of the population.

3.16 Each System Integrated Care Partnership should champion inclusion and transparency and challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place-and neighbourhood-level engagement, ensuring the system is connected to the needs of every community it covers.

3.17 The Integrated Care Partnership will operate as a forum to bring partners, local government, NHS and others together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population. The Integrated Care Partnership will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. This joined-up, inclusive working is central to ensuring that ICS partners are targeting their collective action and resources at the areas which will have the greatest impact on outcomes and inequalities as we recover from the pandemic.

3.18 The Integrated Care Partnership will be tasked with developing an ‘integrated care strategy’ to address the health, social care and public health needs of its system. The ICB and local authorities will have to have regard to that plan when making decisions. The strategy must consider how NHS bodies and local authorities could work together to using section 75 of the NHS Act 2006 and the strategy may also state how health-related services could be more closely integrated.

3.19 **Place-based partnerships (PBPs)**

3.20 Place-based partnerships are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in a locality or community. The form of governance for place-based partnerships (PBPs) is for agreement between local health and care leaders and the ICS, building on or complementing existing local arrangements.

3.21 It will be for system partners to determine the footprint for each place-based partnership, the leadership arrangements and what functions it will carry out. Integrated Care Boards will be able to arrange for functions to be exercised and decisions to be made, by or with place-based partnerships, through a range of different arrangements.

3.22 The Integrated Care Board will remain accountable for NHS resources deployed at place-level and should set out the role of place-based leaders within its governance arrangements. Governance and leadership arrangements for place-based partnerships should support safe and effective delivery of the body's functions and responsibilities alongside wider functions of the partnership.

3.23 The governance arrangements of place-based partnerships (PBPs) and their relationship to the board of the ICB should be agreed by the board of the ICB with place leaders. It will be for local partners to determine place-based partnerships membership. Members must include local authorities as well as the local NHS, and member of ICB.

3.24 The Integrated Care Boards will want to agree with local partners the membership and form of governance that place-based partnerships adopt, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards. Governance arrangements will develop over time, with the potential to develop into more formal arrangements as working relationships and trust increases.

3.25 Place-based partnerships are key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health. All systems will establish and support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise.

3.26 The considerations of what is undertaken at system or place should be guided by the principle of subsidiarity, with decisions taken as close to local communities as possible, and at a larger scale where there are demonstrable benefits or where co-ordination across places adds value.

3.27 Place-based partnerships have common understanding of its population, shared vision, local priorities for the delivery of health, social care and public health services in the place. The place vision and local priorities are developed in response to the needs of communities at neighbourhood and place.

3.28 The place-based partnership will need to play a major role in the delivery of national expectations attached to NHS funding, including transformation commitments in the NHS Long Term Plan and funding commitments such as the Mental Health Investment Standard.

3.29 The place-based partnership will integrate and co-ordinate the delivery of health, social care and public health services around the needs of the population, and to empower people who use services. The place-based partnership will engage wider system partners plans to establish population health intelligence and analytical capabilities at-scale, as well as approaches to draw on this insight to support care redesign locally, building on existing expertise across the place and system. Place-based partnerships work with a wide range of community partners to leverage and invest in community assets and support for improved wellbeing.

3.30 To support joint working, place-based partnerships should embed the principle of mutual accountability, where all partners, irrespective of their own formal accountability relationships, consider themselves mutually accountable to each other and to the population and communities they serve, even where not underpinned in formal arrangements. This is important to ensure there is collective ownership of the partnership's vision, priorities, plans and delivery, and the co-operation required to deliver this.

3.31 **Provider collaboratives**

3.32 From April 2022 trusts providing acute and/or mental health services are expected to be part of one or more provider collaboratives. The purpose of provider collaboratives is to better enable their members to work together to continuously improve quality, efficiency and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience across different providers. Provider collaboratives will help facilitate the work of alliances and clinical networks, enabling specialty-level plans and decisions to be made and implemented in a more coordinated and systematic way in the context of whole system objectives.

3.33 **The role of commissioning at Wirral Place Level**

3.34 Strategic commissioning is based on a population health outcomes approach where providers, working collaboratively, start to take a key role in supporting in delivering required outcomes set by commissioners. As part of this overall shift to system working, the focus is moving from traditional input-based 'transactional' commissioning to strategic commissioning models.

3.35 Each 'Place' within an ICS, defined by Local Authority boundaries, will have its own unique set of population health and inequality challenges. Integrated Care System will devolve a range of commissioning roles, activities and functions to local Place-based ICS NHS commissioning teams, integrated with Council commissioning functions, to allow for genuinely joined-up commissioning at Place that is sensitive to local priorities.

3.36 Pending legislative change, NHS Wirral CCG and Wirral Council are continuing to strengthen the Place-based commissioning arrangements that are already well established, working as a partnership called 'Wirral and Health Care Commissioning'

and underpinned by a pooled budget. This is aligned to the work happening at Cheshire and Merseyside ICS, which is focussed on developing a consistent approach to a commissioning model for all nine Places within its geography.

3.37 **NHS and Council Commissioning Integrated Functions**

3.38 NHS Wirral CCG and Wirral Council, including Social Care, Public Health and Children's commissioned services, have already come together since May 2018 into a commissioning partnership known as 'Wirral Health and Care Commissioning' (WHCC), with staff from both organisations working together on a single commissioning strategy for people and for population health outcomes. The purpose of Wirral Health and Care Commissioning is to jointly commission all age health and care service for residents in Wirral which have a positive impact on the life course of an individual. This has meant that local commissioning has reduced duplication, developed a joint decision-making framework and introduced a single planning approach. This is underpinned by an integrated Intelligence Function that guides where services need to be developed at a local level to tackle inequality improve wellbeing and address population health need. It is also supported by an 'expanded' pooled fund arrangement that goes further than the traditional Better Care Fund pool.

3.39 **Population Health Management (including Outcomes Based Commissioning and Tackling Inequalities)**

3.40 The Population Health Management approach at place level is critical in tackling local inequalities, with the design of outcomes being informed by the specific population needs of the Wirral population. This incorporates the wider determinants of health such as Education and Housing and is therefore a critical aspect of integrated commissioning with Wirral Council. Population health management and outcomes-based commissioning are at the centre of an integrated place commissioning function.

3.41 **New Guidance**

3.42 New guidance published on 2nd September 2021 by NHS England and NHS Improvement and the Local Government Association seeks to support all partner organisations in integrated care systems (ICSs) to collectively define their place-based partnership working, and to consider how they will evolve to support the transition to the new statutory ICS arrangements, anticipated from April 2022. It builds upon the expectations already set out in the ICS Design Framework.

3.43 **Thriving Places**

3.44 'Thriving Places' guidance published in September 2021, will support all partner organisations in ICSs to collectively define their place-based partnership working and

to consider how they will evolve to support the transition to the new statutory ICS arrangements. It is published alongside *Delivering together for residents*, prepared by the Society of Local Authority Chief Executives and Senior Managers. This guidance is aimed at all ICS partners and leaders.

3.45 **Building strong integrated care systems everywhere ICS implementation guidance on effective clinical and care professional leadership**

3.46 Building strong integrated care systems everywhere ICS implementation guidance on effective clinical and care professional leadership guidance, published in September 2021 supports the development of distributed clinical and care professional leadership across ICSs and describes what "good" looks like. It is based on extensive engagement involving more than 2,000 clinical and care professional leaders from across the country, led by a multi-professional steering group. This guidance is aimed at all ICS leaders and ICS clinical and care professional leaders.

3.47 **Building strong integrated care systems everywhere ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector**

3.48 Building strong integrated care systems everywhere ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector, published in September 2021, suggests how voluntary, community and social enterprise (VCSE) sector partnerships might be embedded in ICSs, recognising expectations set out in the ICS Design Framework that support close working with the VCSE sector as a strategic partner. This publication is for health and care leaders from all organisations in ICSs who are developing partnerships across local government, health, housing, social care and the VCSE sector.

3.49 **Building strong integrated care systems everywhere ICS implementation guidance on working with people and communities**

3.50 Building strong integrated care systems everywhere ICS implementation guidance on working with people and communities, published in September 2021, sets out expectations and principles for how ICBs can develop approaches to working with people and communities, recognising that the ICS Design Framework sets the expectation that partners in an ICS should agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. The guidance is designed for all ICS partners and ICS leads.

4.0 FINANCIAL IMPLICATIONS

4.1 There are no financial implications impacted by this report. Place-based partnerships will be backed by devolved funding, simplified accountability, and an approach to governance appropriate to local circumstances.

4.2 **Setting budgets for places**

4.3 The ICB will be able to commission jointly with local authorities under a section 75 joint commissioning arrangement, as CCGs can. Each ICS will have an agreed framework for collectively managing and distributing financial resources to address the greatest need and tackle inequalities in line with the NHS system plan, having regard to the strategies of the Partnership and the Health and Wellbeing Board.

4.4 The ICB will have the freedom to set a delegated budget for place-based partnerships to support local financial decisions to spend ICS NHS resources. However, it must adopt the principle of equal access for equal need and the requirements to reduce health inequalities. The ICB should engage local authority partners on the ICS NHS resources for the NHS services to be commissioned at place and support transparency on the spending made at place level. It should explain any variation from previous CCG budgets and enable the shared planning or pooling of NHS and local authority budgets, including stated minimum NHS contributions to Better Care Fund arrangements. Budget allocated to and managed within a place under the agreed schemes of delegation might include:

- primary medical care
- other primary care as delegated/transferred from NHS England and NHS Improvement – dental, pharmaceutical, ophthalmology services
- community services
- community mental health including IAPT
- community diagnostics
- intermediate care
- any services subject to Section 75 agreement with local authority
- any acute or secondary care services that is has been agreed should
- be commissioned at place-level.

5.0 **LEGAL IMPLICATIONS**

5.1 The Health and Care Bill, published in July 2021, sets out how the Government intends to reform the delivery of health services and promote integration between health and care in England. This is the first major piece of primary legislation for health and care in England since the Health and Social Care Act 2012.

5.2 From April 2022 the Integrated Care System will have the statutory accountability for NHS Commissioning and all associated NHS functions previously held within a Clinical Commissioning Group (CCG), but it will aim to discharge many of those functions to Place-Based Partnerships.

5.3 The new legislation will establish an NHS body to be known as the NHS Integrated Care Board (ICB) along with an Integrated Care Partnership (ICP). The ICP is a broad alliance of organisations and representatives concerned with improving the

care, health and wellbeing of the population, jointly convened by local authorities and the NHS.

5.4 The statutory instruments establishing each ICS cannot be made formally until the Bill has been enacted. However, system partners are charged to commence preparations for the expected new arrangements, to commence in April 2022.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 The CCG staff in Wirral are directly affected by the Health and Care Bill. There are staffing implications in relation to developing the integrated commissioning team in Wirral. The Council will work in partnership NHS Wirral CCG to ensure that the new integrated commissioning team is supported throughout the transition from 2021 into April 2021 when the ICB will replace the previous CCG organisations.

7.0 RELEVANT RISKS

7.1 The system changes outlined in this report will have risk management frameworks as part of their implementation.

7.2 The Council will mitigate risks through working closely with partners to gain insight into all areas of risks to enable mitigating actions to be put in place.

8.0 ENGAGEMENT/CONSULTATION

8.1 Integrated Care System Development Advisory Group

8.2 The Cheshire and Merseyside Integrated Care System (ICS) has established a Development Advisory Group (DAG). The Chief Executive and the Director for Adult Care and Health, Wirral Council and the Chief Officer, NHS Wirral CCG are part of the DAG. This enables Wirral, as a place, to be at the heart of shaping the ICS and to ensure that we are in a position to respond at pace and with clarity to the emerging changes. There is also representation from Wirral in other ICS governance arrangements such as the Partnership Board and Joint Committee of Cheshire and Merseyside Clinical Commissioning Groups. The ICS has established a number of workstreams of which the DAG will have oversight. These include commissioning, workforce, system performance and oversight, finance, governance, communications and engagement, quality, transformation, digital and data, and estates.

8.3 CEO Integrated Care Partnership Development Group

8.4 The CEO Integrated Care Partnership Development is attended by Chief Officers from the Wirral Council, NHS Wirral CCG, Wirral Community Health and Care NHS Foundation Trust, Wirral University Teaching Hospital NHS Foundation Trust, and

Cheshire and Wirral Partnership NHS Foundation Trust work together to develop the strategic Integrated Care Partnership at place level.

8.5 **Integrated Care Partnership Delivery Group**

8.6 Senior Officers from Wirral Council, NHS Wirral CCG, Wirral Community Health and Care NHS Foundation Trust, Wirral University Teaching Hospital NHS Foundation Trust, and Cheshire and Wirral Partnership NHS Foundation Trust work together to implement the strategic Integrated Care Partnership at place level. The Group has developed four workstreams to manage the separate components of the ICP including Integrated Commissioning, Governance, Provider Alliance and Communication and Engagement.

8.7 **Integrated Commissioning and Governance Project Board**

8.8 Since May 2021 Senior Officers from the Council and NHS Wirral CCG attend the Integrated Commissioning and Governance Project Board to develop the commissioning and governance arrangements for ICP.

8.9 **Working with people and communities**

8.10 The parties in an ICS, including those of the ICS Partnership, the NHS ICS body and place-based partnerships will be expected to agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services. Arrangements in a system or place should not just provide a mechanism for commentary on services but should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system.

8.11 **Engagement**

8.12 Engagement will need to take place in regard to the system changes outlined in this report. Local engagement is central to determining the views of residents around the implementation of the Long-Term Plan, Healthy Wirral and other system developments. The insight of local people and service users is vital in commissioning the right services to achieve the best outcomes for patients.

8.13 Neighbourhood areas are the fundamental platform for engagement working with residents and providers of each neighbourhood.

9.0 **EQUALITY IMPLICATIONS**

9.1 An Equality Impact Assessment has been completed in May 2021. An Equality Impact Assessment is a tool to help public services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

9.2 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. Plans will be underpinned by local population health and socio-economic intelligence. The Council will work in partnership with local and regional partners to develop place-based partnership arrangements necessary to deliver improved outcomes in population health by tackling health inequality.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 There are no environmental or climate implications as a result of this report.

10.2 Wirral Council is committed to carrying out its work in an environmentally responsible manner, and these principles will guide the development of the Integrated Care Partnership in Wirral.

11.0 COMMUNITY WEALTH IMPLICATIONS

11.1 The case for Community Wealth Building is stronger than ever, with the pandemic having a clear and significant impact on our residents, communities, and businesses. It is vital that everything we do at the Council contributes to the recovery and the development of a resilient and inclusive economy for Wirral.

11.2 The Council takes a people-centred approach to local economic development. Wirral's Place-based integrated care partnership will improve outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities.

11.3 Community Wealth Building in Wirral focusses on partnerships and collaboration, both within the Council and with external partners and stakeholders, including residents. The Council will work together with partners and residents to develop the place-based partnership arrangements in Wirral that meet the needs of the population, with a focus on reducing health inequalities.

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APPENDICES

There are no additional appendices attached to this report.

BACKGROUND PAPERS

- NHS Five Year Forward View (2014), https://www.england.nhs.uk/five-year-forward-view/
- NHS Planning Guidance (2017), https://www.england.nhs.uk/publication/delivering-the-forward-view-nhs-planning-guidance-201617-202021/
- NHS Long Term Plan (2019), https://www.longtermplan.nhs.uk/
- Designing Integrated Care Systems (ICSs) in England (2019), https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf
- Integrating Care: Next steps to building strong and effective integrated care systems across England (2020), https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf
- *Integration and Innovation: working together to improve health and social care for all*, White Paper (2021), https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all.
- *Legislating for Integrated Care Systems: five recommendations to Government and Parliament* (2021), https://www.england.nhs.uk/publication/legislating-for-integrated-care-systems-five-recommendations-to-government-and-parliament/
- NHS Planning Guidance (2021), https://www.england.nhs.uk/operational-planning-and-contracting/
- The Queen's Speech 2021 – Background Briefing Notes, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/985029/Queen_s_Speech_2021_-_Background_Briefing_Notes..pdf
- *Integrated Care Systems: Design Framework* and *Guidance on the Employment Commitment* (2021), https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/
- NHS People Plan 2020/2021, https://www.england.nhs.uk/ournhspeople/
- Thriving Places - September 2021 – Found at Thriving Places: guidance on the development of place-based partnerships as part of statutory integrated care systems
- Building strong integrated care systems everywhere ICS implementation guidance on effective clinical and care professional leadership - September 2021 - Found at Building strong integrated care systems everywhere: ICS implementation guidance on effective clinical and care professional leadership

- Building strong integrated care systems everywhere ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector- September 2021 - Found at Building strong integrated care systems everywhere: ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector

- Health and Care Bill (2021) https://bills.parliament.uk/bills/3022

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Previous reports presented to Health and Wellbeing Board: • Health & Wellbeing Board Refreshed Purpose Integrated Care System Project Update • Integrated Care System and Integrated Care Partnership Developments	 31st March 2021 16th June 2021 20th July 2021
Previous reports presented to Adult Social Care and Public Health Committee: • Strategic Developments in the NHS • Proposals for Integrated Care Partnership • Integrated Care System and Integrated Care Partnership Developments	 2nd March 2021 7th June 2021 29th July 2021
Previous reports presented to Partnerships Committee • Strategic Developments in the NHS • Strategic Developments in the NHS • Strategic Developments in the NHS • Integrated Care System and Integrated Care Partnership Developments	 9th November 2020 13th January 2021 29th June 2021 28th September 2021

WIRRAL

HEALTH AND WELLBEING BOARD

29 SEPTEMBER 2021

REPORT TITLE:	**POOLED FUND ARRANGEMENTS (S75)**
REPORT OF:	**DIRECTOR OF CARE AND HEALTH**

REPORT SUMMARY

The report requests the Health and Wellbeing Board note the proposal in relation to which a decision will be made by the Adult Social Care and Public Health Committee to continue the pooled fund arrangement and s75 Agreement between the Council and Wirral Clinical Commissioning Group (CCG) for 2021/22.
The report describes the proposed arrangements, key principles, content, and value of the 2021/2022 Section 75 and sets out the additional funding that the CCG will contribute to the pool. The additional funding has been excluded from the risk share arrangements and does not pose a risk to the Council. Public Health contracts are not included in these arrangements.

RECOMMENDATION/S

The Health and Wellbeing Board is recommended to:

1. Note the proposal in relation to which a decision will be made by the Adult Social Care and Public Health Committee to continue the pooled fund arrangement and s75 Agreement between the Council and Wirral Clinical Commissioning Group (CCG) for 2021/22.
2. Note the commissioning pool value of £235m for 2021/22 and the additional funding the CCG will contribute as detailed in Appendix 1 to the report.
3. Note the proposal that the key principles as set out in the pooled fund agreement 2020/2021 be incorporated into the pooled fund agreement 2021/22, including the risk share agreement.
4. Note that the shared risk arrangements are limited to the Better Care Fund (BCF) arrangements only, which is currently reporting a break-even position.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 A section 75 pooled fund agreement must be updated to set out the detail of budget areas that are being pooled in 2021/22 and the associated governance. There is a mandatory legal requirement to have a Section 75 agreement in place to draw down the elements of the pool relating to the BCF. Continuing the current pooled fund

arrangements, including the increased contribution from the CCG, does not increase the financial risk to the Council.

2.0 OTHER OPTIONS CONSIDERED

2.1 The pooled fund arrangements for 2020/21 have delivered benefits to individuals, helped avoid longer term, more intensive care and support needs and have therefore mitigated against broader health and care system risk. It is therefore recommended to continue with the pooled fund arrangement for 2021/22, including the increased contribution from the CCG, and to exit the arrangement is not recommended.

2.2 Broadening the scope of the pooled fund arrangement further to include all NHS Wirral Clinical Commissioning Group (CCG) and Wirral Council social care and health spending could potentially increase risk significantly due to ongoing pressure in the health system, a risk further escalated by the system response to the Covid-19 pandemic. The extension of the scope to include the additional CCG funding only will not expose the Council to increased financial risk and it is therefore recommended that the scope is increased to reflect this.

3.0 BACKGROUND INFORMATION

3.1 The pooled fund arrangements are well established in Wirral and enable a range of responsive services to vulnerable Wirral residents as well as a significant component of BCF funding to protect frontline social care delivery. As we move towards Integrated Care Systems, the importance of pooled budgets as an enabler of commissioner integration is understood from both National Policy and local operational perspectives.

3.2 Healthy Wirral remains the key programme for the delivery of health and care outcomes in Wirral. The pooled fund and integrated commissioning and service delivery arrangements enable a focus on the best outcomes for people.

The following key features of integration have been outlined as essential to success:

- Pooling resources, intelligence, and planning capacity.
- Delivering the Right Care in the Right Place at the Right Time.
- Managing demand and reducing the cost of care.
- Clear accountability and governance arrangements.
- Resilience and flexibility to emerging issues in service delivery.
- Enabling people to live well in their communities.

3.3 The Joint Health Care Commissioning Executive Group (JHCCEG) continues to oversee and monitor the effective use of pooled fund resources and will report into member committees and boards as required.

- Ensures effective day to day management of the pooled funds under the Section 75.
- Maintains an overview of the use of the pooled fund and service delivery.
- Reports on performance of the pooled fund to various committees and boards.
- Is accountable for the delivery of objectives to the partners of the pooled fund.

3.4 The effectiveness of Better Care Fund (BCF) schemes is currently being reviewed under

the stewardship of the Living Well in Our Community Board. The financial distribution of the pool as set out in section 4 of this report may therefore need to be amended to reflect changes in BCF allocation, alongside inflationary pressures. The BCF is currently reporting a break-even position.

3.5 Individually commissioned Public Health funded contracts were removed from the pooled fund arrangement for 2020/21. Public Health funding is ringfenced, with contracts commissioned at fixed costs, and protected from the risk share agreement within the pool. It was agreed that there was little value in retaining these within the pooled fund arrangements and to continue to fund these services outside of the pool, whilst continuing to maximise independence and tackle health inequalities.

4.0 FINANCIAL IMPLICATIONS

4.1 Note the commissioning pool value of £235m ant the requirement to seek retrospective approval of the 2020/21 commissioning pool value of £131.5m as detailed in Appendix 1.

5.0 LEGAL IMPLICATIONS

5.1 A section 75 agreement for the pooled fund is the contractual agreement which sets out the terms of the arrangement. Such an agreement is required to draw down resources under the BCF and to enable the pooling of wider funding elements which are in the scope of the arrangement. Each year, legal services are fully engaged in the development of the Section 75 agreement.

5.2 The Section 75 pooled fund agreement for 2021/22 will reflect the withdrawal of Public Health funded services and the increased contribution as described above.

6.0 RESOURCE IMPLICATIONS: ICT, STAFFING AND ASSETS

6.1 There are no new resource implications because of this proposal, as it is a continuation of current arrangements.

7.0 RELEVANT RISKS

7.1 The extension of the scope to include the additional CCG funding only will not expose the Council to increased financial risk and it is therefore recommended that the scope is increased to reflect this. The current risk share arrangements remain the same.

8.0 ENGAGEMENT/CONSULTATION

8.1 A range of engagement and consultation processes related to the integration of services and commissioning functions have been undertaken in previous years. There is no requirement for further consultation to continue with arrangements as proposed.

9.0 EQUALITY IMPLICATIONS

9.1 There are no equality implications from this report. However any associated actions may need an Equality Impact Assessment.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 There are no climate or environmental implications associated with this proposal.

11.0 COMMUNITY WEALTH IMPLICATIONS

11.1 There are no community wealth implications associated with this proposal.

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APPENDICES
Appendix 1 - Pooled Fund 2021/22
Appendix 2 - BCF Allocation 2021/22

BACKGROUND PAPERS
Section 75 agreement.

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Cabinet	27/07/20
Adult Care and Health Overview and Scrutiny Committee	21/01/20
Pooled Fund Scrutiny Workshop	30/10/19
JSCB - Approval of Pooled Fund arrangements for 2019/20	05/02/19
Adult Care and Health Overview and Scrutiny Committee	29/01/19
Wirral Council debated the Section 75 Pooled Budget arrangements in response to a scrutiny call, the arrangements were supported by a majority vote	10/12/18
Adult Care and Health Overview and Scrutiny Committee (Wirral Health and Care Pooled Fund Arrangements)	27/11/18
Integrated Social Care Transfer	12/09/18
Health and Care Integration	30/01/18

Better Care Fund - 2-Year Plan	13/09/17
All Age Disability and Mental Health Service (Joint with Children's scrutiny).	02/08/17
Key Issues for Health and Care	28/06/17

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Section 75
Appendix 1 - Financial Contributions of Partners

Organisation	Commissioner	Sub Category		2021-22 Budget
Wirral Council	Adult Social Care	INCOME		
		Client Charges	(£3,561,600)	
		Joint-Funded Income	(£7,938,900)	
				(£11,500,500)
		EXPENDITURE		
		Learning Disabilities	£46,164,600	
		Mental Health	£13,834,200	
		Children with Disabilities	£1,102,200	
				£61,101,000
	Total Adult Social Care			**£49,600,500**
	Children & Young People	Children's Social Care	£1,700,000	
	Total Children & Young People			£1,700,000
Total Wirral Council				**£51,300,500**
Clinical Commissioning Group	CCG	CHC	£58,603,582	
		Prescribing	£66,400,000	
		Primary Care	£10,200,000	
		Efficiency	(£7,000,000)	

	Total CCG			£128,203,582	
Total Clinical Commissioning Group					**£128,203,582**
TOTAL NON BCF					**£179,504,082**
Better Care Fund	BCF	Integrated Services	£23,014,040		
		Adult Social Care Services	£23,405,969		
		CCG Services	£1,957,944		
		DFG	£4,723,627		
		Innovation Fund	£452,000		
		Known Pressures & Contingency	£1,942,377		
	Total BCF			£55,495,957	
TOTAL BETTER CARE FUND					**£55,495,957**
GRAND TOTAL					**£235,000,039**

App 2 - Figures for Schedule 6 - BCF Plan

BCF Scheme Types	BCF Scheme Title	Commissioner	Annual Budget
Assistive Technologies and Equipment	Tele-triage recurrent costs	ASC	278
	Wirral Independence Service	ASC	3,985
Assistive Technologies and Equipment Total			4,263
Care Act Implementation Related Duties	Care & Support Bill	ASC	497
Care Act Related Duties Total			497
Carers Service	Carers Service	ASC	740
Carers Service Total			740
Community Based Schemes	CCG Third Sector	CCG	485
	Existing Schemes	CCG	4,909
	Protection of Social Care	ASC	18,342
Community Based Schemes Total			23,737
DFG Related Schemes	DFG	ASC	4,724
DFG Related Schemes Total			4,724

Enablers for Integration	Communication & Engagement Lead Role	CCG	5
	Whole System Modelling /Capacity Demand Modelling	ASC	40
Enablers for Integration Total			45
HICM for Managing Transfers of Care	Acute Visiting Service (AVS)	CCG	645
	Increased Capacity of Brokerage Team	ASC	27
	Care Homes Scheme - Nurse	CCG	47
	Clinical Streaming at Front Door	CCG	150
	D2A Nurse South Cheshire	CCG	22
	Trusted Assessor - Care Homes	ASC	100
	Ward Discharge Coordinators	ASC	165
HICM for Managing Transfers of Care Total			1,156
Home Care or Domiciliary Care	Dom Care (stabilising the market - 15 min & 7 day retainer)	ASC	412
	Mobile Night Service	ASC	800
	Reablement - Commissioned Care	ASC	1,231
	Winter Funding - Supporting Dom Care	ASC	1,800
Home Care or Domiciliary Care Total			4,244
Housing Related Schemes	Homeless Service (BAME)	CCG	93
Housing Related Schemes Total			93
Integrated Care Planning and Navigation	Community Offer (ASC)	ASC	3,972
	Community Offer (CCG)	CCG	854
	Complex Needs Service	CCG	250

	Crisis Response	CCG	151
	Dementia LES	CCG	71
	Dementia Nurse	CCG	75
	Early onset Dementia	CCG	146
	Joint Posts - Mental Health	ASC	475
	Street triage	CCG	152
Integrated Care Planning and Navigation Total			6,146
Intermediate Care Services	Home First - MDT (Enhanced Rapid Response Service)	CCG	952
	IV Antibiotics	CCG	627
	Transfer to Assess - Primary Care & Therapies	CCG	1,073
	Transfer to Assess T2a Beds	ASC	3,841
Intermediate Care Services Total			6,494
Other	Comms - Home First	CCG	3
	Mental Health detention transport	CCG	70
	Mobilisation Officer	ASC	0
	21/22 Increase - minimum CCG allocation	CCG	1,515
	Winter Planning	ASC	226
Other Total			1,814
Personalised Budgeting and Commissioning	Complex/Specialist Commissioning Support	CCG	200
	Home To Assess (D2A)	ASC	143
Personalised Budgeting and Commissioning Total			343
Prevention / Early Intervention	Early Intervention & Prevention (Going Home Scheme £69K CCG 20/21)	ASC	1,199

Prevention / Early Intervention Total	1,199
Grand Total	**55,495**

WIRRAL

HEALTH AND WELLBEING BOARD

WEDNESDAY 29 SEPTEMBER 2021

REPORT TITLE:	**HEALTH AND WELLBEING BOARD WORK PROGRAMME**
REPORT OF:	**DIRECTOR OF LAW & GOVERNANCE**

REPORT SUMMARY

The report provides the Health and Wellbeing Board with its current work programme and affords the Board the opportunity to propose additional items for consideration at future meetings.

It is envisaged that the work programme will be formed from a combination of standing items, requested officer reports and items for consideration from partners. This report provides the Board with an opportunity to plan and regularly review its work across the municipal year. The work programme for the Health and Wellbeing Board is attached as Appendix 1 to this report.

RECOMMENDATION

The Health and Wellbeing Board is recommended to:

(1) note and comment on the proposed Health and Wellbeing Board work programme for the of the 2021/22 municipal year.

(2) suggest further items to be included on the work programme for consideration at future meetings.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 To ensure Members of the Health and Wellbeing Board have the opportunity to contribute to the delivery of the annual work programme.

2.0 OTHER OPTIONS CONSIDERED

2.1 A number of workplan formats were explored, with the current framework open to amendment to match the requirements of the Board.

3.0 BACKGROUND INFORMATION

3.1 3.1 The work programme should align with the priorities of the Council and its partners. The programme will be informed by:

- The Council Plan
- The Council's transformation programme
- Service performance information
- Risk management information
- Public or service user feedback
- Referrals from partner organisations
- Referrals from other Committees

Terms of Reference

The principal role of the Health and Wellbeing Board is to discharge functions pursuant to sections 195 and 196 of the Health and Social Care Act 2012. The Health and Wellbeing Board will not be responsible for directly commissioning services, but will provide oversight, strategic direction and coordination of the following activities:

a) To develop a shared understanding of the needs of the local community through the development of an agreed Joint Strategic Needs Assessment
b) To seek to meet those needs through leading on the ongoing development of a Health & Wellbeing Strategy
c) To provide a local governance structure for local planning and accountability of health and wellbeing related outcomes
d) To work with HealthWatch in Wirral to ensure appropriate engagement and involvement within existing patient and service user involvement groups takes place
e) To drive a collaborative approach to commissioning of improved health and care services which improve the health and wellbeing of local people
f) To consider and take advantage of opportunities to more closely integrate health and social care services in commissioning and provision

g) To review the financial and organisational implications of joint and integrated working across health and social care services, ensuring that performance and quality standards of health and social care services are met, and represent value for money across the whole system
h) To establish a key forum for local democratic accountability relating to commissioning against agreed health outcomes
i) To develop and update the Pharmaceutical Needs Assessment (PNA)
j) To ensure the Better Care Fund plan is monitored regarding its progress and performance and ensure the health and social care partners effectively plan regarding the implications of this work.

4.0 FINANCIAL IMPLICATIONS

4.1 This report is for information and planning purposes only, therefore there are no direct financial implication arising. However, there may be financial implications arising as a result of work programme items.

5.0 LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from this report. However, there may be legal implications arising as a result of work programme items.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There are no direct implications to Staffing, ICT or Assets.

7.0 RELEVANT RISKS

7.1 The Board's ability to undertake its responsibility may be compromised if it does not have the opportunity to plan and regularly review its work across the municipal year.

8.0 ENGAGEMENT/CONSULTATION

8.1 Not applicable.

9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

This report is for information to Members and there are no direct equality implications.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 This report is for information to Members and there are no direct environment and climate implications.

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APPENDICES

Appendix 1: Health and Wellbeing Board Work Programme

BACKGROUND PAPERS
Wirral Council Constitution
The Health and Social Care Act 2012

SUBJECT HISTORY (last 3 years)

Council Meeting	Date

Health and Wellbeing Board Work Programme

Report	Lead Officer	Approximate timescale
Tackling Health Inequalities through Physical and Social Regeneration	Rachael Musgrave	3 November 2021
Regeneration Agenda	Alan Evans/Rachael Musgrave	3 November 2021
Community Safety Strategy 2021-26	Mark Camborne	3 November 2021
Wirral Pharmaceutical Needs Assessment 2022-2025 First Draft	John Highton	23 March 2022

FUTURE ITEMS TO BE SCHEDULED

Item	Lead Officer
Restoration and Development of NHS Services after Covid-19	Paula Cowan/Simon Banks
Leisure Strategy	Nicki Butterworth
CWP Community Services	Dr Faouzi Alam
ADDER	Julie Webster
CHAMPS	Julie Webster
2019/20 Council Lifelong Learning Service Adult Education Delivery	Simone White

STANDING ITEMS AND MONITORING REPORTS

Item	Reporting Frequency	Lead Officer
Healthwatch	Quarterly	Karen Prior

WORK PROGRAMME ACTIVITIES OUTSIDE COMMITTEE

Report	Lead Officer	Timescale
Community, Voluntary and Faith Sector Working Group	Nikki Jones/Rachael Musgrave	Ongoing
Community, Voluntary and Faith Sector Reference Group	Rachael Musgrave	Ongoing

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