8th November 2022
15:00pm – 17:00pm
Seqirus Room, Partnership For Learning, South Street,
Liverpool, L24 9PZ

NHS
Cheshire and Merseyside

Meeting of the Health and Care Partnership
Agenda
Chair: Dr Raj Jain

** Please note refreshments will be available from 2.30 onwards to allow opportunity for networking and introductions in advance of the meeting*

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PACK PAGE NUMBER
15:00pm	**Preliminary Business**			
HCP/11/22/01	Welcome Introductions and Apologies	RJ	Verbal	
HCP/11/22/02	Declarations of Interest *(HCP members are asked to declare if there are any declarations in relation to the agenda items)*	RJ	Verbal	
15:10pm	**Business Items**			
HCP/11/22/03 15:10 – 15:15	Appointment of Chair & process for appointment of Joint Vice Chair	RJ	Verbal Approval	
HCP/11/22/04 15:15 – 15:30	The influence and opportunities of the ICP	LG	For Discussion	
HCP/11/22/05 15:30 – 15:40	Health and Care Partnership Terms of Reference	LG	Paper Approval	3
HCP/11/22/06 15:40 – 4:00	Marmott – Progress	IA/MJ	Paper For noting	11
HCP/11/22/07 4:00 – 4:30	Cost of Living & Fuel Poverty -facilitated discussion	AL/IA	Presentation For Discussion	27
HCP/11/22/08 4:30 – 4:45	ICP Strategy Update	NE	Paper For noting	39
HCP/11/22/09 4:45 – 4:55	Review of Meeting	LG	For Discussion	
17:00pm	**Close of Meeting**			

Dates of future meetings:

Date	Time	Venue
22 December 2022 – (single agenda item – approval of ICP strategy)	4:00 – 5:00	MS Teams
17 January 2023	3:00 – 5:00	The Portal, Ellesmere Port Room G2 and 3.
7 March 2023	3:00 – 5:00	Regatta Place ? Change if now Lewis's building
9 May 2023	3:00 – 5:00	The Portal, Ellesmere Port Room G2 and 3.
18 July 2023	3:00 – 5:00	Regatta Place? Change if now Lewis's building
19 September 2023	3:00 – 5:00	The Portal, Ellesmere Port Room G2 and 3.
14 November 2023	3:00 – 5:00	Regatta Place? Change if now Lewis's building

Apologies –
Cath Murray- Howard, Paul Warburton attending on behalf
Daren Mochrie – Salman Desai attending on behalf

NHS
Cheshire and Merseyside

Cheshire and Merseyside Health Care Partnership (HCP)

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
19 October 2022	0.1	Initial ToR		Natalie Robinson

Review due
November 2023

1. Introduction

1.1 The engagement document: Integrated Care System Implementation[1] produced by the Department of Health and Social Care and NHS England set the role of the Integrated Care Partnership (ICP) as:

"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 as equal partners in order to facilitate joint action to improve health and care outcomes and experiences, influence the wider determinants of health, and plan and deliver improved integrated health and care."

1.2 An ICP is a statutory committee which is formed between an NHS Integrated Care Board and all upper-tier local authorities that fall within the same Integrated Care System (ICS) area. The ICP will play a critical role within the ICS with the intent to bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally.

1.3 Cheshire and Merseyside (C&M) has an established Health and Care Partnership, which has been in place since 2020 and is the committee from which the C&M ICS's ICP will develop from. It has been proposed that the new ICP will be known as / referred to as the Cheshire and Merseyside Health and Care Partnership (HCP) because this is a trusted and well-respected brand with partners and stakeholders.

1.4 The HCP is where partners in the ICS will come together to develop the C&M Integrated Care Partnership Strategy and strategic priorities, in response to the evidence, and agree what we want to do differently to serve our populations.

1.5 The work of the HCP does not duplicate the work of the nine Cheshire and Merseyside Health and Wellbeing Boards but should work in conjunction where appropriate to help achieve common objectives and aims to benefit the population.

1.6 These terms of reference set out the membership, remit, responsibilities, and reporting arrangements of the joint committee.

2. Role and Purpose

2.1 The primary purpose of the HCP will be to act in the best interests of people, patients, and the system as a whole, rather than representing individual interests of any one constituent partner.

2.2 The HCP will develop strong relationships and a collaborative culture across all partners, with representation from across the health and care system with membership including representatives from both statutory / non-statutory partners and individual organisations.

2.3 The HCP will be governed by a set of principles and ways of working which are based on a combination of what has been deemed important by local stakeholders together with national expectations.

2.4 The HCP will:

- Involve local organisations and people in preparing its Integrated Care Partnership Strategy that sets out how the assessed needs in relation to its area are to be met by the exercise of functions of the ICB, NHS England and Local Authorities. The HCP will ensure that best available evidence and data is used to inform the development of the Integrated Care Partnership Strategy through

[1] https://www.england.nhs.uk/publication/integrated-care-systems-guidance/

drawing upon the joint strategic needs assessments and other sources of rich data, insight and intelligence, with support of public health teams to ensure robust application of evidence to work programme design.

- Oversee the work on integration between the NHS and Social Care (including conversations about shared budgets / BCF; and NHS / Public Health), driving a shift of resources into prevention.

- Work with a broad range of partners including those on the frontline, to develop a clear view on the contribution of the Health and Social Care system into prevention and the wider determinants of health, including our collective "anchor" approach, and help in the development and delivery of the local framework for addressing inequalities. The HCP provides opportunity for a system level forum to support and enhance work programmes to improve population health outcomes and reduce health inequalities by addressing complex, long term issues that require a system level integrated approach across stakeholders.

- Support the work of the nine Cheshire and Merseyside Health and Wellbeing Boards (HWBBs) and have due regard to and respond to their Health and Wellbeing Strategies and Joint Strategic Needs Assessments. The HCP provides opportunity for a system level forum where work undertaken by individual Health and Wellbeing Boards can be shared in the spirit of collective learning, economies of scale and to the benefit of the local people

- Enable, encourage and support partners, places and collaboratives to improve and innovate, including advocating for new approaches and transformational ways of working, improving population health outcomes and reduce health inequalities at Place by addressing complex, long term issues that require a system level integrated approach across stakeholders.

- Provide a forum to build on the joint positive working between the NHS, Local Authorities and other partners that was demonstrated during the COVID-19 pandemic period

2.5 The HCP will play an important role to enable system partners to deliver on the following statutory duties:

- *Duty to commission certain specified health services*
- *Duty as to reducing inequalities*
- *Duty as to patient choice*
- *Duty to exercise functions effectively, efficiently, and economically*
- *Duty to obtain appropriate advice*
- *Duty to promote innovation*
- *Duty in respect of research*
- *Duty to promote integration*
- *Duty as to public involvement and consultation (in accordance with ICB direction and potential Place implementation) Duties as to climate change*
- *Duty to have regard to the wider effect of its decisions in relation to—*
  (a) the health and well-being of the people of England;
  (b) the quality of services provided to individuals—
  (i) by relevant bodies, or
  (ii) in pursuance of arrangements made by relevant bodies, for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England;
  (c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

3. Authority

3.1 The HCP is a Statutory Joint Committee, convened under the 2022 Health & Care Act. It operates on a partnership and collaborative basis. Each of the constituent statutory partner members organisations remains responsible for discharging their sovereign statutory duties.

3.2 However, the HCP is able to make decisions on matters within its statutory remit (e.g. agreeing system priorities to steer Place-based planning and delivery which achieve the aims of the Integrated Care Strategy). The intention is that it will be responsible for holding partnership discussions to help achieve the stated role and purpose as outlined within Section 2.

3.3 Members commit to working collaboratively; openly and supporting the development and role of the HCP. Subject to the limitations, each partner organisation is expected to support any decisions made by the HCP.

3.4 The HCP is authorised to create any relevant sub-groups in order to take forward specific programmes of work considered necessary by the membership.

4. Membership & Attendance

4.1 Members

4.1.1 Members are selected to be representatives of constituent partners and attend HCP meetings to promote the greater collective endeavour. Therefore, members are expected to make effective two-way connections between the Cheshire and Merseyside HCP and constituent organisations, adopting a partnership approach to working together, as well as listening to the voices of citizens, patients and the public we serve.

4.1.2 It is expected that members will prioritise these meetings and make themselves available; where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this group. For Local Authority (LA) representatives this will be in accordance with the due political process.

4.1.3 Representative Members will be asked to make connections between the HCP and the sector in which they are representing. The core focus of this role is not to champion the interests of any single organisation.

4.1.4 The meetings will be Chaired by a nominated Local Authority Political Leader, with two Joint Vice Chairs, one being the Cheshire and Merseyside ICB Chair and the other being an appointed representative of the VCSE sector.

4.1.5 **The proposed core membership of the HCP (statutory committee) is:**

ICP Chair	Local Authority Political Leader
ICP Vice Chair (2)	NHS Cheshire and Merseyside ICB Chair Voluntary Sector Representative
ICB	Chief Executive Executive Medical Director, NHS Cheshire and Merseyside Assistant Chief Executive Director of Finance
Local Authority Partners	Political Representation x 9 (including ICP Chair) Executive x 2 Directors of Public Health x 2
Northwest Ambulance Service	
Police	X 2 (Cheshire Police, Merseyside Police)
Fire and Rescue	X 2 (Cheshire, Merseyside)
Voluntary, Community and Faith Sector	X 2 (Cheshire & Warrington, Merseyside)
Local Enterprise Partnership	X 2 (Cheshire, Merseyside)
Primary Care	X2
Provider Collaborative	X2 (CMAST, MHLDSC)
Carers	
Housing	
Healthwatch	X2
Higher Education/University	X2
Social Care Provider	

The HCP may also request attendance by appropriate individuals to present agenda items and/or advise the HCP on particular issues.

4.2 Attendees

4.2.1 Only members of the HCP have the right to attend HCP meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the HCP.

4.2.2 Meetings of the HCP may also be attended by the following individuals who are not members of the HCP for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5. Meetings

5.1 Quorum

The meeting will be quorate when 50% of members are present. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken. If any member of the HCP has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

5.2 Decision-making and voting

5.2.1 The HCP will usually make decisions by consensus. Where this is not possible, the Chair may call a vote.

5.2.2 Only voting members, as identified in the "Membership" section of these terms of reference, may cast a vote.

5.2.3 A person attending a meeting as a representative of a HCP member shall have the same right to vote as the HCP member they are representing.

5.2.4 In accordance with paragraph 6, no member (or representative) with a conflict of interest in an item of business will be allowed to vote on that item.

5.2.5 Where there is a split vote, with no clear majority, the Chair will have the casting vote.

5.3 Frequency of meetings

5.3.1 The HCP will meet in public.

5.3.2 The HCP will meet up to six times each year. Additional meetings may take place as required.

5.3.3 The HCP Chair, in consultation with and with the support of both Vice Chairs, may ask the HCP to convene further meetings to discuss particular issues on which they want advice.

5.3.4 The HCP may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.4 Reporting and Accountability

There will be no formal line of accountability between the HCP and the Cheshire and Merseyside ICB.

The ICP will receive reports from the Cheshire and Merseyside statutory HWBBs, which will inform its own priorities and strategy; and the HCP may also provide reports to the HWBBs on matters concerning delivery of ICS priorities and outcomes framework.

The ICP will also provide reports to the ICB, providing a summary of any deep dive work undertaken, including the issues considered and recommended actions, and any key outputs (in particular the Integrated Care Partnership Strategy) from its meetings.

5.5 Administrative Support

The HCP shall be supported with a secretariat function. Which will ensure that:

- the agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- the Chair is supported to prepare and deliver reports for onward reporting.
- the HCP is updated on pertinent issues/ areas of interest/ policy developments; and
- action points are taken forward between meetings.

6. Behaviours and Conduct

6.1 The HCP shall conduct its business in accordance with any national guidance. The seven Nolan principles of public life shall underpin the committee and its members.

6.2 HCP members should:

- Inform the chair of any interests they hold which relate to the business of the HCP.
- Inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- Abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the HCP.
- Inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- Declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- Abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

6.3 As well as complying with requirements around declaring and managing potential conflicts of interest, HCP members should:

- Attend meetings, having read all papers beforehand
- Arrange an appropriate deputy to attend on their behalf, if necessary
- Act as 'champions', disseminating information and good practice as appropriate
- Comply with the HCP' administrative arrangements to support the HCP around identifying agenda items for discussion, the submission of reports etc.
- Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

7. Review

7.1 The HCP will review its effectiveness at least annually

7.2 These terms of reference will be reviewed at least annually and earlier if required.

All Together Fairer

Update on our Marmot Programme

8th November 2022

Working together to improve health and wellbeing in Cheshire and Merseyside

Background

- In September 2019, health and care leaders from across Cheshire and Merseyside agreed that the sub-region would become what's known as a Marmot Community.
- in July 2021 more than 280 partners came together to discuss health inequalities and kick-start the sub-region's journey to become a Marmot Community.
- Nine place-based workshops, one for each borough in Cheshire and Merseyside, were held in November and December 2021 for local areas to advise and input into the programme and shape final recommendations.
- 'All Together Fairer: Health Equity and the Social Determinants of Health in Cheshire and Merseyside' was published and successfully launched in a high profile event in May 2022.
- The All Together Fairer programme deliberately and specifically focuses on the social determinants of health - the social, economic and environmental conditions in which people are born, grow, live, work and age.
- Shifting to a social determinants of health approach means taking action in the drivers of ill health as well as treating ill health when it is presented in healthcare settings recognising that it is almost impossible to live healthily when in poverty.

INSTITUTE of HEALTH EQUITY

All Together Fairer

Professor Michael Marmot

@MichaelMarmot

www.instituteofhealthequity.org

Champs | Public Health Collaborative (champspublichealth.com)

May 2022

Working together to improve health and wellbeing in Cheshire and Merseyside

The Themes

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention
7. Tackle racism, discrimination and their outcomes*
8. Pursue environmental sustainability and health equity together*

System change recommendations

1. Increase and make equitable funding for social determinants of health and prevention
2. Strengthen partnership for health equity
3. Create stronger leadership and workforce for health equity
4. Co-create interventions and actions with communities
5. Strengthen the role of business and the economic sector in reducing health inequalities
6. Extend social value and anchor organisations across the NHS, public service and local authorities
7. Develop social determinants of health in all policies and implement Marmot Beacon Indicators.

Implementing the recommendations

- The IHE All Together Fairer Report is **extensive and comprehensive**. It is **ground-breaking** in setting the agenda on health inequalities for Cheshire and Merseyside.
- A key point in all the IHE reports is that **action is required across all the recommended areas**. There is no one thing that will reduce inequality in health; health equity in all policies is the key.
- Important we make this extensive programme feel doable and not impossible, accessible and not overwhelming and **enabling of action.**
- We will seek to embed the recommendations in the **ICP 5 Year Strategy** and **local Place Plans**

Three key initial priorities – for system wide focus

1. **Healthy work** – Extending the work to date on a **Fair Employment Charter** to include the whole of Cheshire and Merseyside and focus initially on the public sector as a significant employer.
2. **Anchor institutions** – Extend the work to date on the NHS in Cheshire and Merseyside as Anchor Institutions and link into other public sector organisations as place anchors.
3. **Mental wellbeing** – With a focus on the mental wellbeing of children and young people.

NHS Prevention Pledge - To support adoption of the Pledge by NHS Trusts, embedding prevention of ill health in core service delivery and environments.

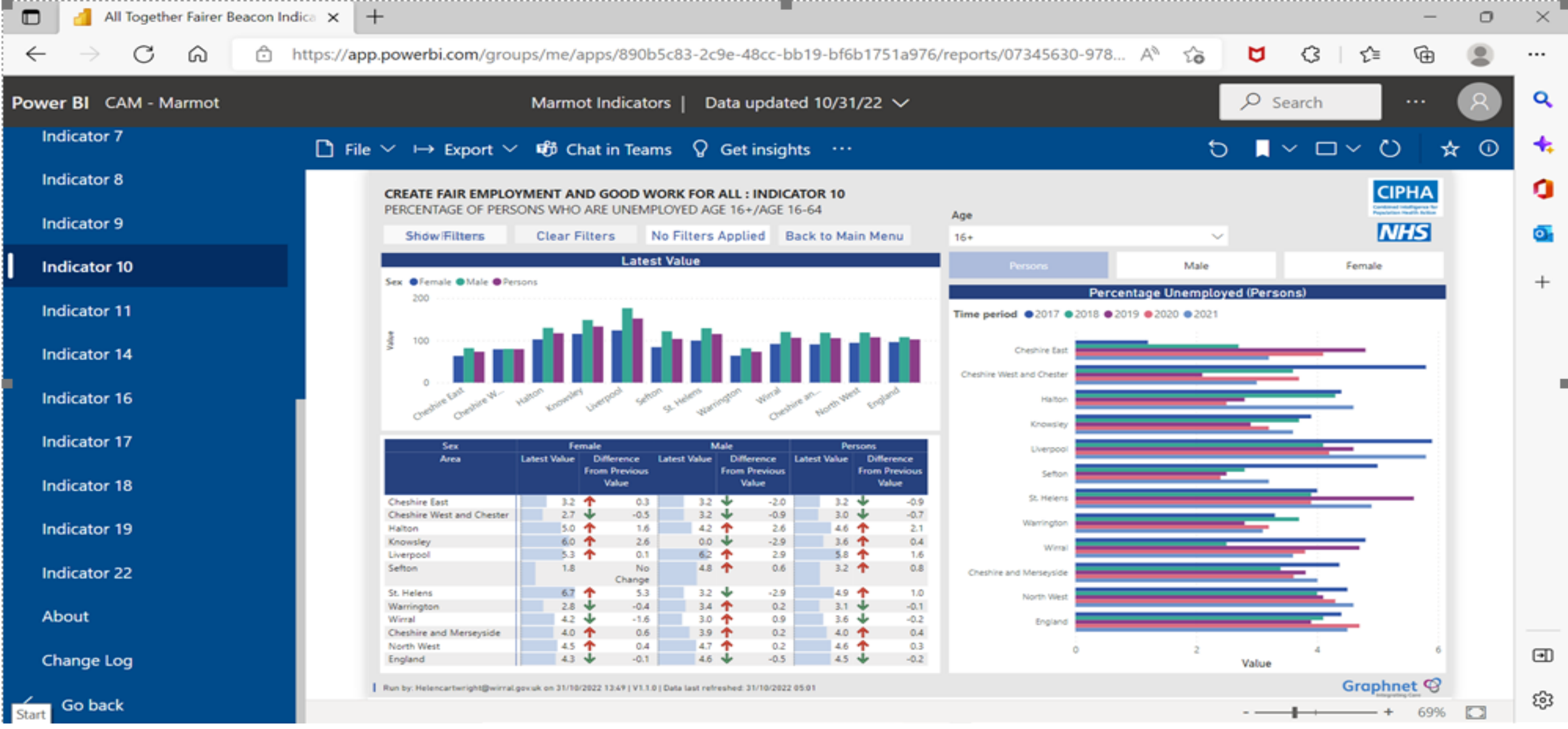
- 14 core commitments on cross-cutting prevention themes
- Working across three cohorts, now encompassing all provider trusts across C&M; 8 trusts from Phase 1 and Phase 2 cohorts have formally adopted the Pledge to date.
- Aligned to ATF programme and wider population health programmes and is one of the key principles for trusts applying for C&M Anchor Institution Charter
- Agreement from all Phase 3 trusts to start Pledge adoption.
- Community of practice meeting for Phase 1 & 2 Trusts
  - Updates from Phase 1 and Phase 2 trusts on progress towards chosen Pledge commitments and priority actions
  - Special focus on activity within trusts towards Commitment 8 (workforce development)

Place based All Together Fairer (ATF) programmes

- Place based borough level ATF programmes are essential to link with other elements of local government activity and to complement the C&M level work.
- All boroughs and partners have engaged locally with the ATF agenda. Strong theme of working the programme through Health and Wellbeing boards and into wider local government strategy
- Significant alignment with response to the cost of living crisis and fuel poverty
- All Together Fairer Leads meeting is a positive networking forum – being revamped for greater effectiveness.

Beacon Indicators Update

- The Beacon Indicators dashboard is now live on the CIPHA website
- Tweaks in the layout of the dashboard to be made for more intuitive navigation. However, to avoid delays, the dashboard has been released as it currently stands and will be updated as developments arrive.
- The dashboard is interactive and we need to align actions and work programmes to the relevant indicators to facilitate scrutiny of progress by the Health & Care Partnership Board.



Sex / Area	Female Latest Value	Female Difference From Previous Value	Male Latest Value	Male Difference From Previous Value	Persons Latest Value	Persons Difference From Previous Value
Cheshire East	3.2	0.3	3.2	-2.0	3.2	-0.9
Cheshire West and Chester	2.7	-0.5	3.2	-0.9	3.0	-0.7
Halton	5.0	1.6	4.2	2.6	4.6	2.1
Knowsley	6.0	2.6	0.0	-2.9	3.6	0.4
Liverpool	5.3	0.1	6.2	2.9	5.8	1.6
Sefton	1.8	No Change	4.8	0.6	3.2	0.8
St. Helens	6.7	5.3	3.2	-2.9	4.9	1.0
Warrington	2.8	-0.4	3.4	0.2	3.1	-0.1
Wirral	4.2	-1.6	3.0	0.9	3.6	-0.2
Cheshire and Merseyside	4.0	0.6	3.9	0.2	4.0	0.4
North West	4.5	0.4	4.7	0.2	4.6	0.3
England	4.3	-0.1	4.6	-0.5	4.5	-0.2

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Champs Public Health Collaborative

Working together to improve health and wellbeing in Cheshire and Merseyside

Development Programme on Social Determinants

- Learning and development opportunities will be multi-faceted and include access to online resources, workshops, attendance and feedback from external training courses, residential courses and other development mediums. Starting before end December 2022.
- Client groups to include
  - ICS Place Directors
  - Clinicians
  - Directors of Finance from NHS and local government
  - Primary care services
  - ATF Borough level leads
- Focus will be a mix of whole sub-region when appropriate and place focussed when appropriate with a mix of single discipline and multi discipline forums.
- This is in addition to a current programme of Health Equity Assessment Tool training that enables professionals to systematically identify and address health inequalities and equity in their work programmes or services.

How is the programme implementation proceeding?

Forums and partnerships are taking ownership of parts of the ATF agenda

- The Health & Care Partnership Board took ownership and responsibility for progression of implementation of the Marmot recommendations.
- Children & Young Persons (CYP) Beyond programme taking leadership on the policy areas and recommendations relating to CYP. Bid to Health Equity Collaborative submitted.
- Mental Health programme taking lead role on mental health and CYP recommendations
- Work on employment and good work owned by the C&W LEP and the LCR CA and DWP initiative being picked up by NHS Trusts
- LCR CA developing projects and coherence in action on inequalities in health

How is the programme implementation proceeding?

- Work on race equality is underway through the LCR Mayoral Office
- Place led programmes are coming together in each borough. Example of work on child poverty by Sefton Council.
- Work on fuel poverty is linked with immediate action in response to cost-of-living crisis. Need to progress this work and long term work on fuel poverty.
- Prominent within the developing Integrated Care Partnership Strategy
- Launch of the All Together Active Strategy

Asks to the Partnership

- Working in partnership is key to changing social determinants of health

  How will the Board support, and expect results from, partnerships across the NHS, local government and voluntary sector etc to change the impact of social determinants of health?

- Keeping the focus on the determinants and action to reduce inequality

  What can you do in your leadership position to help make this a success, and what additional contributions could your organisations make?

- Committing to the long term on All Together Fairer

  How can the Board maintain focus on the longer term in the face of immediate pressures?

Thank you

Comments or questions?

champscommunication@wirral.gov.uk

Working together to improve health and wellbeing in Cheshire and Merseyside

Fuel Poverty & Health Impacts Update

Professor Ian Ashworth
Director of Public Health, Cheshire West
Alison Lee
Place Director, Knowsley

8th November 2022

Working together to improve health and wellbeing in Cheshire and Merseyside

Cold Homes and Fuel Poverty – Impacts

- Unpublished findings from work in the North West OHID:

  From Winter 2022/3, and applying 2019 absolute thresholds of household poverty:

  - Total North West households below the 2019 income threshold for fuel poverty is projected to increase from 379,366 to 528,120 (39% increase)
  - Household residents living below the 2019 income threshold projected to increase from 13% to 18% of total
  - The average fuel poverty gap for North West households below the 2022 income threshold in 2022/23 is projected to increase during 2022/23 from £3,994 to £6,309.
  - In general (and allowing for announced relief payments), fuel poverty will affect households with multiple occupants, households where the youngest member is aged 10-15, and fuel poverty gaps are projected to be greater for fuel poor ethnic minority households, and households where the reference person is unemployed;
  - Fuel poverty is one aspect of poverty. The same populations will likely be experiencing food insecurity as well as the broader impacts of overall poverty.

Impact of Cold Homes & Fuel Poverty on Healthcare Activity in Winter 2022/23

- Report presented at meeting 30th June and updated 1st September.
- **Key Action:** Each local Place and NHS Providers to benchmark against existing NICE Guidance (NG6) - 12 recommendations
- Responses varied but reflect system wide collaboration at place level.
- Compliance and non compliance to recommendations – further work is required by Places.
- Emerging gaps
  - Development of multi agency strategies to address the health consequences of cold homes.
  - Training Gaps: a) health and social care practitioners

    b) housing professionals and faith and voluntary sector workers to help people whose homes may be too cold for their health and wellbeing

    c) heating engineers, meter installers and those providing building insulation to help vulnerable people at home

Examples of Good Practice

- Inclusion of the health consequences of living in a cold home within the joint strategic needs assessment process.
- “Vulnerability to cold” included in assessments prior to discharge from health or social care to home and acted upon if raised.
- Awareness raising planned to include e.g. turning heating on before discharge and appropriate access to fuel grants and access to benefits.
- Triangulation of a range of data sets/indicators to identify those at risk and potential to add a flag to health and social care systems
- Promotion of COPD rescue packs in primary care
- Inclusion of cold home risk assessment in Fire Service “Safe and Well checks”
- Identification of a single point of contact to access support for residents and professionals with a free phone number to advise professionals and help vulnerable residents and carers
- Local Place workshops being planned as part of wider Cost of Living Responses, e.g. with Health & Wellbeing Boards

Fuel Poverty, Cold Homes & Health Inequalities Report: Institute of Health Equity

- Launch of report by Institute of Health Equity - 1st September 2022, with our local authors
- Dr Alice Lee, Research and Clinical Fellow, Alder Hey Children's Hospital
- Professor Ian Sinha, Consultant Respiratory Paediatrician, Alder Hey Children's Hospital

The new review, Fuel Poverty, Cold Homes and Health Inequalities, predicts

- significant health, social and education detriment for a new generation of children if, as forecast*,
- 55% of the UK's households (around 15 million people), fall into fuel poverty by January 2023 without effective interventions

Fuel Poverty, Cold Homes and Health Inequalities Report: Institute of Health Equity

5A REDUCING DEPRIVATION AND INCOME INEQUALITY

5B IMPROVING HOUSING QUALITY AND ENERGY EFFICIENCY

5C ADDRESSING ENERGY COSTS

5D ADDRESSING HEALTH NEEDS AND NHS INTERVENTIONS

Examples of Council led Responses to Cost-of-Living

- Application of an emergency planning governance structure to the Cost-of-Living crisis.
- Establishment of a hardship fund, provision of an additional £200 support for pensioners in receipt of pensioner credit, providing access to food vouchers for children on free school meals throughout holidays up to end of Easter (£15 per week for low income families), winter warmth/warm homes programmes (families with under 5s and older people), energy project plus scheme and provided assistance to the community and voluntary sector.
- Expanding the number of food pantries and sustainable food provision networks
- An online portal that links people to various local offers.

Example of Council led Responses to Cost-of-Living

- Dedicated working groups established in response to the cost of living crisis which include:
  - Cold Homes Project Group
  - Winter Planning Group
  - Warm Spaces Task & Finish Group
  - The Fuel Poverty Steering Group is focused on proactive long term planning and implementation.
- A ‘Cost of Living Action Group’ has been established, chaired by the Chief Executive to co-ordinate local action. The group’s mission is to “mitigate the impact on people already experiencing financial hardship, to prevent others from becoming financially insecure and to prepare to support people when they need help”.
- A collaborative, wide-ranging communications campaign will promote the financial and non-financially support more widely across the Borough. The method for communications will be through current channels, as well as utilising Community Champions to promote key messages.

Fuel poverty in Cheshire and Merseyside

Having a long term condition such as a cardio vascular and respiratory disease, mental health or a disability can make a person more vulnerable to fuel poverty.

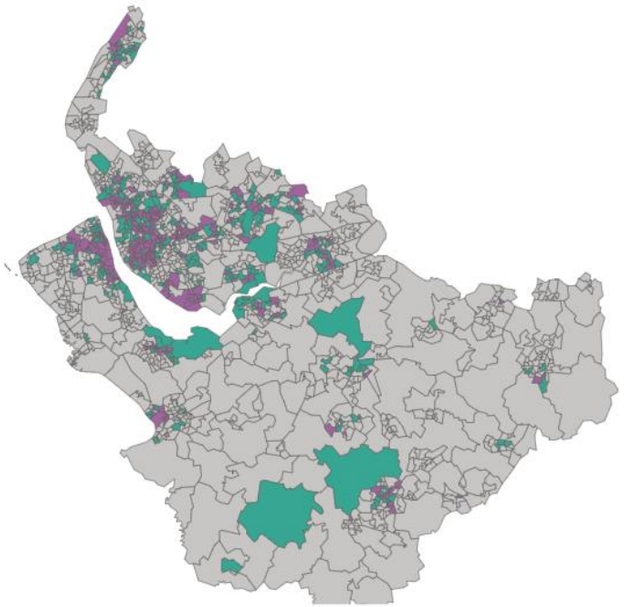
The table below demonstrates counts of patients across an ICB with a fuel poverty vulnerable condition, who live in a fuel poor LSOA with a home which has an energy rating of D-G. There are **119,346 people.**

Condition By Fuel Poverty Quintile

Cold Homes Condition	Quintile 1:LSOAs with the Highest % of Fuel Poverty	Quintile 2
CVD		
Atrial fibrillation Register	2,424	2,620
Coronary heart disease (CHD) Register	5,025	4,983
Heart failure Register	1,552	1,457
Hypertension diagnosis Register	18,857	19,247
Peripheral arterial disease (PAD) Register	1,205	1,008
Stroke/TIA Register	5,560	4,635
Disability		
Learning disability register	1,298	1,175
Physical disability	3,534	3,048
Mental Health		
Depression diagnosis register	34,713	30,886
Severe Mental Illness register	3,070	2,212
Respiratory		
Asthma diagnosis Register <= 18	1,702	1,572
Asthma diagnosis Register 19+	9,688	9,336
Chronic obstructive pulmonary disease (COPD) Register	5,222	4,275
Total	**61,705**	**57,641**

The map demonstrates the location of the fuel poor LSOA's with poor energy ratings, again clustered in the north of the ICB.

Analysis by place of the same patients by place shows that the majority of the condition /fuel poverty vulnerable patients live in Liverpool.



	Fuel poverty LSOA Q1	Fuel poverty LSOA Q2	Total	% of Total
Cheshire	6304	9501	15805	13%
Halton	2104	4860	6964	6%
Knowsley	4360	4400	8760	7%
Liverpool	24672	12417	37089	31%
South Sefton	4708	3440	8148	7%
Southport and Formy	2066	4405	6471	5%
St Helens	3421	5821	9242	8%
Warrington	2599	2959	5558	5%
Wirral	11471	9838	21309	18%
Total	61705	57641	119346	100%

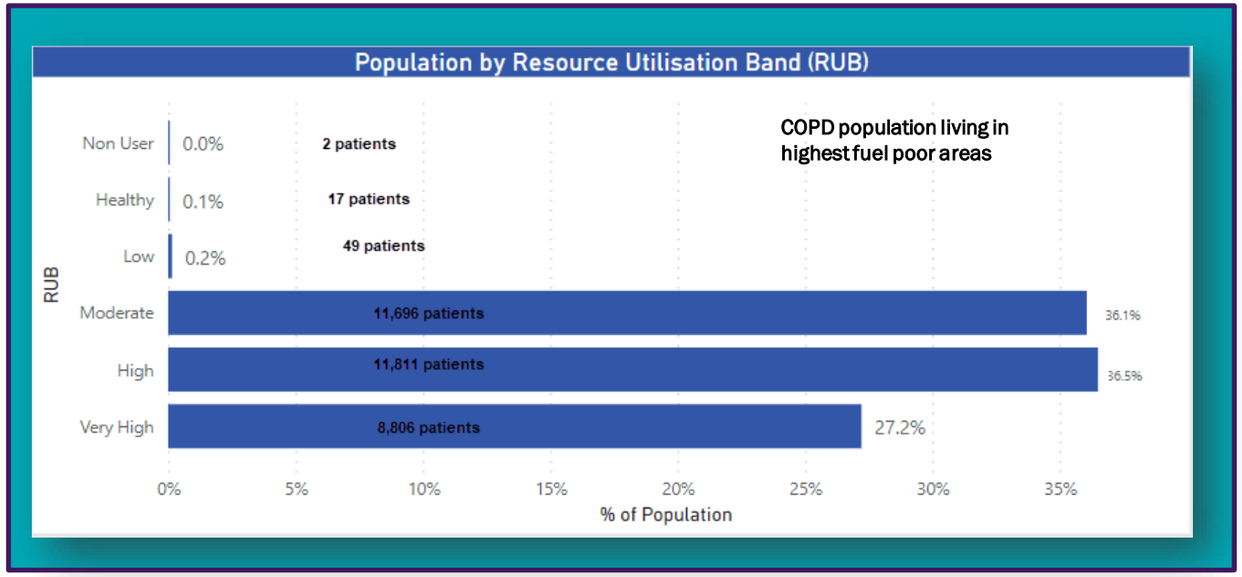
What is this guideline about? | Excess winter deaths and illness and the health risks associated with cold homes | Guidance | NICE

Fuel poverty in Cheshire and Merseyside

CIPHA
Combined Intelligence for Population Health Action

Cheshire and Merseyside
Health and Care Partnership

The ability to segment and stratify the fuel poor population is essential to target vulnerable patients. Cipha can stratify the fuel poor population using risk of admission, mortality risk and other factors such as living alone.



Patients with COPD with > 50% chance of emergency admission living in the most fuel poor geographies

Cold Homes Condition	Quintile 1:LSOAs with the Highest % of Fuel Poverty	Quintile 2
CVD		
Atrial fibrillation Register	167	164
Coronary heart disease (CHD) Register	292	258
Heart failure Register	159	137
Hypertension diagnosis Register	284	281
Peripheral arterial disease (PAD) Register	99	94
Stroke/TIA Register	168	177
Disability		
Learning disability register	0	5
Physical disability	122	104
Mental Health		
Depression diagnosis register	234	214
Severe Mental Illness register	57	50
Respiratory		
Asthma diagnosis Register <= 18	0	0
Asthma diagnosis Register 19+	96	124
Chronic obstructive pulmonary disease (COPD) Register	508	475
Total	**509**	**476**

Worked example – COPD

- There are **32,565** patients with COPD living in the highest 2 Poverty fuel LSOA areas.
- **20,617** of these patients have high or very high resource usage.
- **9485** have an energy certificate linked to their house which is rated worst at D-G**
- We think that **2699** of these patients may live on their own. **1757** of these patients are aged 65+.
- **67** of these patients flag as having a 50% probability of emergency admission in the next 12 months.
- Regardless of age, household occupancy and Household energy ratings, there are **985** patients with a >50% risk of emergency admission* in the next 12 months who have COPD. **43** of these patients flag the highest relative mortality risk score* across the ICB
- Many of these patients are multi-morbid with Cardiovascular disease and mental illness being key co-morbidities.
- More of these patients live in Liverpool city region than in Cheshire.
- This example could be worked for all of the Nice recommended disease groups. Further stratification could identify patients without a recent clinical review.

*Risk of emergency admission and Mortality risk are part of the Johns Hopkins ACG algorithms incorporated into CIPHA. Mortality risk is the Ontario model, developed by Austin et al www.HopkinsACG.org

**This analysis could also identify those citizens living in low fuel risk areas with a poor energy efficiency rating certificate.

National and Regional Action On Cost of Living

- **Local Government Association Cost of Living hub**
  - This hub has been designed to share best practice and help councils to support their residents with the rise in the cost of living and includes a cost of living bulletin

  Cost of living hub | Local Government Association
- **NHS Confederation – The Rising Cost of Living**
  - explores the risks to health, wellbeing and healthcare services, making the case that the cost-of-living crisis is a health crisis.

  The rising cost of living | NHS Confederation
- **North West collaboration**

Next steps

- Place Directors continue to review self assessments for key gaps in compliance that require immediate action with partners.
- Using the CIPHA Dashboards and intelligence to inform targeting of local support.
- Sharing of best practice between Place leads on fuel poverty approaches and wider local system led Cost of Living Action Plans.
- Promotion of IHE report and core recommendations across Cheshire & Merseyside.
- Engaging with our ICS Health and Housing Groups, and our Fire Services ‘Safe & Well’ programme following findings.
- Communications plan on wider available interventions and mitigations to promote to staff and residents e.g. from warm places, child health perspective and wider welfare support offers.
- Engage with longer term planning and intervention.

NHS
Cheshire and Merseyside

Committee Report

Cheshire and Merseyside HCP
Developing the HCP Strategy

Date: 8 November 2022

Date of meeting:	8 November 2022
Agenda Item No:	
Report title:	Developing the HCP Strategy
Report Author & Contact Details:	Neil Evans (neilevans@nhs.net or 07833685764)
Report approved by:	Clare Watson

Purpose and any action required	**Decision/ Approve** →		**Discussion/ Gain feedback** →		**Assurance** →	x	**Information/ To Note** →	

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)
The approach outlined in this report has been discussed at the ICB Transformation Committee, Population Health Board, Directors of Public Health Forum and a number of the Health and Wellbeing Boards within Cheshire and Merseyside.

Executive Summary and key points for discussion

- The Department of Health and Social Care issued statutory guidance for the publication of an Integrated Care Partnership (ICP) Strategy by December 2022. There will be a need to update this strategy during 2023-24 to reflect updated Joint Strategic Needs Assessment (JSNA) information and revised national guidance expected in June 2023.

- As a result of the challenging timescales, and in reflection of both the previous work in developing our plans across Cheshire and Merseyside, as well as feedback from Cheshire and Merseyside Health and Care Partnership (HCP) stakeholders the approach being taken to publish the ICP Strategy is to build from the existing strategies and plans developed across Cheshire and Merseyside; including the 2021 HCP Strategy and 2022 All Together Fairer Plans.

- Through September and October, the approach and content has been discussed with a range of stakeholders and we are in the process of receiving proposed content, which will be incorporated into a single document. This will be widely shared with stakeholders at the end of November for feedback prior to being shared with the HCP Board and considered for publication by the HCP Board on 22 December 2022.

Recommendation/ Action needed:	**The Board is asked to:** Receive assurance in relation to the publication of our HCP Strategy by the nationally set deadline of the end of December 2022.

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	x
2. Tackle health inequality, improving outcome and access to services	x

Which purpose(s) of an Integrated Care System does this report align with?	
3. Enhancing quality, productivity and value for money	x
4. Helping the NHS to support broader social and economic development	x

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	
2. Recovery	x
3. Getting Upstream	x
4. Building systems for integration and collaboration	x

Governance and Risk	Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? (*please list*)					
	What level of assurance does it provide?					
	Limited		**Reasonable**	x	**Significant**	
	Any other risks? There is a challenge in meeting the timescales specified nationally for developing a strategy If **YES** please identify within the main body of the report. • The key risk is the time available to produce the Strategy being limited and may mean more material changes are required for a revision in 2023-24. • The ICB has limited resource capacity to work with our ICP partners in the development of the strategy and additional resource will need to be diverted from other activities.					
	Is this report required under NHS guidance or for a statutory purpose? (*please specify*) No (strategy itself is mandated by Department of Health and Social Care)					
	Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. No					
	Any current services or roles that may be affected by issues as outlined within this paper? No					

Document Development	**Process Undertaken & Impact Considerations**	**Yes**	**No**	**N/A**	**Comments** (i.e., date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
	Financial – any resource impact?	x			The Strategy will cover all aspects of the responsibilities of the ICB/P.
	Patient / Public Involvement / Engagement	x			
	Clinical Involvement / Engagement	x			

	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?	x			
	Regulatory or Legal - any impact assessed or advice needed?	x			
	Health Inequalities – any impact assessed?	x			
	Sustainable Development – any impact assessed?	x			

Next Steps:	Development of: • Producing draft document to be shared with stakeholders by the end of November for feedback. • By Mid-December final draft produced in advance of HCP Board Meeting on 22 December. • During 2023 undertake wider engagement on the strategy content, alongside Health and Wellbeing and Place Strategies and ICB 5 Year Joint Forward Plan; developing effective implementation plans and monitoring mechanisms

Responsible Officer to take forward actions:	Neil Evans Associate Director of Strategy and Collaboration

Appendices:	

Glossary of Terms	**Explanation or clarification of abbreviations used in this paper**
EDI	Equality, Diversity, and Inclusion
ICB	Integrated Care Board
ICP/HCP	Integrated Care Partnership in Cheshire and Merseyside we refer to the ICP as a Health and Care Partnership (HCP)
ICS	Integrated Care System
JSNA`	Joint Strategic Needs Assessment
HOSC	Health Overview and Scrutiny Committee

Developing the HCP Strategy

1. Executive Summary

1.1 The Department of Health and Social Care issued statutory guidance[1] for the production of an ICP (HCP) Strategy by December 2022. There will be a need to update this strategy during 2023-24 to reflect updated JSNA information and revised national guidance expected in June 2023.

1.2 The approach used to develop the HCP Strategy has been to build on our existing strategic plans including the 2021-25 HCP Strategy, the 2022 All Together Fairer Report and associated approved strategies and plans.

1.3 Additionally, the plans will reflect the contextual challenges being experienced in our plan in relation to their health and wellbeing; including cost of living pressures and challenges accessing some services in a timely manner.

1.4 As the existing strategies have been engaged upon in their development, we haven't undertaken more extensive engagement activities but plan to do so, alongside work in Places in relation to Health and Wellbeing or Place Plan developments and in relation to the ICB Five Year Forward Plans that will be developed during the early part of 2023.

1.5 The time-scales to produce the document content remain challenging with the key dates being:

1.5.1 A draft to be circulated to stakeholders by the end of November
1.5.2 Feedback incorporated into a revised draft by 15 December
1.5.3 Extraordinary HCP Board Meeting on 22 December to review final draft

2. Introduction / Background

2.1 On 29 July the Department of Health and Social Care issued statutory guidance for the production of an ICP Strategy, which should be published by the ICP by December 2022. There will also be a requirement to publish a "five-year joint forward plan" by April 2023. This means that the ICP will need to sign off the strategy in the December meeting (date not yet confirmed) and the Five-year joint forward plan at the ICB Meeting on 23 February. The guidance describes the strategy as:

The integrated care strategy should set the direction of the system across the area of the integrated care board and integrated care partnership, setting out how commissioners in the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life. The integrated care strategy presents an opportunity to do things differently to before, such as reaching beyond 'traditional' health and social care services to consider the wider determinants of health or joining-up health, social care and wider services.

2.2 In line with the stretching timescales set in the guidance, and the relative immaturity of Integrated Care Systems (ICS), the DHSC have outlined that the publication in December that will be an interim document offering the opportunity to continue to develop and refine the content in the coming year. This will both reflect developments

driven by the local Joint Strategic Needs Assessments (JSNA) and from revised national guidance in the summer of 2023.

2.3 The HCP strategy is designed to describe the areas of work being undertaken collectively at a Cheshire and Merseyside level and should complement Health and Wellbeing Board Strategies/Place Plans and not duplicate.

2.4 The guidance outlines the need for strategies to consider the following areas, we will need to agree which are component strategies and which are golden threads running through, or both:

a. personalised care;
b. addressing disparities in health and social care;
c. population health and prevention;
d. health protection;
e. babies, children, young people and their families, and healthy ageing;
f. workforce;
g. research and innovation;
h. health-related services;
i. and data and information sharing.

2.5 The local approach has been designed following discussions with a range of stakeholders including; ICP founder members, in September, Directors of Public Health, Health and Wellbeing Board feedback, ICB Executive and Board discussions, Healthwatch and ICS Population Health Board. The approach being taken builds from our existing strategic plans, and associated documents, and will include:

a. Cheshire and Merseyside Strategy (2021)
b. All Together Fairer - Health equity and the social determinants of health in Cheshire and Merseyside (2022)
c. ICS Digital and Data Strategy (2022)
d. Social Value and Anchor Institute Charter (2022)
e. Public Engagement Framework (2022)
f. Green Plan (2022)
g. A range of other plans in relation to the prevention agenda and our key transformation programmes.

2.6 Through discussions with our nine Healthwatch organisations we will respond to the major challenges being experienced most by our population, in relation to

a. Cost of living and fuel poverty pressures
b. Access to services (including General Practice, Dentists, Elective Care, Social Care)

2.7 In reflection that the core content of the report will be built from existing strategies and plans that have been developed with our community we haven't undertaken widespread engagement with our communities in pulling together our December Strategy Document but would intend engaging as part of Place based plans in updating Health and Wellbeing strategies and other Place based engagement.

2.8 We will be outlining the approach being taken to the Joint Overview and Scrutiny Committee on 11 November and would similarly seek further engagement post December, alongside the emerging NHS Cheshire and Merseyside Five Year Joint Forward Plan to be published by April 2023. At this point national guidance has not been issued in relation to the Five Year Joint Forward Plan.

2.9 In line with those areas described in sections 2.4 and 2.5 a range of subject matter experts are preparing strategy content by week commencing 7 November. This information will then be combined into a single document.

2.10 By the end of November a draft document will be shared widely with stakeholders across the Cheshire and Merseyside ICS system seeking feedback as to key areas of development. A final document will then be shared by 15 December for review and potential approval to publish the interim strategy at an extraordinary HCP Board Meeting on 22 December.

3 Recommendations

4.1 Note for information the contents of the report.

4 Officer contact details for more information

5.1 Neil Evans, Associate Director of Strategy and Collaboration.
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07833685764