Cheshire and Merseyside Health and Care Partnership (HCP)

Cheshire and Merseyside Health and Care Partnership

All Together Fairer Stocktake and Alignment of All Together Fairer and HCP Strategy

16th January 2024

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**Summary:**

This paper provides an update on progress against All Together Fairer (ATF), the development of the ATF Beacon Indicators and outlines how we might better align the HCP strategy with ATF. It includes the following progress reports:

**All Together Fairer Implementation Progress Report.**

A report on the progress made since April 2022 in implementing the Marmot All Together Fairer programme, reviewed against the World Health Organisation’s Four Pillars of implementing Health In all Policies.

**All Together Fairer Stocktake Commentary and Spreadsheet of Stocktake Responses**.

The Excel spreadsheet contains an edit of all responses to the request for information on the activity against the eight Marmot themes at borough, combined authority, and ICS level (See Appendix A for embedded Excel Spreadsheet).  The commentary provides a reflection on what we have learned from the stocktake.

**ATF Beacon Indicators Review**

A review of the development in the 22 beacon indicators since April 2022 and a brief discussion on what needs to be done next to develop the monitoring function.

**Healthcare Partnership Strategy and All Together Fairer Alignment**

A summary of how the implementation of All Together Fairer works in practice and the rationale for what we will be adding by focussing on transformational procedures, anti-poverty, and equity in all policies (See Appendix B for All Together Fairer Report and Appendix C for HCP Interim Strategy)

**All Together Fairer Implementation Progress Report**

1. **Background**
	1. Although the implementation of the Marmot All Together Fairer programme formally began after the report was launched in May 2022, there was already implementation of activity on the social determinants of health underway across Cheshire and Merseyside.
	2. The All Together Fairer programme clarified the scale of the challenge by:
* Providing detailed data analysis
* Setting out the evidence of what works and best practice elsewhere.
* Providing the context to inspire existing programmes of work and initiate specific new programmes to address inequality through the social determinants of health.
1. **Examples of good practice**
* Work, such as the Liverpool City Region Fair Employment Charter, preceded the Marmot final report but is clearly working to the Marmot theme on “Create fair employment and good work for all”. There are now a total of 100 Aspiring Level Fair Employment Charter organisations in the City Region, and eleven healthcare and nine social care organisations have completed an application form to become part of the Fair Employment Charter.
* The NHS Prevention Pledge programme is successfully working with NHS Trusts across Cheshire and Merseyside to support, inspire and challenge trusts to adopt employment practices that recruit people from the poorest areas in the sub-region.
* The Beyond programme is working with Barnardo’s and two other ICSs to develop and implement a Children and Young People’s Health Equity Framework that is specifically focussed on social determinants of health.
* The C&M NHS Anchors programme is supporting Trusts to look at their wider societal role and a group of GPs have initiated a Deep End initiative to support those practices working with the most deprived populations.
* New strategies and excellent work have been initiated in boroughs and includes the Sefton Child Poverty Strategy, Liverpool Housing and Health programme, Halton Wider determinants programme and more.
1. **World Health Organisation four pillars for structured action.**
	1. This review of activity will focus on what has been done to further implement the Marmot programme since May 2022. In doing so the review will adopt the structure used by the World Health Organisation to recommend action on health in all policies of four pillars for structured action:

**Pillar One – Governance and Accountability**

**Pillar Two – Leadership at All Levels**

**Pillar Three – Ways of Working**

**Pillar Four – Resources, Financing and Capabilities**

* 1. 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 to reduce inequality in health at a level that can be seen in population changes. This means acting on 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. This is a significant challenge given the decades of movement in a direction that has exacerbated inequality but an essential one to achieve an altogether fairer Cheshire and Merseyside.
1. **Pillar One – Governance and Accountability**
	1. Commitment from the Cheshire and Merseyside ICB and ICS to the implementation of the ATF programme has been evident from the start. The commitment has been set from the top of the partnership structure. A governance structure has been in place through the ATF Advisory Board and Population Health Board and this structure is evolving into the next phase of Integrated Care System development with a strengthened focus on social determinants of health. The social determinants programme, with a key place for the All Together Fairer Board, will be one of the four programmes of the Cheshire and Merseyside ICS Population Health function. It will sit alongside the programmes on healthy behaviours, health care inequalities and screening and immunisation and under the Health and Care Partnership of the ICB.
	2. A challenge for the governance structure is to ensure the link with activity happening through councils. This is provided through the meeting of the Directors of Public Health and, through the DsPH, to the council led Health and Wellbeing Boards in each borough. The link across the ICS to council work is also provided by the political leadership present on the ICB and Health and Care Partnership drawn from councils and the council chief executives present on the ICB and Health and Care Partnership.
	3. Finally, governance must include the community and voluntary sector which is represented on the above forums but whose assessment of the adequacy of the governance structure to keep that sector involved and informed should be continuously sought. Similarly, the engagement of the NHS Foundation Trusts and other providers in the ATF programme through the governance structure should also be assessed.

* 1. The evolution of the ATF Board into a key component of the population health programme should see a further strengthening of the governance structure.
	2. Beneath the ATF Board there is a forum to bring together the people who are leading the implementation of the ATF programme in the Marmot Leads meeting. This forum is successful in supporting an exchange of information on what is happening in each borough and providing an insight into borough level working for the ICS. Further development of this forum into a network should happen in 2024.

* 1. Finally, the Champs public health collaborative provides strategic leadership capacity to the overall ATF implementation programme. This capacity is key to the coordination of activity and the future development of the programme.
	2. The governance structure for the ATF programme is extensive and in further development. When fully functioning, it will support the implementation of the programme well.
	3. Accountability for the implementation of the programme is underpinned by the Beacon Indicator Set. A separate briefing on the indicator set and action needed to develop a fully functioning monitoring tool is provided.
1. **Pillar Two – Leadership at all levels**
	1. The social determinants of health programme are multi-sectoral and multi-factorial and demands a systems leadership approach in which leadership is developed and supported at all levels and points. The following actions have been taken or are in train to support this systems leadership for the ATF Marmot programme.
	2. Attendance at the Marmot Summer School 2023
		1. Eight Marmot leads from across Cheshire and Merseyside, including the LCR Combined Authority, attended a week-long event at the Institute of Health Equity in July 2023. The event included participants from across the UK and internationally to hear about and discuss different approaches to work on the social determinants of health.
		2. It was clear that a significant benefit for participants from CM was in meeting each other, spending time together and with others from the NW and other parts of the UK. This points to the need for further opportunities for engagement and relationship building within Cheshire and Merseyside as a must do for 2024 and onwards.
	3. Four workshops to develop leadership awareness at a senior level are in place for January and February 2024. The workshops are aimed at ICS directors, ICB members, Local authority councillors and HWB leads, Directors of Finance in NHS and local government, Directors of Growth, Transport, Planning, Environmental Health, Regeneration, and policymakers. The workshops will:
* Increase understanding of social determinants of health amongst attendees.
* Better support ICS system leaders in understanding their role and the health system’s role in tackling health inequalities.
* Improve the effectiveness of the strategies to address the social determinants of health in the ICS system.
* Accelerate progress on tackling health inequalities in Cheshire and Merseyside.
	+ 1. Pending the success of the workshops, consideration will be given to extending the programme for other levels of leadership.
	1. A third development coming into place in 2024 is an online hub to provide a platform for the exchange of information on work on social determinants of health across the Cheshire and Merseyside system and access to the latest evidence base and reports nationally and internationally.
1. **Pillar Three – Ways of Working**
	1. The All Together Fairer programme functions through the provision of an overarching framework, the eight Marmot themes and system recommendations, which is evidence-based and draws on a thorough analysis of the data on health inequalities in health in Cheshire and Merseyside. This framework has broad and strong support across the system and good recognition in most parts of it.
	2. The governance structure as mentioned above provides support to the implementation of actions. The majority of the actions are taken at council level and below and through NHS organisations such as Foundation Trusts and primary care.

* 1. There is much that happens through local government to act on the social determinants of health. Councils have strategies and policies on poverty, employment support, transport, green space, etc. and a lead responsibility for public health. Some of the work the councils initiate is funded through the public health grant but much of the work on social determinants is core council business. These include the Sefton Child Poverty Strategy, Liverpool Housing and Health programme, Halton Wider determinants programme and more.
	2. NHS Foundation Trusts have been acting to review employment practices to ensure people from the surrounding area or with particular needs are supported through the recruitment processes. The General Practitioner-led ‘Deep End’ initiative seeks to develop work on inequalities in health that can best be addressed through primary care services.
	3. Sitting above this work is activity at system level to coordinate work across boroughs and Foundation Trusts. These initiatives include the NHS Prevention Pledge, Anchors Programme and working with Barnardo’s and the Institute of Health Equity to design a Children and Young People’s Health Equity Framework. Work on Fair Employment Charters in Liverpool City Region and in Warrington and Cheshire is at different points but both programmes aim to engage public and private sector employers to improve the quality of work for employees. This is a key social determinant of health in the Marmot programme.
	4. In summary, the Marmot report set the overarching analysis and recommendations for action on the social determinants of health, the building blocks on which good health and reduced inequalities in health are built. The ICS endorsed the analysis and recommendations from the top and made clear that implementing the overall approach of All Together Fairer and recommendations is the Health and Care Partnership strategy. Councils, the key bodies in tackling the social determinants of health, also endorsed the ATF approach and are progressing with implementation.
	5. There is, as expected, variation in implementation as councils balance priorities, opportunities and relative local challenges. Foundation Trusts and primary care also engage with the social determinants of health. The ICS supports this work by providing: -
* leadership development
* networking opportunities
* coordinating programmes
* innovation in developing frameworks.
* access to inspiration from elsewhere

Alongside the development of monitoring tools that will tell the system whether, and how, it is making progress to achieve a healthier and fairer Cheshire and Merseyside.

1. **Pillar Four – Resources, Financing and Capabilities**
	1. Resourcing work on a relatively new approach is challenging at any time and more so at present. Public sector budgets are under significant pressure. Inequalities in health have been made worse through the impact of economic austerity policies, the Covid-19 pandemic, and the cost-of-living crisis.
	2. In this context, much is being done with less. Even in this context, there is a willingness to fund this activity and that must be maintained.
	3. Capability to do this work in Cheshire and Merseyside is high and being developed. Capacity is an area for further development. In this context, system-wide leadership is key to engage greater capacity and to link the work on social determinants of health to the core work of councils, foundation trusts, public and private sector employers.

**All Together Fairer Stocktake Commentary**

1. **Introduction**
	1. The attached stocktake of activity has been constructed by inviting leads in local authorities, in the LCR combined authority, and at the Warrington and Cheshire level, to record what work they are doing under each of the eight Marmot themes and seven system recommendations and to add the work being done at ICS level. The information is recorded in the Excel spreadsheet.
	2. There is no shortage of activity in Cheshire and Merseyside that can come under the All Together Fairer banner. This stocktake has been of great value to capture that activity but also to highlight what needs to be done.
2. **Categorisation of Information**
	1. In the Excel table each of the eight Marmot themes, seven system recommendations and beacon indicators are set out in rows and information is presented on work at:
* C&M level activity
* Cheshires and Warrington level activity
* LCR CA level activity
* Borough-level activity.
1. **Comments on the Stocktake Information**

* 1. **There is a wide range of activity underway in Cheshire and Merseyside.**
		1. There is much good practice on the social determinants of health at all levels in Cheshire and Merseyside. This work is also at a significant volume. Each borough is able to note innovation in family hubs, employment workshops, movement towards paying a real living wage for social care work, a child poverty strategy and so on. Work at the next administrative level includes fair employment charters, work in foundation trusts coordinated and inspired through the NHS Prevention Pledge, and the development of the healthy equity framework for children and young people. At ICS level there is activity to understand the relevance of social determinants of health and the development of leadership capability to act. It is important to note that whilst the stocktake has drawn on feedback from Place we are aware that there is also additional activity taking place.
	2. **A systematic coherence between recommendations, indicators and actions is not apparent.**
		1. From the information provided it seems that at the borough level, the work has been inspired by the overall Marmot themes, be it giving every child the best start in life or creating fair employment for all, and then activity is generated that is relevant to the overall theme.
		2. A systematic approach could be to take each theme and series of recommendations and generate work on the recommendations while also measuring the relevant beacon indicator to determine progress towards improvement. There are some exceptions where the information suggests that action is linked to specific recommendations.
		3. However, noting the absence of that linear thread from theme to recommendations to action and measurement is not a criticism of the way the work is being handled. The recommendations were not intended to be a checklist. Implementation at council level will require some sifting of which recommendations have particular relevance at this point in time in each borough. Action will depend on which recommendations fit with the corporate plan and Health and Wellbeing Strategy, have momentum already behind them and for which opportunities exist, possibly through political backing or funding circumstances, to make progress.
	3. **A strategic approach is embedding in some boroughs.**
		1. Work in Liverpool CC and Knowsley appears well organised with staff capacity dedicated to taking it forward. Work in Halton is shaping up with a wider determinants programme led by the voluntary sector with good engagement across a number of sectors; work in Cheshire East and Warrington is organised and determined and dealing with funding challenges; St Helens’ council also won a national award for A Whole Council approach to tackling health inequalities. In other boroughs, there is great work happening specific to particular themes, but it is less clear that there is an overall approach on social determinants of health.
	4. **Much of the activity on social determinants of health is not initiated with a health outcome in mind but could be given greater coherence as a health equity activity.**
		1. Activity relevant to social determinants of health and recorded in council and combined authority settings crosses over a wide range of policy areas from transport to economy to housing etc. Work on poverty reduction, housing support or transport developments all have obvious primary goals. Many of the programmes referenced in the stocktake have not been commissioned/progressed with specific reference to the ATF themes and recommendations. However, improvements in each of them will be a significant contribution to health equity if they are implemented on the basis of proportionate universalism and achievement of equity.
		2. There is an opportunity to achieve greater coherence and drive to the All Together Fairer programme by more explicitly linking the non-health outcome work to the longer-term goal of greater health equity through improving the social determinants of health. This applies to work at the ICS level, in individual boroughs, with NHS Foundation Trusts and between combined authority and boroughs.
	5. **Variation in the quantity of activity between themes is evident.**
		1. Activity tends to be strongly reported under themes related to children and young people (Give every child the best start, maximise capability and control), themes on employment and healthy standard of living and places and communities but less well on themes seven and eight from the ATF report on racism and discrimination and environmental sustainability. The latter two are more recent additions to the Marmot themes, although they have been included since the report was launched in Cheshire and Merseyside.
	6. **System recommendations.**
		1. There are seven system recommendations in the ATF report and a wide range of activity at different levels reported in the stocktake. The first recommendation, “Increase and make equitable funding for social determinants of health and prevention”, has information recorded at ICS, combined authority and Cheshire and Warrington level but little at the borough level. This is not surprising given the financial challenges facing local authorities.
		2. Most boroughs and system levels have action recorded against partnership and leadership development, co-creating interventions and social value. Some places have been successful in engaging the business and economy sector (recommendation number five). The responses indicate a wide variation in activity but also that significant activity is in place.

**All Together Fairer Beacon Indicators Review December 2023**

1. **Introduction**
	1. The 22 beacon indicators relate to the eight Marmot themes and are the outcome measures that will ultimately show whether the action and investment in activity on the social determinants of health has made a difference in Cheshire and Merseyside. Some points are worth making to set the context in which to view progress in the beacon indicators:
* The indicators are chosen to measure progress in the social determinants of health and therefore the majority are not measures of activity in health services.
* Some, but not all, will change slowly no matter what the level of success in programme implementation. This is in part due to the national process of annual updating and three-year aggregation of data and in part because of the longer time for activity to have an impact on population health measures. This is the case for life expectancy and healthy life expectancy indicators.
* Many, if not all of the indicators, are affected by the level of deprivation in the population and therefore vary by deprivation across Cheshire and Merseyside. The higher the population deprivation level the worse the indicator is a good rule of thumb when looking at social determinants of health.
* In attempting to improve the social determinants of health and the beacon indicators, the task is to counter the impact of deprivation on health that has been in place for decades and, before the pandemic, could be seen to have had an impact in recent years to slow what had been year-on-year in improvements in life expectancy.
* The Covid-19 pandemic, and action in response, had the effect of worsening inequalities in health across the country and this effect is apparent in the beacon indicators for Cheshire and Merseyside.
	1. Of the 22 indicators chosen, all but four of the indicators are currently live i.e. data exists at the appropriate level and is being updated on the dashboard. Three of the indicators still not live relate to the Anchor Institutions work and their viability is yet to be determined.
	2. Anchor Institution indicators:
* Percentage of employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter (indicator 12)
* Percentage of employees who are from Black, Asian and Minority Ethnic backgrounds and pay band/level (indicator 20)
* Percentage (£) spent in the local supply chain through the contract (indicator 21)
	1. One of the agreed indicators is no longer available at the local level and a decision needs to be made as to whether we remove or seek an alternative.
	2. The one no longer available is:
* Percentage of individuals in absolute poverty after housing costs (indicator 15)
	1. A case could be made for regarding 2022 as the beacon indicator baseline for assessing progress in the ATF programme. Although work on the social determinants of health preceded the launch of the ATF report, the period from 2019 onwards has been dominated by the Covid pandemic. Although the legacy of the pandemic will still be felt in population health data for years to come it feels reasonable to begin the measurement of progress in the All Together Fairer programme in data from 2022.
1. **Indicators**

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| **Theme and Indicator** | **Comments** |
| **Life expectancy** |
| **1** | Life expectancy, Female, Male | Data is from 2014 to 2020 in three-year age bands. Variation across CM is in line with deprivation levels. Change over time by boroughs is variable; more deprived boroughs seeing a fall in LE and others either a slight rise or static. |
| **2** | Healthy life expectancy, Female, Male | HLE reflects mortality rates and the individual’s self-assessment of their own health aggregated up to borough level. Cheshire East has better HLE than the national figure and other boroughs are mostly lower than the national level. Change over time (2014 – 2020) is variable with no clear picture of improvement. |
| **Theme 1. Give every child the best start in life** |
| **3** | Percentage children achieving a good level of development at 2-2.5 years (in all five areas of development) \* | Data from 2017 to 2021 for the 2- to 2.5-year-olds shows variation across CM but majority of boroughs are above the national figure for level of development at this age. There is significant variation year by year with two boroughs showing consistent improvement. |
| **4** | Percentage children achieving a good level of development at the end of Early Years Foundation Stage (Reception)  | Data for reception age (4-5 years) is from 2013 to 2022 and shows improvement in each borough from 2013 which may indicate better data collection and real improvement in level of development. More variation between boroughs than for the earlier age measure and all boroughs have had a fall in the reception year measure in 2022 with the pandemic a likely association. |
| **Theme 2. Enable all children, young people and adults to maximise their capabilities and have control over their lives** |
| **5** | Average Progress 8 score\*\* | Average progress 8 compares pupils’ achievement across 8 subjects to the pupils who has a similar starting point. The picture across CM is not good. The majority of boroughs show a low score and variation with CM reflects the distribution of deprivation. Pupils on free school meals show worse progress than others. |
| **6** | Average Attainment 8 score\*\* | Attainment 8 measures the results of pupils at state-funded mainstream schools in England in 8 GCSE-level qualifications. Most boroughs in CM are around or slightly below the England average score with one borough being noticeable below the average. There is little consistency in trend data from 2015 to 2022. |
| **7** | Hospital admissions as a result of self-harm (15-19 years) | Data on admissions for self-harm shows variation between boroughs and no great consistency in direction of travel over time from 2017 to 2022. In all boroughs, as with the national data, there are more females than males admitted as a result of self-harm. |
| **8** | NEETS (18 to 24 years) | Some boroughs in CM show better than national performance in the percentage of 16 - 17-year-olds not in education or training and the overall direction across CM is to decrease this indicator. |
| **9** | Pupils who go on to achieve a level 2 qualification at 19 | The national average for percentage of pupils who achieve level 2 at 19 years is 81.6 in 2021 although this is after 6 years of steadily falling performance. This pattern is reflected in CM where all boroughs are showing decreasing performance on this indicator since around 2013. Most boroughs in CM are at or around the national performance level although one borough is noticeably lower owing to lower performance for pupils on free school meals. |
| **Theme 3. Create fair employment and good work for all**  |
| **10** | Percentage unemployed (16-64 years) | The England figure for percentage unemployed is 3.7% and boroughs across CM vary around that figure with the highest being 4.7% and the lowest 2%. All but two of the boroughs saw a decrease (improvement) in the unemployment rate in 2022 compared to 2021 although there is significant annual variation in this statistic with no borough showing a consistent improving trend. |
| **11** | Proportion of employed in permanent and non-permanent employment | Most boroughs in CM have a smaller percentage of the employed population in self-employed or non-permanent employment with Cheshire East and West, Wirral and ST Helens being exceptions. |
| **12** | Percentage employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter\*\*\* | No data on percentage of employees who are local. |
| **13** | Percentage of employees earning below Real Living Wage | A higher proportion of women than men earn less than the Real Living Wage (RLW) and in five boroughs more people earn less than the real living wage than the England average. All boroughs are seeing a downward trend (improvement) in the proportion of the population earning less than the RLW. |
| **Theme 4. Ensure a healthy standard of living for all** |
| **14** | Proportion of children in workless households | Sefton stands out as having achieved a noticeable reduction in the percentage of children living in workless households. Halton and Wirral also achieved reductions. Most boroughs across CM have seen an increase in that percentage between 2021 and 2022. Most boroughs are well above the England average. |
| **15** | Percentage of individuals in absolute poverty, after housing costs |  No data on individuals living in absolute poverty. |
| **16** | Percentage of households in fuel poverty | Fuel poverty data in CM has been well reported over the last year and this beacon indicator shows the highest proportion of homes in fuel poverty in Liverpool and Knowsley and most boroughs in CM are above the England average. |
| **Theme 5. Create and develop healthy and sustainable places and communities** |
| **17** | Households in temporary accommodation\*\*\*\* | The proportion of households in temporary accommodation increased in each borough between 2019/20 and 2020/21 but all boroughs in CM are well below the England average. The England figure is 4.03% and the highest in CM is 1.81%. The NW figure is 1.64%. |
| **Theme 6. Strengthen the role of prevention and ill health prevention** |
| **18** | Activity levels  | Activity levels are highest in Cheshire East although year by year fluctuations are apparent in that borough and across CM. |
| **19** | Percentage of loneliness in population  | Three boroughs in CM have higher values for the percentage of the population feeling lonely than the England average of 22.26%. Sefton has the lowest value at 16.17%. |
| **Theme 7. Tackle racism, discrimination and their outcomes** |
| **20** | Percentage employees who are from ethnic minority background and band/level.\*\*\* |  No data |
| **Theme 8. Pursue environmental sustainability and health equity together** |
| **21** | Percentage (£) spent in local supply chain through contracts\*\*\* |  No data. |
| **22** | Cycling / walking for travel (3-5 times / week) | Warrington has the highest value for percentage of adults cycling and/or walking at 4.13% which is higher than the England value of 2.33%. With the exception of Liverpool all remaining boroughs in CM gave lower levels of people cyclin/walking |

1. **Developing the Beacon Indicator Set**
	1. The Marmot beacon indicator set was developed through workshops across Cheshire and Merseyside in 2022. The work was exemplary in being inclusive of different perspectives and mindful of what is possible given national data collection options. The final set of 22 indicators was agreed in the appropriate forums in Cheshire and Merseyside by summer 2022. The Beacon Indicator set is to be a visible indication of the commitment across Cheshire and Merseyside to seeing, and then reducing, inequality in health.
	2. The indicator set needs further development to act as the monitoring tool needed to guide implementation of the All Together Fairer programme. When fully functioning, the dashboard will provide evidence of progress towards a reduction in inequality in health in Cheshire and Merseyside. The indicators in the dashboard will be linked to strategies, policies, investment programmes and actions that, when implemented, will move the indicator towards a reduction in health inequality. The dashboard will be readily accessible and open to interpretation without expert knowledge.
	3. A gap analysis is required to mark the extent of inequalities in health in Cheshire and Merseyside and to show progress towards closing them. Such analysis would show differences in indicators within Cheshire and Merseyside and between the sub-region and other parts of the country. This analysis would show inequality in data and should be evident on the beacon indicator dashboard.
	4. Where possible, data should be aggregated to the Cheshire and Merseyside level. This will provide a reference point for comparison with other regions and for comparison over time to measure progress in Cheshire and Merseyside.
	5. Finally, the table below is a mock-up of how the beacon indicator set will function as a monitoring tool.

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| --- | --- | --- | --- |
| **Theme** | **Programmes and Action** | **Milestones** | **Outcome Indicator** |
| **Life Expectancy** |  |  | Life expectancy, Female, Male |
|  |  | Healthy life expectancy, Female, Male |
| **Theme 1. Give every child the best start in life** |  |  | Percentage children achieving a good level of development at 2-2.5 years (in all five areas of development) |
|  |  | Percentage children achieving a good level of development at the end of Early Years Foundation Stage (Reception)  |
| **Theme 2. Enable all children, young people and adults to maximise their capabilities and have control over their lives** |  |  | Average Progress 8 score |
|  |  | Average Attainment 8 score |
|  |  | Hospital admissions as a result of self-harm (15-19 years) |
|  |  | NEETS (18 to 24 years) |
|  |  | Pupils who go on to achieve a level 2 qualification at 19 |
| **Theme 3. Create fair employment and good work for all** |  |  | Percentage unemployed (16-64 years) |
|  |  | Proportion of employed in permanent and non-permanent employment |
|  |  | Percentage employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter\*\*\* |
|  |  | Percentage of employees earning below Real Living Wage |
| **Theme 4. Ensure a healthy standard of living for all** |  |  | Proportion of children in workless households |
|  |  | Percentage of individuals in absolute poverty, after housing costs |
|  |  | Percentage of households in fuel poverty |
| **Theme 5. Create and develop healthy and sustainable places and communities** |  |  | Households in temporary accommodation |
| **Theme 6. Strengthen the role of prevention and ill health prevention** |  |  | Activity levels  |
|  |  | Percentage of loneliness in population  |
| **Theme 7. Tackle racism, discrimination and their outcomes** |  |  | Percentage employees who are from ethnic minority background and band/level |
| **Theme 8. Pursue environmental sustainability and health equity together** |  |  | Percentage (£) spent in local supply chain through contracts\*\*\* |
|  |  | Cycling / walking for travel (3-5 times / week) |

**Healthcare Partnership Strategy and All Together Fairer Alignment**

1. **Introduction**
	1. The approach to implementing the ATF programme in Cheshire and Merseyside is:
* The Marmot report set the overarching analysis and recommendations for action on the social determinants of health, the building blocks on which good health and reduced inequalities in health, are built. The ICS endorsed the analysis and recommendations from the top and made clear that implementing the overall approach of All Together Fairer and recommendations is the health care partnership strategy.
* The All Together Fairer programme functions through the provision of an overarching framework for action. The actions are taken forward through:
	+ Local authorities
	+ NHS Foundation Trusts
	+ Combined Authority and appropriate Cheshire and Warrington level bodies
	+ Community and voluntary sector organisations
	+ NHS primary care organisations
* Activity at the system level to coordinate work across boroughs and Foundation Trusts sits above this work. These initiatives include the NHS Prevention Pledge, Anchors Programme and working with Barnardo’s and the Institute of Health Equity to design a Children and Young People’s Health Equity Framework, work on Fair Employment Charters and other commissioning and implementation programmes.
* The ICS supports this work by providing leadership development, networking opportunities, coordinating programmes, innovation in developing frameworks and access to inspiration from elsewhere and by developing the monitoring tools that will tell the system whether and how it is making progress.
	1. The Healthcare Partnership Strategy will add focus to this work by bringing the following three essential components of work on social determinants of health to the fore of the ICS and to underpin the work that is carried out on the Marmot themes at each level of organisation in CM.
* Transformational procedures
* Anti-Poverty work
* Equity in all policies
1. **Transformational Procedures**
	1. Work on social determinants in other countries has shown that, as the work has matured, there has been more focus on transformational procedures. In the earlier stages, the work has tended to focus on specific social determinants – housing, transport, food poverty, etc. The transformational procedures for the HCP Strategy alignment are:
* Develop an allocation strategy that supports best use of resources to reduce inequalities and improve population health outcomes.
* Implement a proportionate universalism approach to resource management and distribution and continuously reviewing procedures to ensure this happens in practice.
* Increase, and make equitable, funding for social determinants of health and prevention.
	1. Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need. Proportionate universalism has been described as a hybrid approach which combines a focus on improving the health of the most disadvantaged groups and a focus on reducing the entire social gradient.
	2. The principle of proportionate universalism is adopted in CM through the adoption of the Marmot report and recommendations, but it will not happen in practice without explicit commitment to make it happen. Without explicit action, the default practice will be towards a realisation of the inverse care law in which those with less need of services get better services.
1. **Anti-Poverty**
	1. The main social determinant that we need to address is poverty. One way to do that is to organise and support activity that focuses on an aspect of poverty – furniture poverty, digital poverty, food poverty etc. There are people to work with or to support in each of these areas. This is valid activity. Anything that can be done to alleviate current suffering should be done.
	2. Another approach is to organise and support activity that gets more money to people. This will alleviate poverty, reduce health problems, and reduce demand on primary care health services, hospitals and social care. Action at an ICS level through the HCP Strategy could include working with others (CAB, DWP and others) to increase benefit take-up by increasing knowledge of what is available and providing support to people to apply for benefits. A significant move would be to act to reduce the stigma associated with being on benefits. The ICS could openly support the uptake of benefits as a health measure.
	3. Other actions to increase money for people in poverty are in place but could be more rigorously enforced in the public sector and through contracts with the private sector. This includes payment of a living wage and equality of pay for women. Currently, public sector employers sign up voluntarily to the Liverpool City Region Fair Employment Charter. (A charter for Cheshire and Warrington is under consultation). This could be given a higher profile in the healthcare strategy with explicit encouragement for employers to sign up to and implement the charter standards as, again, a way of reducing demand for health care services.
2. **Equity In All Policies**
	1. The more progressive thinking has moved on from the push for health-in-all-policies. What we are seeking is equity in all policies. We are looking for equity in education, employment, access to green space, etc. in the knowledge that achieving equity there will bring equity in health. It is the essence of the social determinants approach to reducing inequality in health and improving population health that the health sector pushes for, supports and invests in equity in policy and practice outside its remit in healthcare services.
	2. The HCP strategy can support the development and adoption of tools to support the review of health services, by the manager closest to the service delivery, to identify the equity issues in access and outcomes of the service and what action needs to be taken to resolve the problems for greater equity in provision. This work will be aligned to the implementation of the NHS Core 20 Plus 5 programme.
	3. The HCP Strategy can acknowledge the work that is happening across the region through councils, hospitals, schools, third sector and voluntary sector organisations and groups to alleviate poverty and achieve equity and make it clear that this work is valued, funding will be allocated to support it and the Board will constantly focus on this work. The ICS and Board through the HCP Strategy will commit to long term focus, will seek to support and develop the work in other sectors and will ask, when something isn’t happening or changing, what it can do to make it happen and then do it.

**Appendices**

Appendix A: All Together Fairer Stocktake



Appendix B: [All Together Fairer Report](https://www.instituteofhealthequity.org/resources-reports/all-together-fairer-health-equity-and-the-social-determinants-of-health-in-cheshire-and-merseyside)

Appendix C: [Cheshire and Merseyside Health and Care Partnership (ICP) Interim Strategy](https://www.cheshireandmerseyside.nhs.uk/media/hxqpdrot/cheshire-merseyside-draft-interim-hcp-strategy-2023.pdf)