NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside ICB

Annual Report 2023/24 Addendum

Health Inequalities Report

1. Health Inequalities Report

1.1. It is a core purpose of the ICB to tackle inequalities in outcomes, experience and access. ICB's are required to "have regard to the need to – a) reduce inequalities between persons with respect to their ability to access health services, and b) to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

1.2. Information should be used to develop an understanding of general healthcare needs, understand healthcare access; experience and outcomes; be published within or alongside annual reports; and inform service improvements and reductions in healthcare inequalities.

1.3. At a minimum, ICBs should publish information [1]at ICB level but may also wish to publish at Trust level subject to discussion with Trusts.

1.4. Our main ICB Annual Report for 2023/24 provides the narrative detail around the work undertaken across the ICB during 2023/24 and provides an overview of our system led approach to tackling inequalities with our Health and Care Partnership and groundbreaking All Together Fairer Strategy.

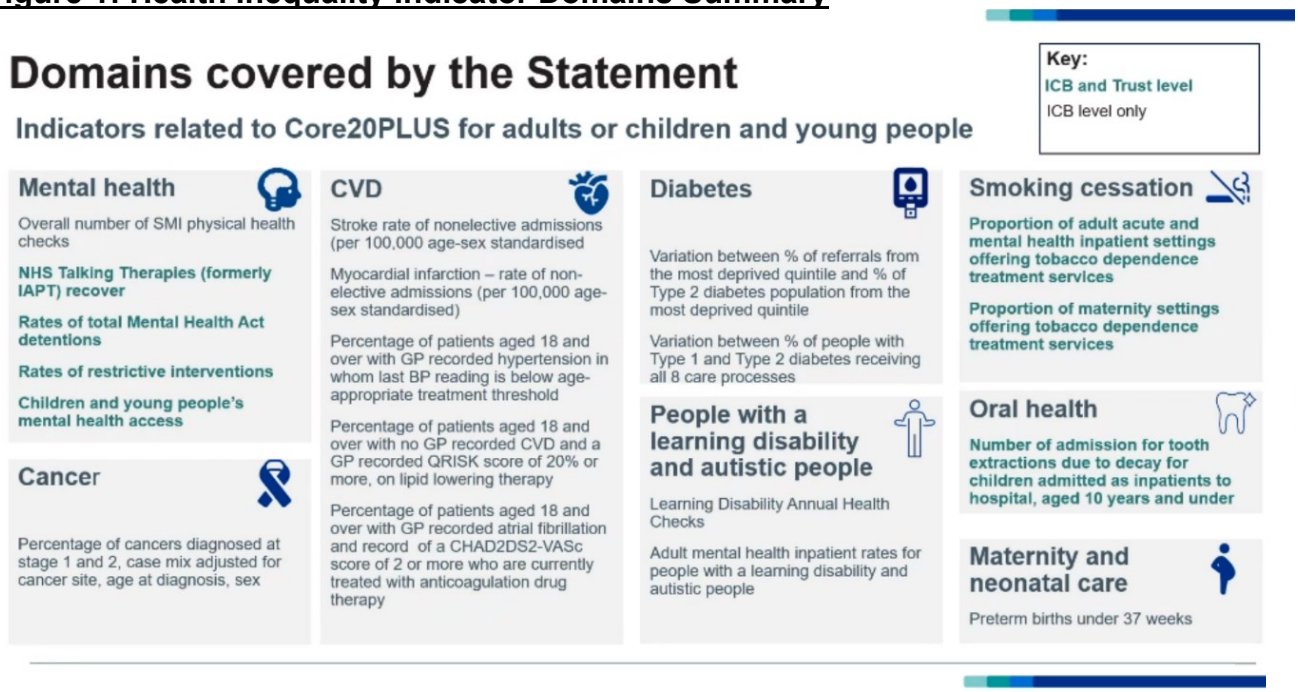
1.5. This document provides an overview summary of the published data and metrics that are used to monitor and inform health inequalities across our Cheshire and Merseyside population and provides a summary of the actions undertaken as a consequence of this.

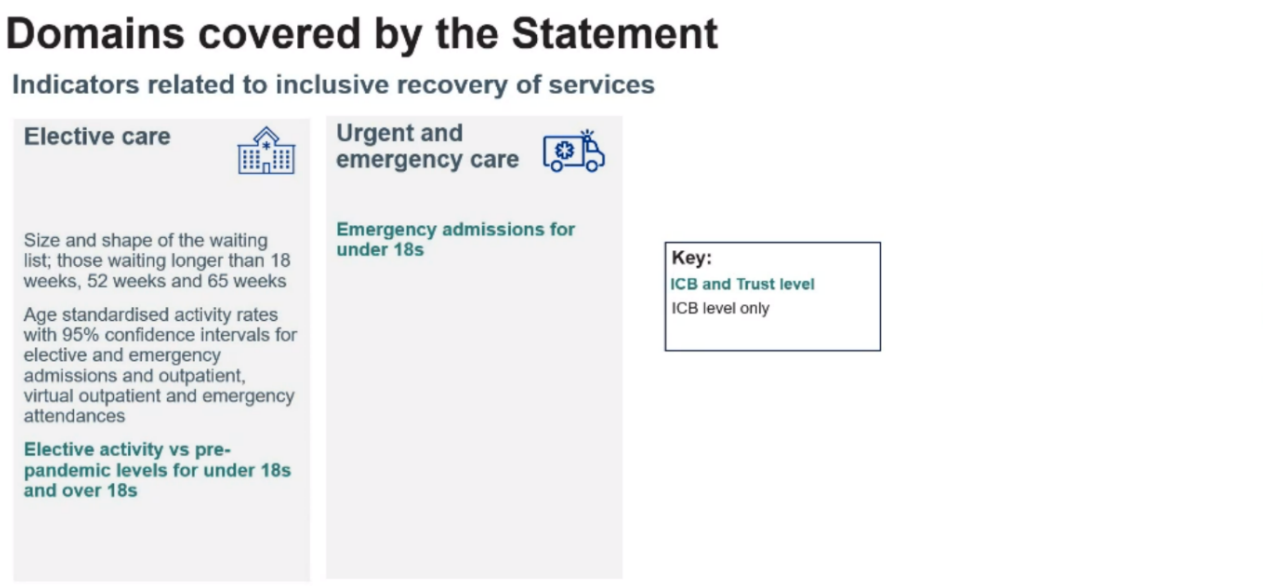
1.6. An interactive published data set is being developed for 2024/25 that will provide a consistent accessible approach to how we publish, monitor and interact with the key data sets for tackling health inequalities.

1.7. This appended report provides an overview of the key domains related to inequalities and published data we use against those domains and health care inequalities. The domains that are required to be published in line with the Health Inequalities Statement are described in Figure 1.

[1] NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

Figure 1: Health Inequality Indicator Domains Summary





2. Tackling Inequalities in Cheshire and Merseyside

2.1. In Cheshire and Merseyside, there are 2.7 million people living across areas of both significant wealth and substantial deprivation. The mental and physical health and care challenges are faced by some of the most deprived neighbourhoods with the greatest health inequalities in England. We know that 33% of our population live in the most deprived neighbourhoods in the country and 26% of our children (0-15 years) live in poverty. We also know that those in more deprived areas suffer reduced quality of life, increased mental health problems, and die earlier than those from more affluent backgrounds.

2.2. Through our Joint Forward Plan (JFP) we aim to prevent ill health and tackle inequalities and improve the lives of the poorest fastest and believe we can do this best by working in partnership across our system. This will allow everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer.

2.3. In 2022, the ICB commissioned Sir Michael Marmot and the Institute of Health Equity to publish the All Together Fairer report[2]. All Together Fairer is Cheshire and Merseyside's collaborative approach to reducing health inequalities in the subregion, it brings together public, private and third sector organisations with one shared aim: build a fairer, healthier Cheshire and Merseyside.

2.4. The report was built upon local health inequalities data packs across all nine of our local authority places, and also led to the development of a number of Beacon Indicators to help baseline and monitor the complex inequalities that exists in am ICB of our geographical size, detailed analysis of the indicators can be viewed in Section 12 of this report.

2.5. In January 2024, the Health and Care Partnership received an annual stocktake of progress against these Beacon indicators, with detailed interventions and levels of progress across our nine places and against the eight key All Together Themes for Action. The meeting held in public, and its associated detailed papers are accessible on the NHS Cheshire and Merseyside website[3].

2.6. Our new Data into Action programme was launched during 2023/24 and uses evidence to understand our expenditure and activity across different settings to determine where we optimally invest/disinvest our existing resources for improved outcomes and efficiency. Where we have developed increasingly sophisticated ways of understanding the health and care needs of our population, we are committed to turning 'intelligence into action'. This is our ability to bring focussed, and therefore meaningful, interventions to those who most need it. Finding and intervening for those in greatest need 'turns the dials' on improvement in the health and care outcomes of our population in an equitable way. This is underpinned by our Digital and Data Strategy which describes some of the key challenges to our population, and our plans to use data and digital tools to help address these challenges.

2.7. Information is used to inform service improvement and reductions in healthcare inequalities. This includes using the information to inform:

- strategy development
- policy options review
- resource allocation
- service design
- commissioning and delivery decisions
- service evaluations.

[2] Cheshire-and-Merseyside-report_interactive-v6.pdf (champspublichealth.com)
[3] https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/cheshire-and-merseyside-health-and-care-partnership/2024/16-january-2024/

2.8. Our clinical priorities are clearly documented in the JFP. They are evidenced based to not only improve health outcomes of our population, but also to make best use of resources to avoid ill health. These cover diagnostic groups of cancer, cardiovascular disease, respiratory disease and mental health. We also recognise segments – complex lives (physical health, mental health, drug/alcohol misuse and children in the care system) and frailty and dementia. These areas are known to have differential outcomes for different groups within our population, so it is vital that we can view the data about these services and conditions through a lens of inequality in order to target improvement activities.

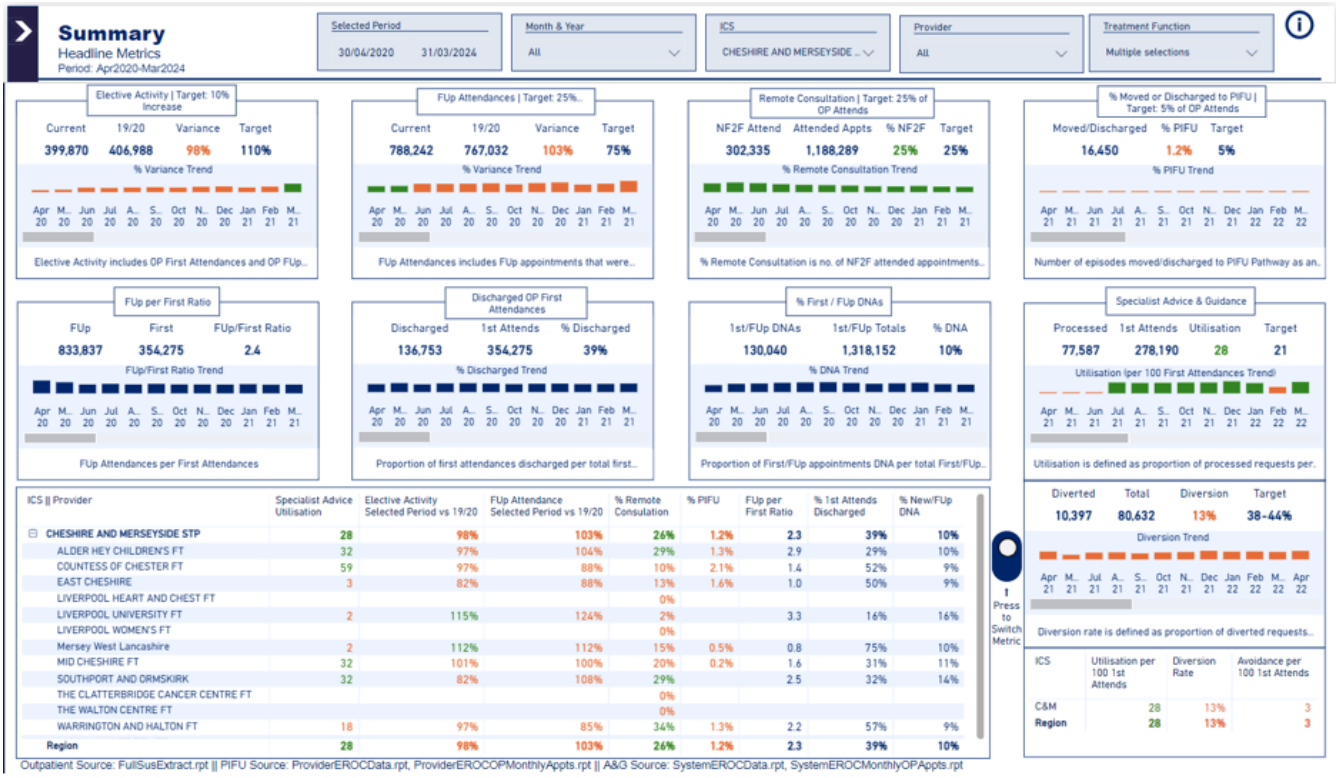
2.9. The following sections provide a summary of the types of information and reports used in Cheshire and Merseyside to guide improvement actions, with examples of the actions completed for each area during 2023/24.

3. Elective and Urgent Care

3.1. Age standardised activity rates with 95% confidence intervals for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances:

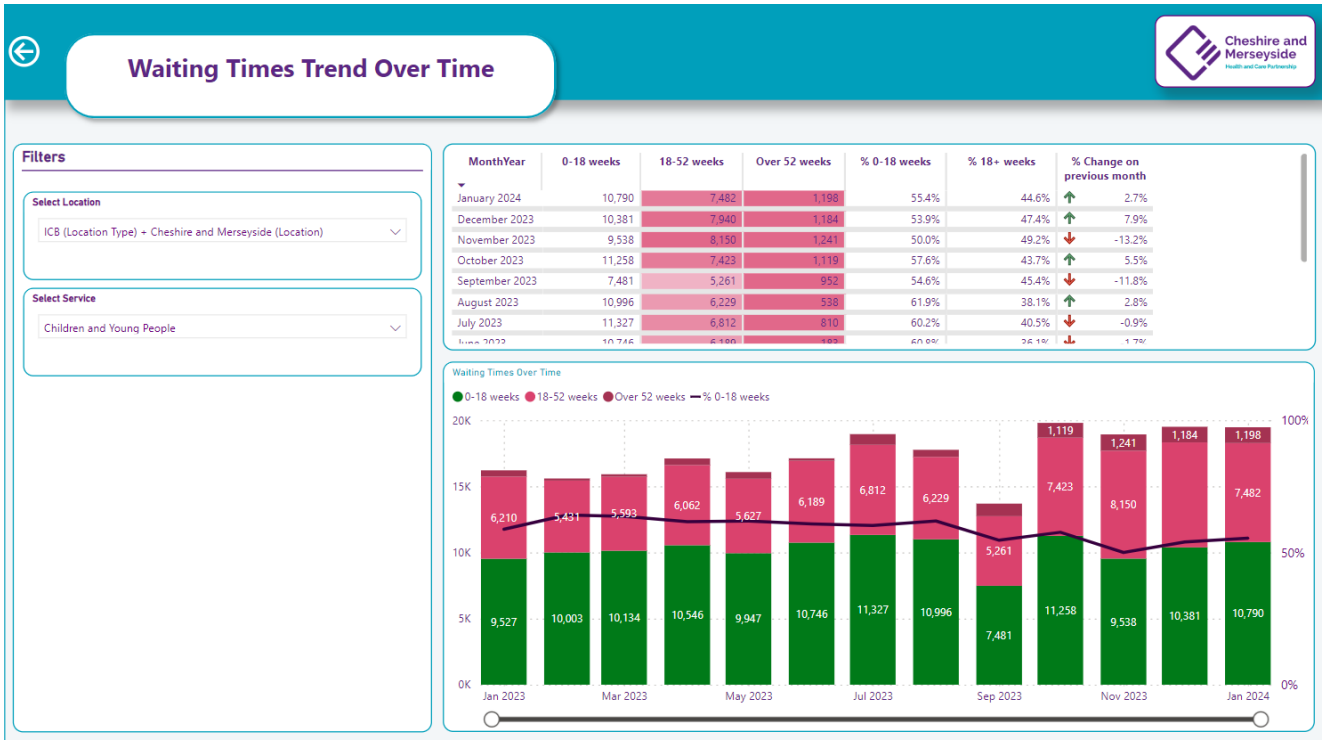
Source: Secondary Uses Service (SUS)

3.2. Elective activity vs pre-pandemic levels for under 18s and over 18s:



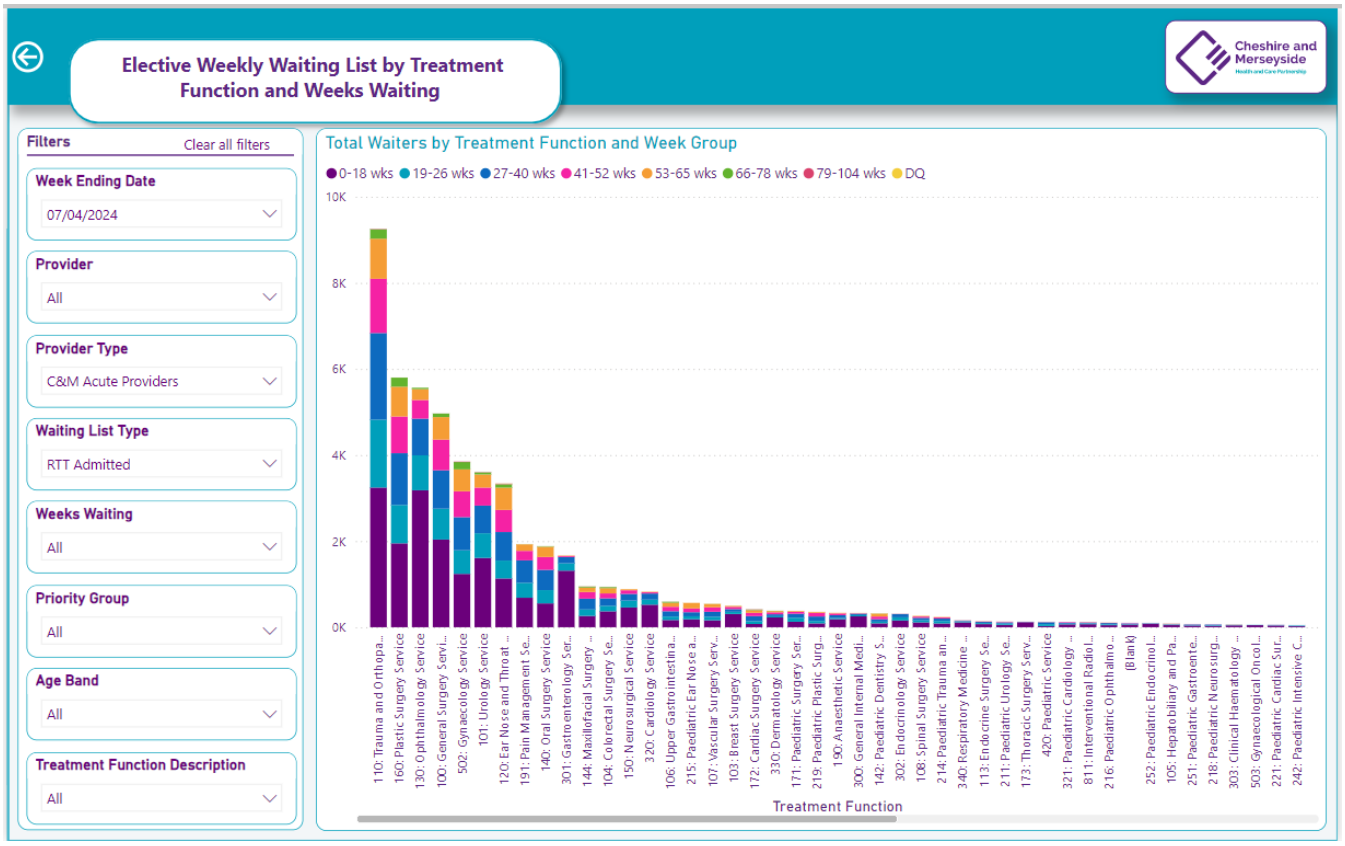
Source: Secondary Uses Service (SUS), Elective Recovery Outpatient Collection (EROC)

3.3. Community Services waiting times for children and young people:

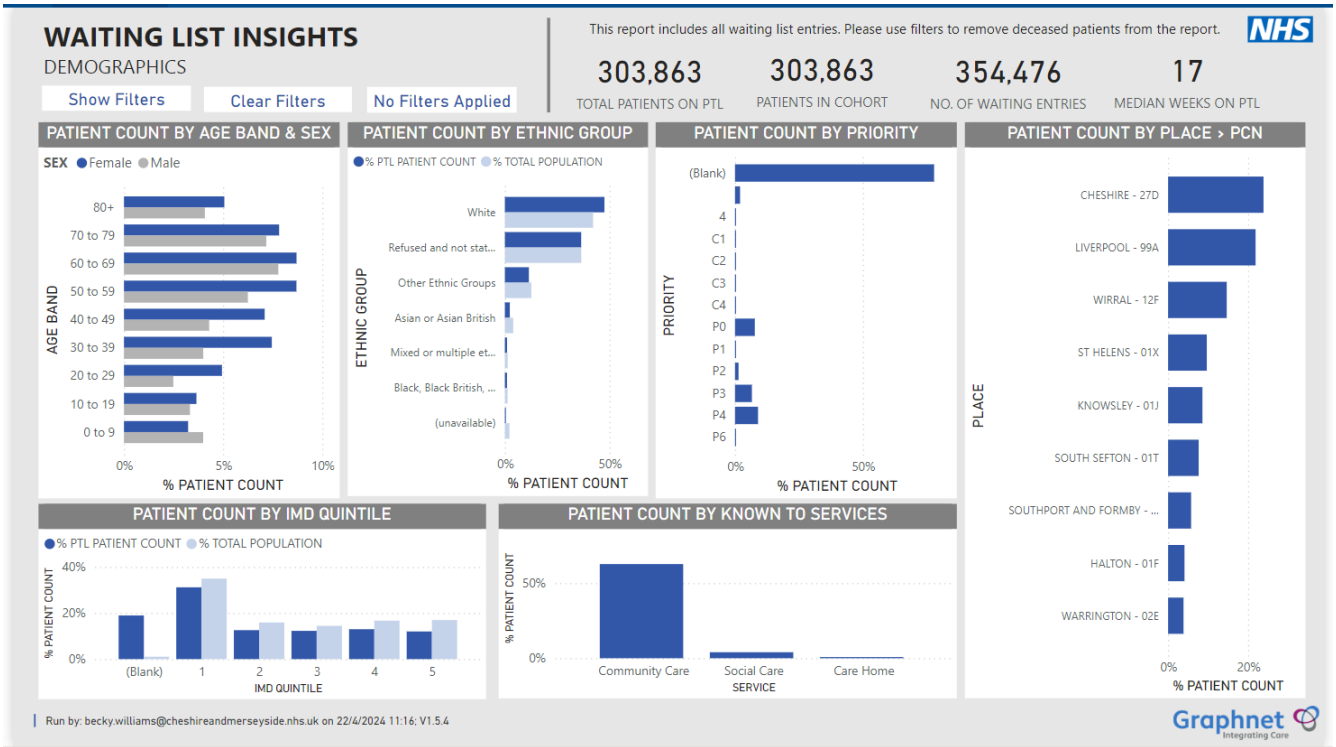


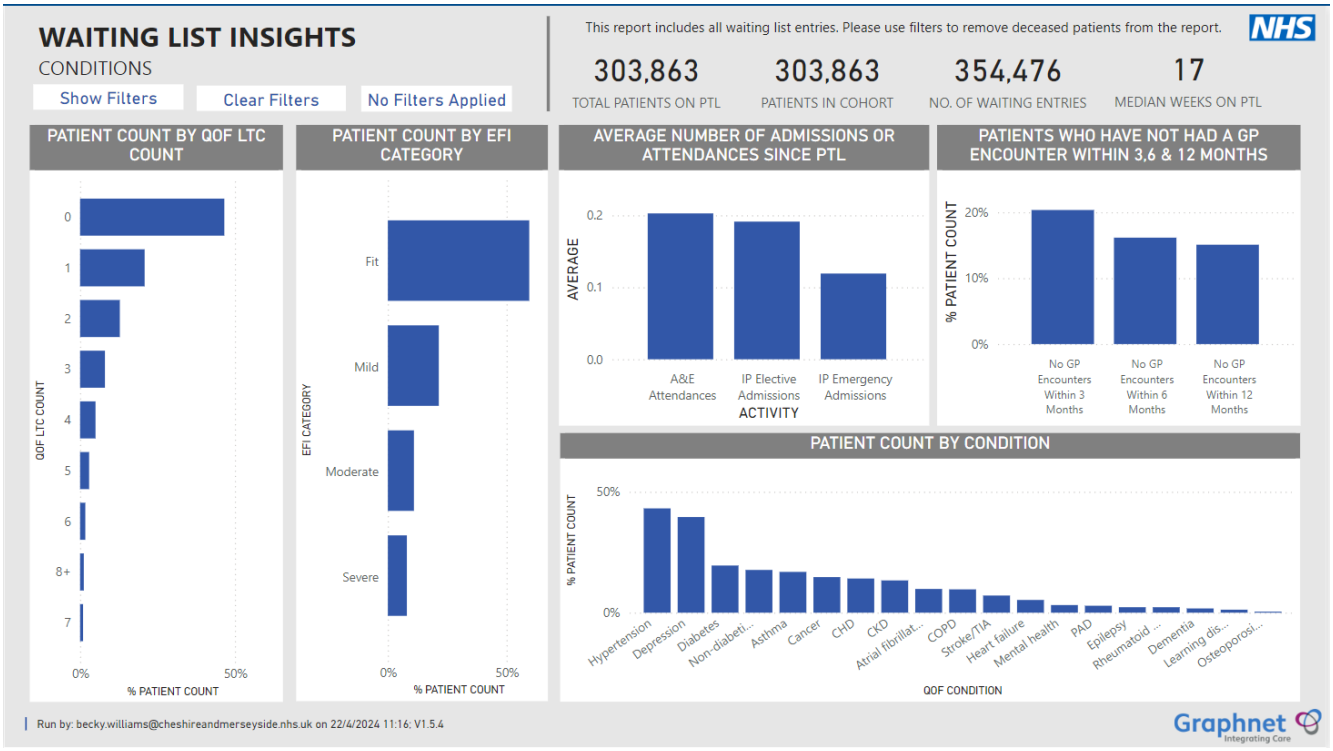
Source: Community Services Data Set (CSDS)

3.4. Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks:



Source: NHS Referral to Treatment (RTT) collection





Source: Secondary Uses Service (SUS), Primary Care records, Johns Hopkins ACG system.

3.5. Emergency admissions for under 18s

Source: Secondary Uses Service (SUS)

3.6. **Summary of Actions**

3.6.1. The use of data tools to enhance Patient Tracking List (PTL) triage systems, helps identify individuals waiting for surgery who may deteriorate more quickly. It enables surgical teams to prioritise people, take steps to reduce these risks, or to prepare expert treatment if these risks happen.

3.6.2. Cheshire and Merseyside (C&M) implemented PTL across the whole ICB, and the results have been very positive. Independently verified evidence shows that >1 excess bed day is saved per patient, including 8% reduction in A&E attendances, 54% reduction in avoidable harm, 35% conversion to day case, 27% reduction in waiting list in first 6 months of deployment and >60 mins of consultant surgeon administrative time saved per patient per year.

3.6.3. In helping restore NHS Services equitably, we have an established system leadership team for health inequalities across our elective recovery and transformation pathways, we continue to lead the preparation for upcoming changes to the reporting of health inequalities metrics at the beginning of April by both integrated systems and individual trusts across Cheshire & Merseyside, this includes regular sharing of new information and continuous engagement with colleagues across Health Inequalities, Equalities and Diversity, Business Intelligence and public/population health departments.

3.6.4. We continue with the development of our own system-wide DNA Predictor Tool which – once fully implemented across all trusts – will give individual trusts the power to heavily reduce their missed appointment rates through pre-appointment administrative validation of patients who are more likely to miss their appointments based on a set of pre-agreed socio-economic, geographic and trust operational (short notice clinics, pre- outpatient/follow-up appointment diagnostic tests, etc) factors.

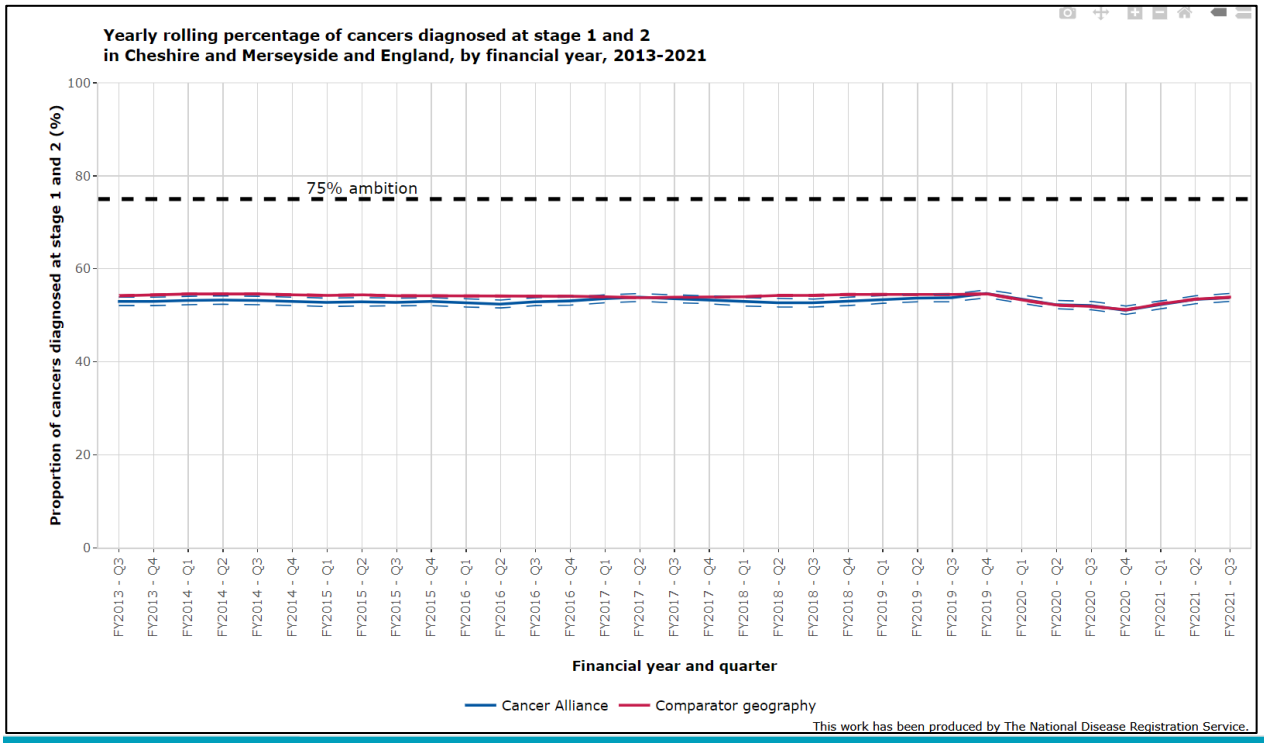
3.6.5. Cheshire & Merseyside's missed appointment rate once again fell between December 2023 and February 2024 from 8.5% to 8.1%, freeing up approximately 5k appointments across specialities and trusts throughout the traditionally busy winter period. The focus of our efforts surrounded a continued reinforcement of health inequalities responsibilities and targets across our trusts, specifically around waiting list validation measures, utilising our CIPHA tool and a focus on paediatric Was Not Broughs (WNBs).

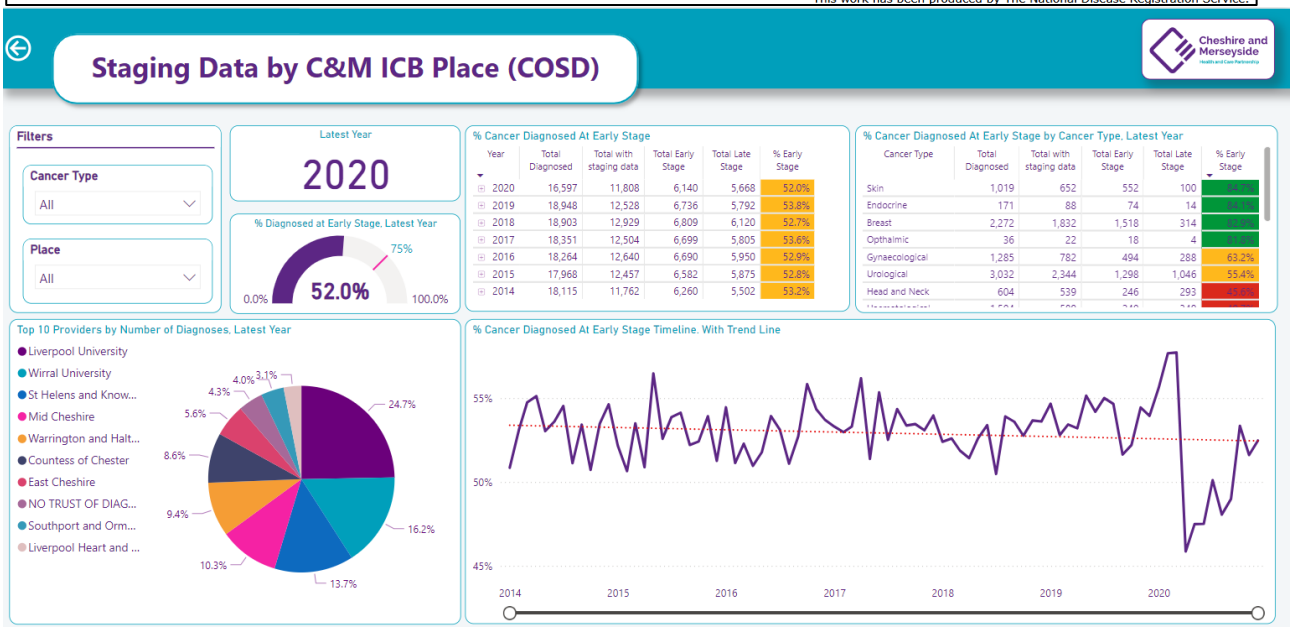
3.6.6. Dental caries (tooth decay) is the leading cause of admission to hospital for children aged between 6 and 10 years. Dental decay is highly prevalent in Cheshire & Merseyside (C&M) and the impact on both society and the individual is significant, causing pain, discomfort, sleepless nights, limitation in eating leading to poor nutrition, and time off school and work. Our 5-year-old children living in the most deprived areas in the country (37%) were almost 3 times more likely to have experienced dental caries than children living in the least deprived areas (13%). Nearly 67, 000 (42%) of our 2-7 years old in C&M live in the 20% most deprived areas of the country. With 8 of our 9 places all worse than the England average for dental decay in 5-year-olds.

3.6.7. To help tackle this leading cause of admissions, the ICB have introduced a new Oral Health Inequality Improvement programme, commencing in q4 2023/24 with full implementation due in 2024/25, supervised tooth brushing and the provision of oral health packs to targeted 2–7-year-olds in our 20% most deprived communities will be undertaken. Section 11 provides further data and detail on this specific area.

4. Cancer

4.1. Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex





4.2. **Cancer Summary Actions**

4.2.1. Work has been undertaken on an early campaigns' strategy, and an early diagnosis innovations project due for launch during 2024. Over 100,000 patients have been invited for a lung health check across the region (over 10% of the total invites issued nationally).

4.2.2. Mobilisation work has been completed to extend the offer of Targeted Lung Health Checks (TLHC) to Wirral, Warrington, and North Sefton. The approach has used a comprehensive suite of data in relation to deprivation, smoking status, and cancer incidence and prevalence to target the populations with the greatest need first.

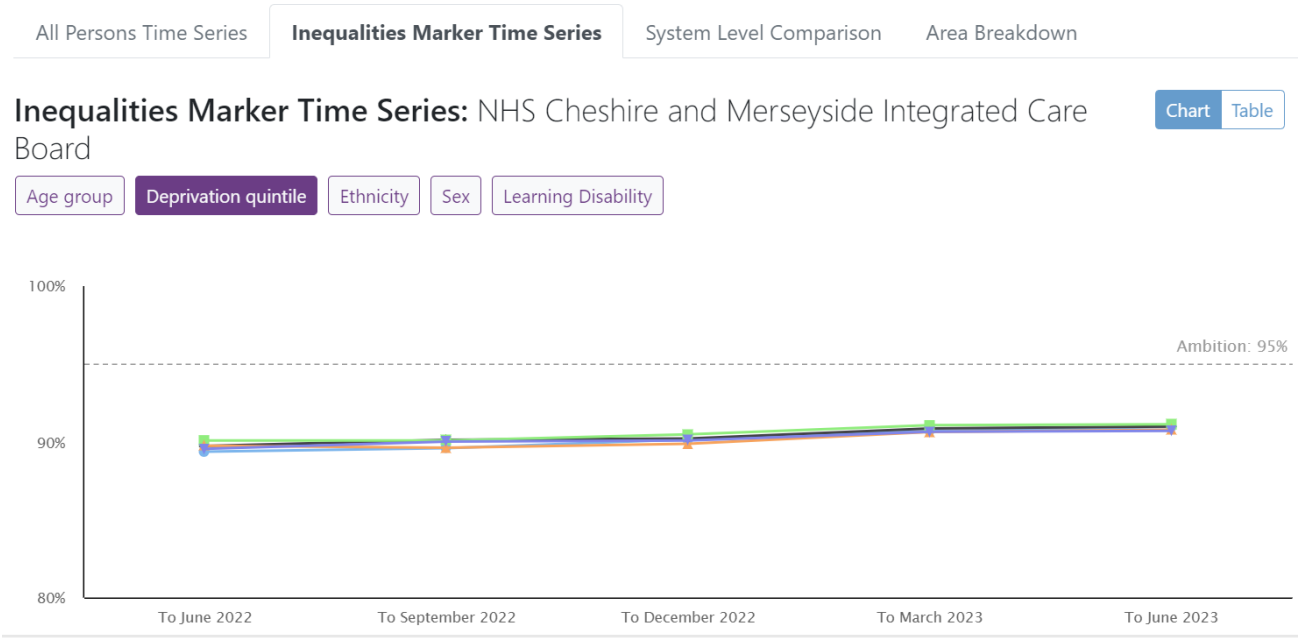
4.2.3. A specialised, tailored TLHC marketing/awareness campaign that will target the areas of highest deprivation and reach non-engaged communities is being developed with input from partners in NHS Place, Primary Care and the community through the Alliance's Social Action Leads and Community Engagement colleagues.

4.2.4. Engagement with Screening and Immunisations team on the workplan for 2024/25 has been undertaken around improving screening rates and HPV vaccination uptake. The ICB is establishing a new Screening and Immunisations Oversight Group that is due to commence in Q2 of 204/25

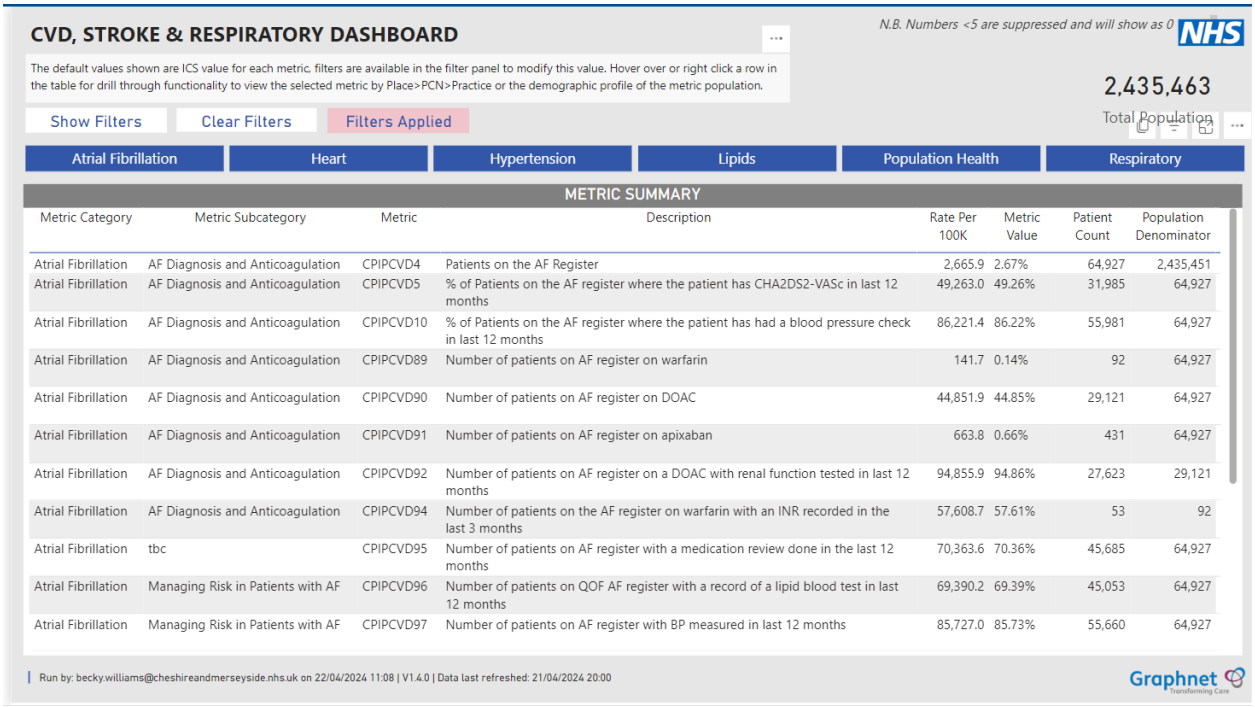
4.2.5. Our Maternity Cervical Cancer Screening Project was launched which saw the introduction of a cervical screening toolkit for midwives (developed by Women's Health and Maternity (WHaM) in conjunction with NHSE North West) to upskill the maternity workforce and enable more informed conversations with women about the importance of attending for cervical screening postnatally (when due). Positive feedback from midwives received with a media release developed in collaboration with C&M Cancer Alliance to promote the project and encourage women to attend screening – launched during Cervical cancer prevention week (22nd to 28th Jan), alongside a successful social media campaign.

5. Cardiovascular Disease

5.1. CVDP002AF: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy:

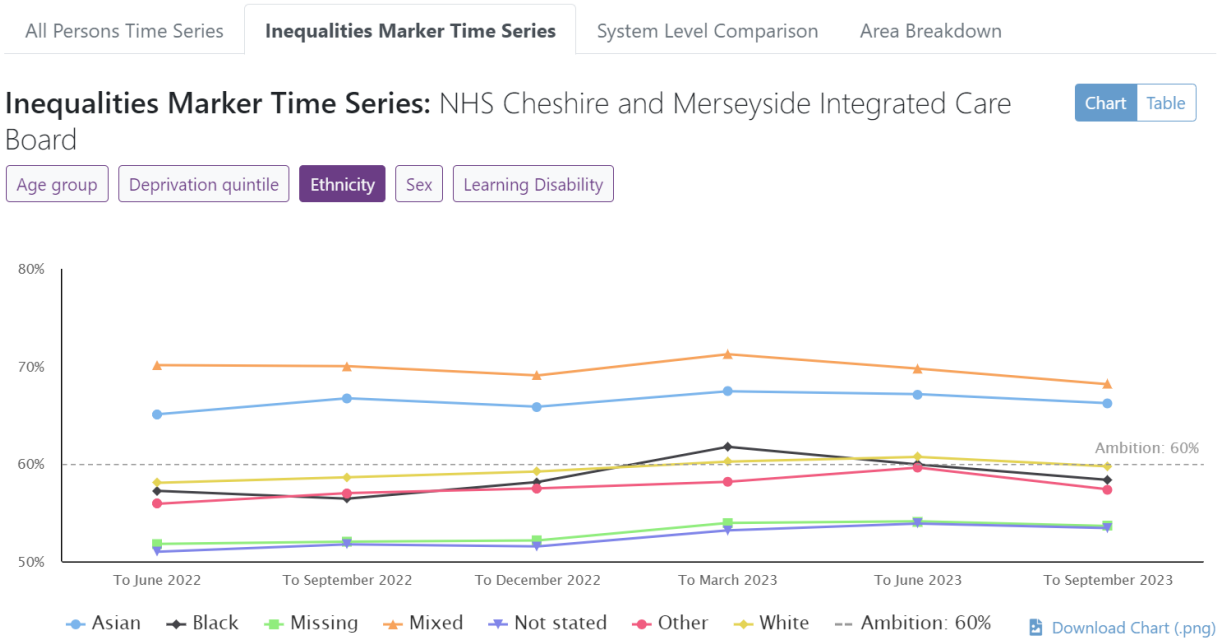


Source: CVD Prevent

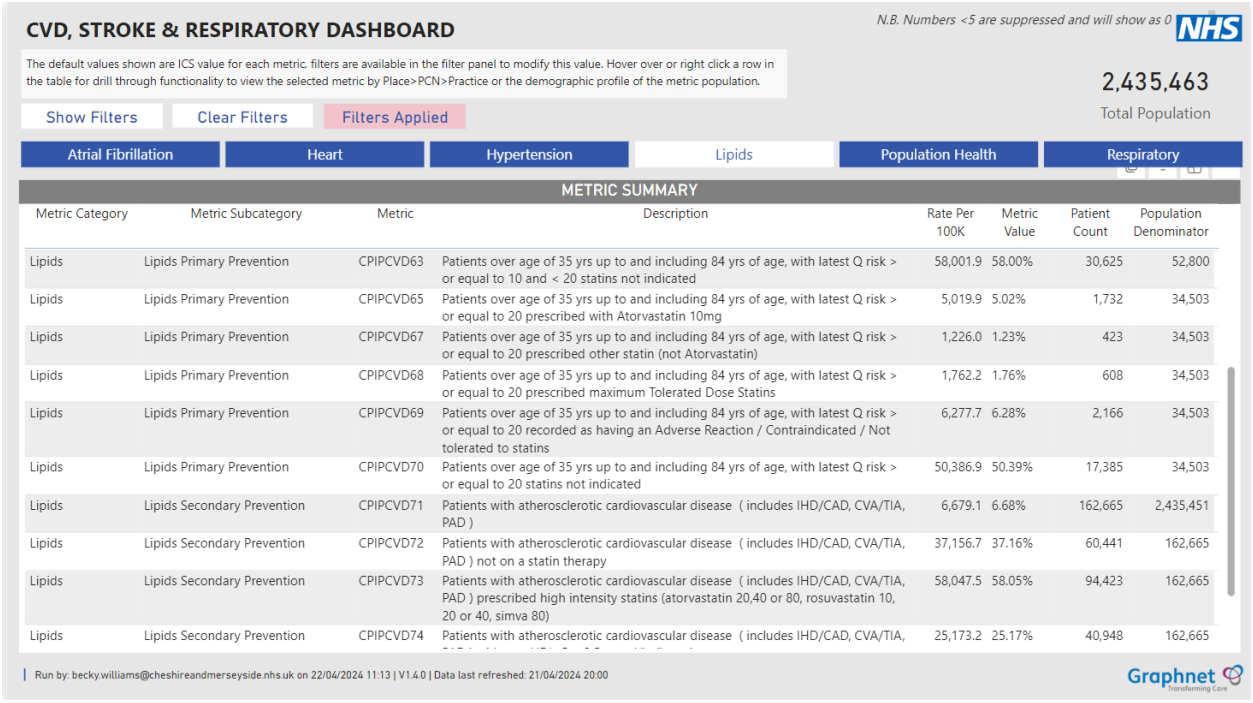


Source: Primary Care records

5.2. CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy:

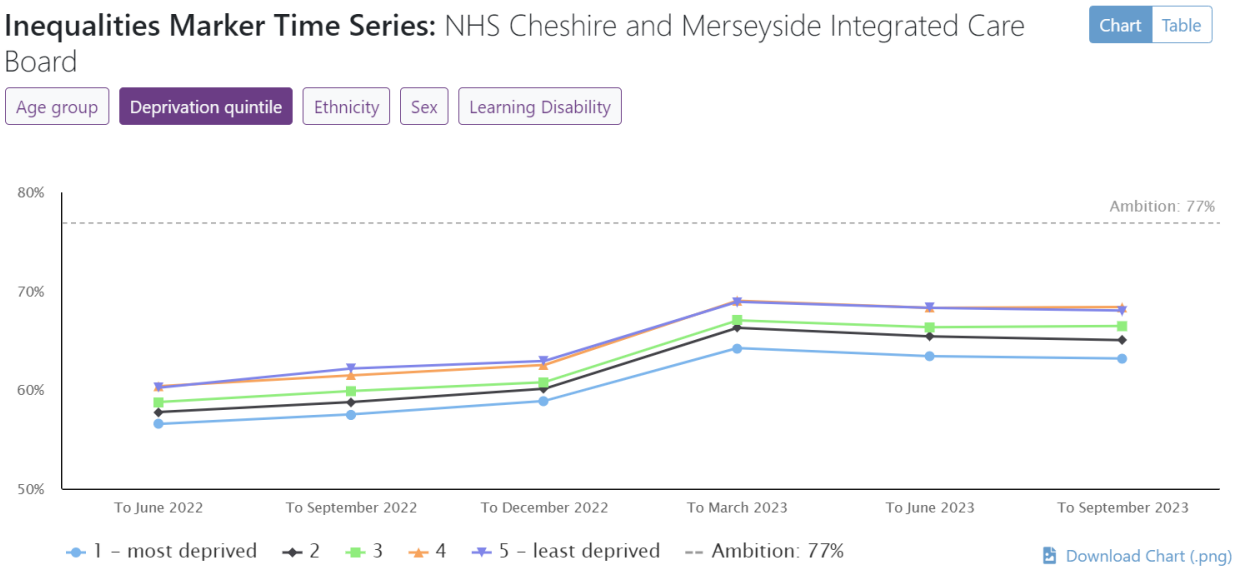


Source: CVD Prevent

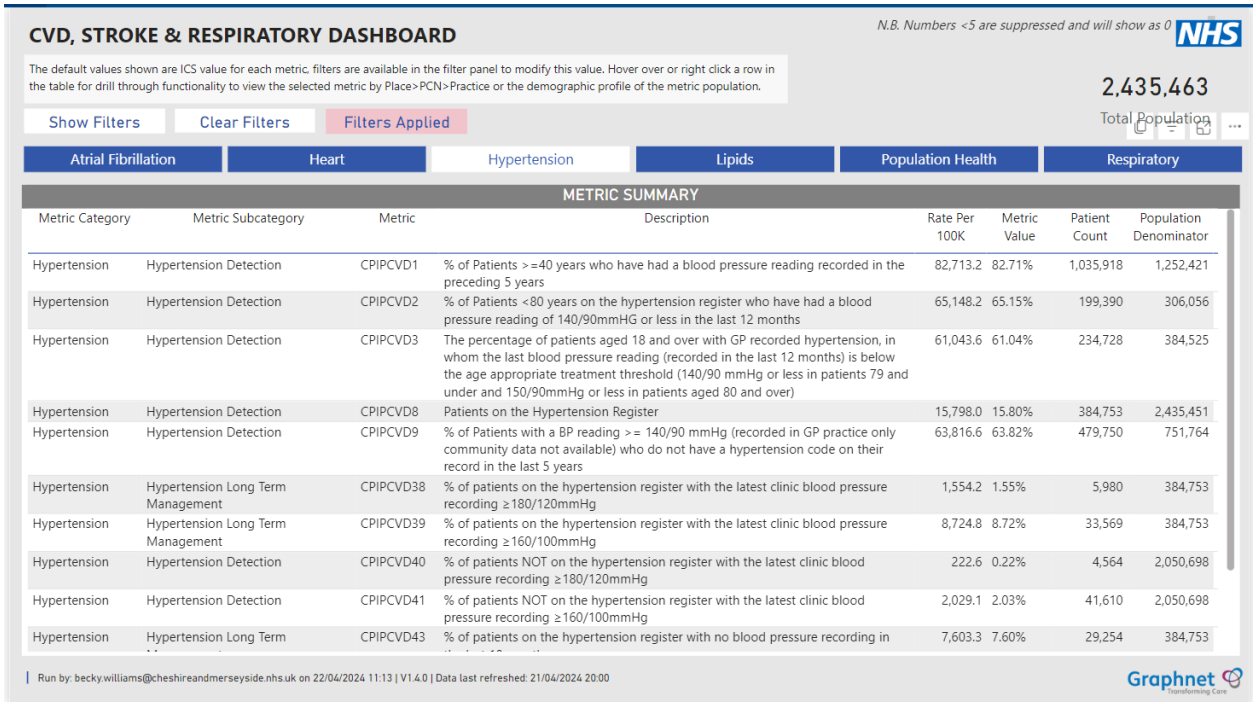


Source: Primary Care records

5.3. CVDP007HYP: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold, by data

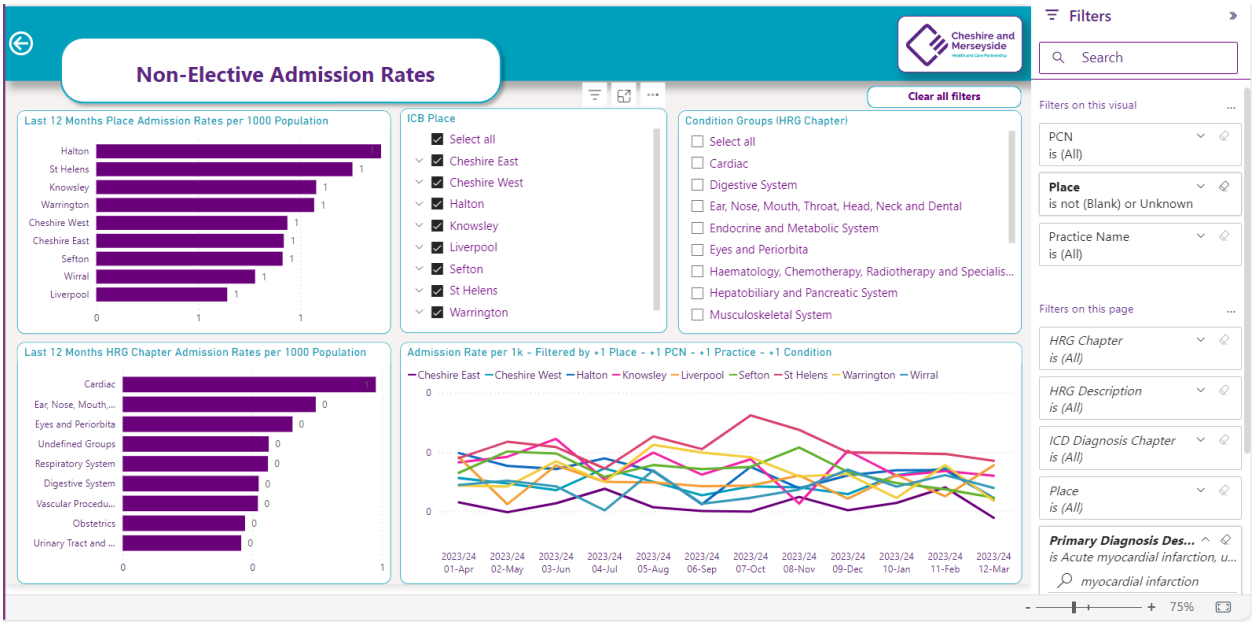


Source: CVD Prevent

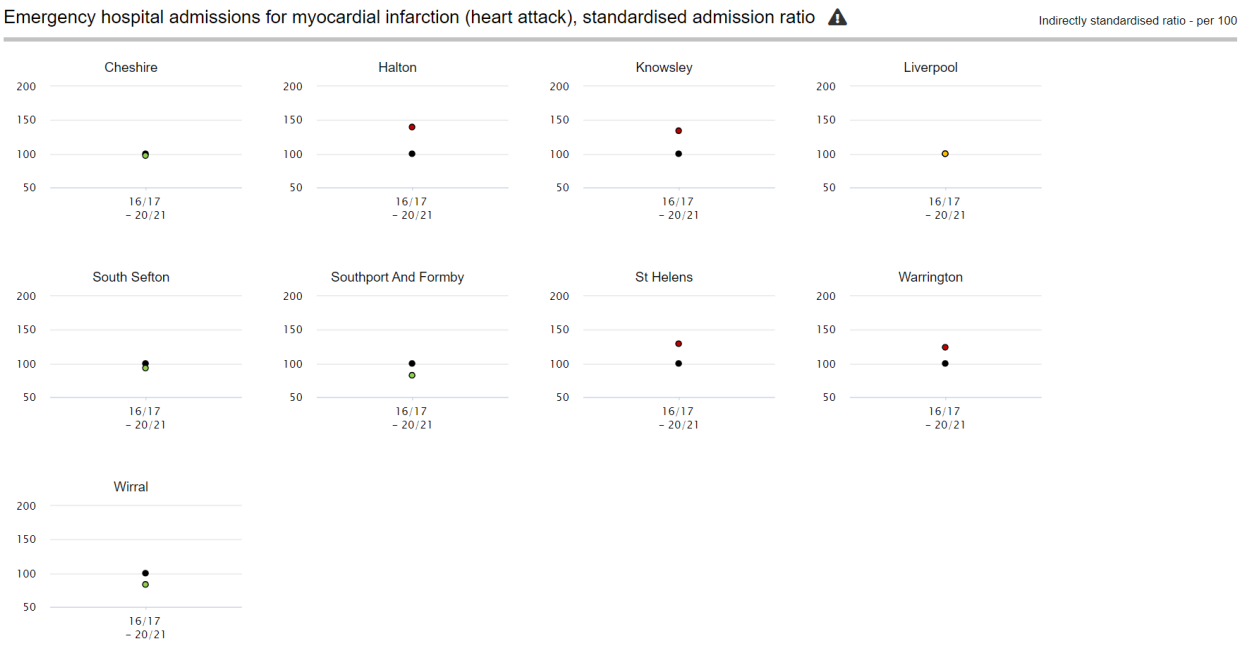


Source: Primary Care records

5.4. Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)

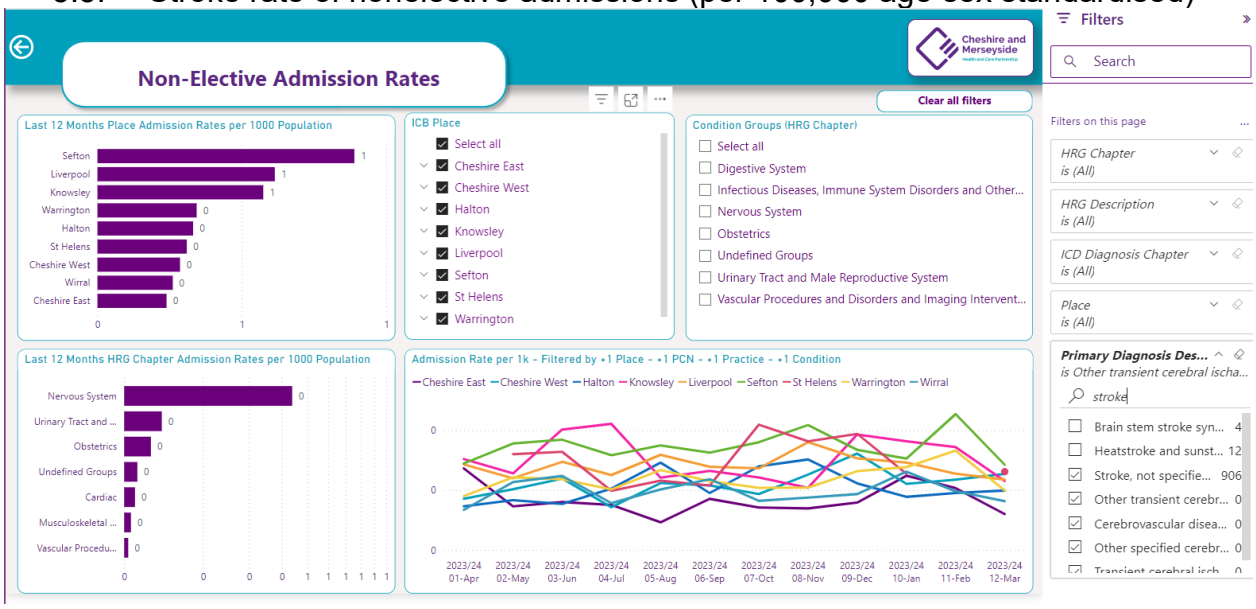


Source: Secondary Uses Service (SUS)

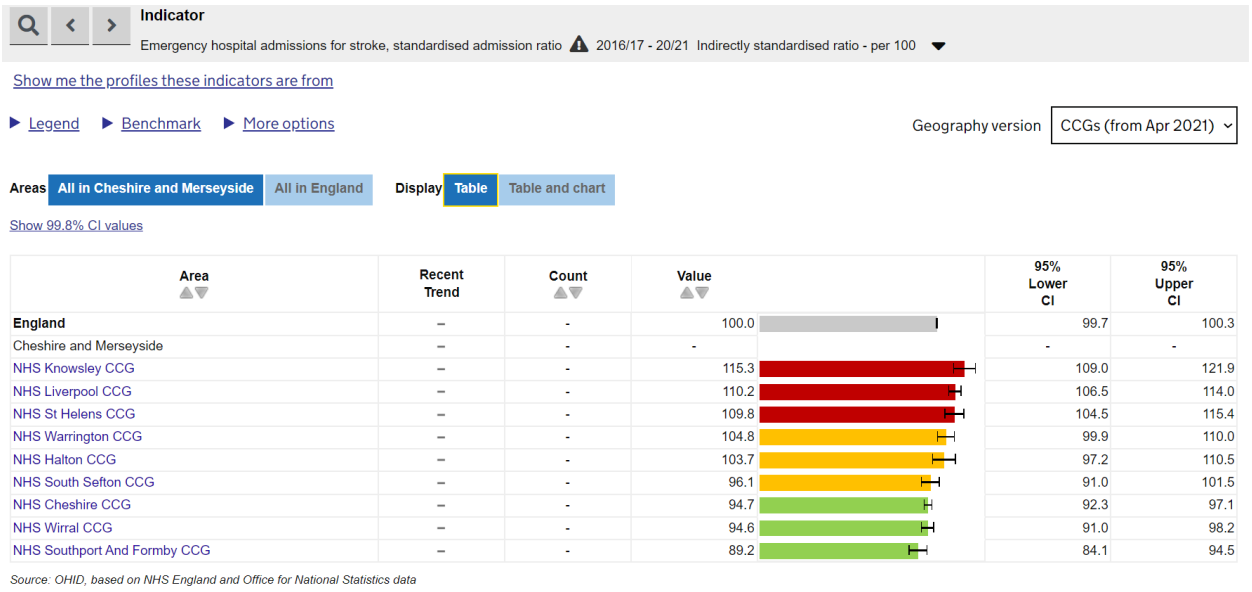


Source: PHE Fingertips

5.5. Stroke rate of nonelective admissions (per 100,000 age sex standardised)



Source: Secondary Uses Service (SUS)



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	100.0	99.7	100.3
Cheshire and Merseyside	–	-	-	-	-
NHS Knowsley CCG	–	-	115.3	109.0	121.9
NHS Liverpool CCG	–	-	110.2	106.5	114.0
NHS St Helens CCG	–	-	109.8	104.5	115.4
NHS Warrington CCG	–	-	104.8	99.9	110.0
NHS Halton CCG	–	-	103.7	97.2	110.5
NHS South Sefton CCG	–	-	96.1	91.0	101.5
NHS Cheshire CCG	–	-	94.7	92.3	97.1
NHS Wirral CCG	–	-	94.6	91.0	98.2
NHS Southport And Formby CCG	–	-	89.2	84.1	94.5

Source: OHID, based on NHS England and Office for National Statistics data

5.6. **<u>CVD Summary Actions</u>**

5.6.1. During 2023/24 additional funding was secured for C&M, to support CVD Prevention c. £465k for Q3/Q4 23/24 and 24/25 (FYE).

5.6.2. This continued to several targeted interventions, including resources allocated to local by Places in support of voluntary sector BP monitoring awareness raising and education.

5.6.3. Our work with the British Heart Foundation has evolved and led to the development a BP 'patient facing materials' resource/toolkit for C&M (the ICB are a pilot for a wider national programme).

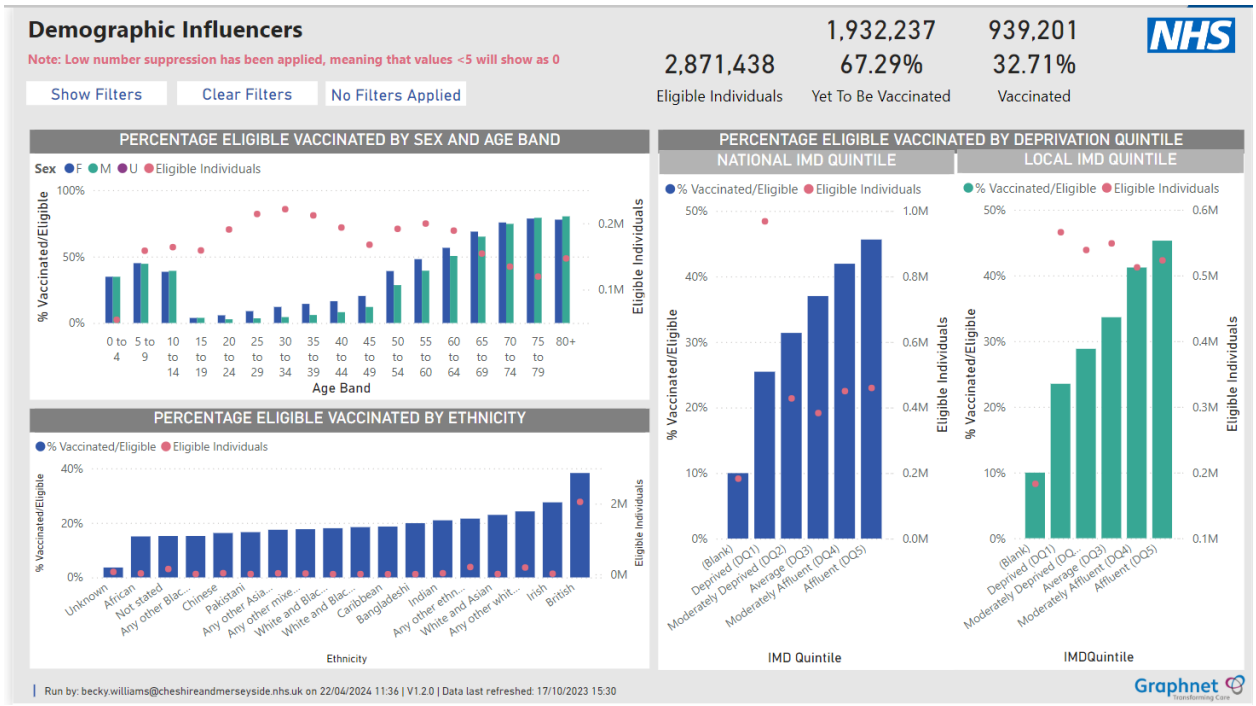
5.6.4. A number of innovation pilots have concluded, to inform the evidence base and potential scaling of activity in 24/25, such as: Familial Hypercholesterolaemia (FH) Service; Automated BP testing machinery and three CLEAR pilots.

5.6.5. During Q4 of 2023/24 the ICB worked with Cheshire Fire Service & NWAS to deliver opportunistic CVD prevention checks targeted to area of inequality and higher risk.

5.6.6. The advancing CVD Prevention Strategy is being considered by Place as they develop operational delivery plans for the Joint Forward Plan. All Places have established locality CVD Groups or Boards to lead on the delivery of their locality plans

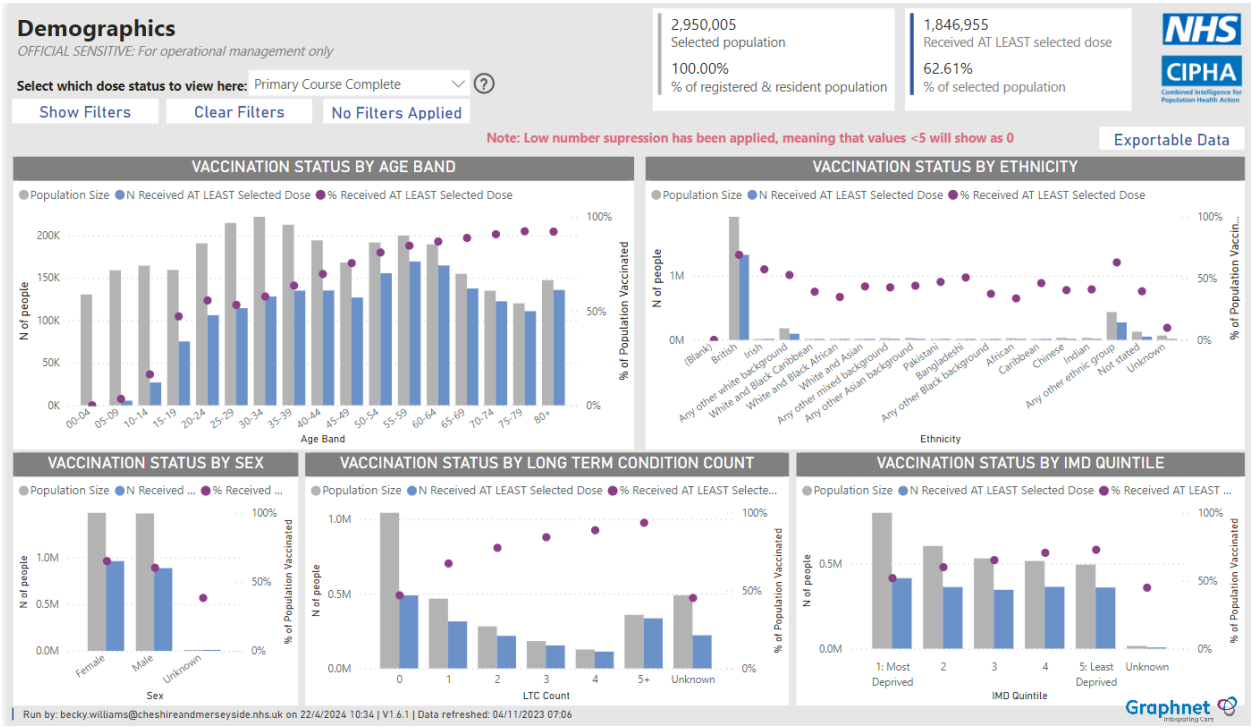
6. Respiratory

6.1. Uptake flu vaccination by socio-demographic group



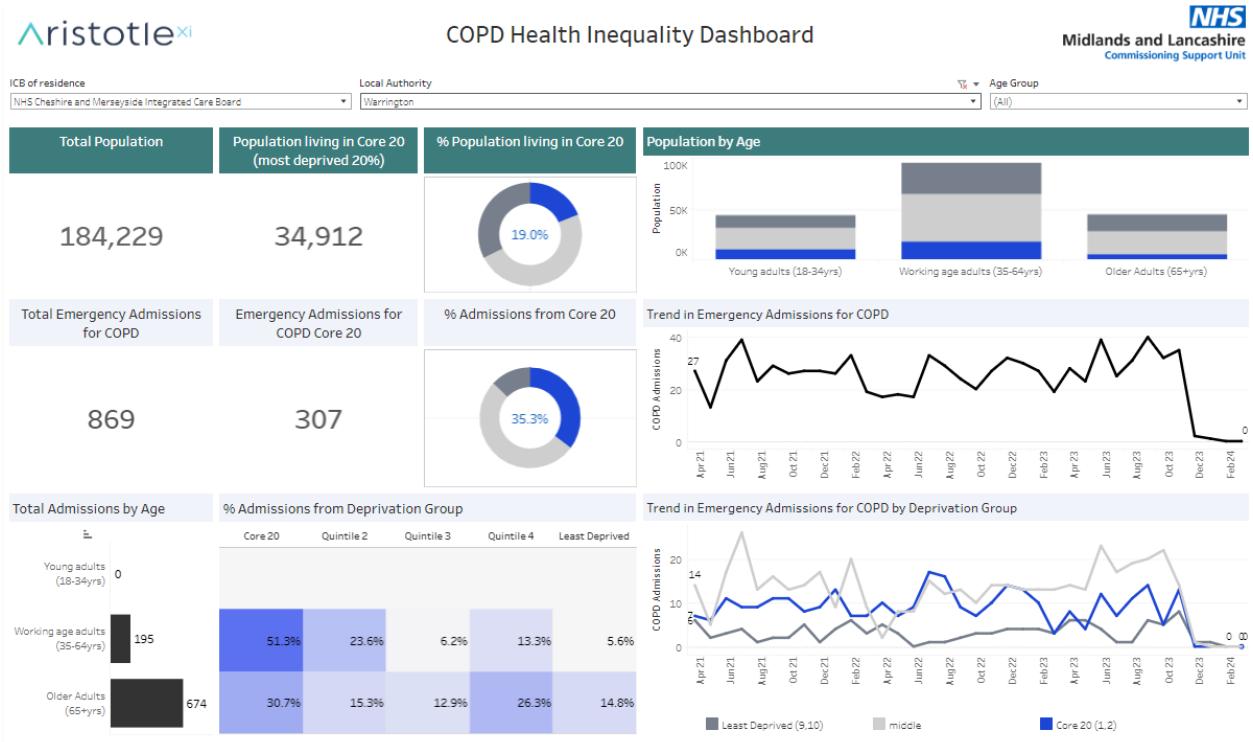
Source: Primary Care records

6.2. Uptake of COVID vaccination by socio-demographic group

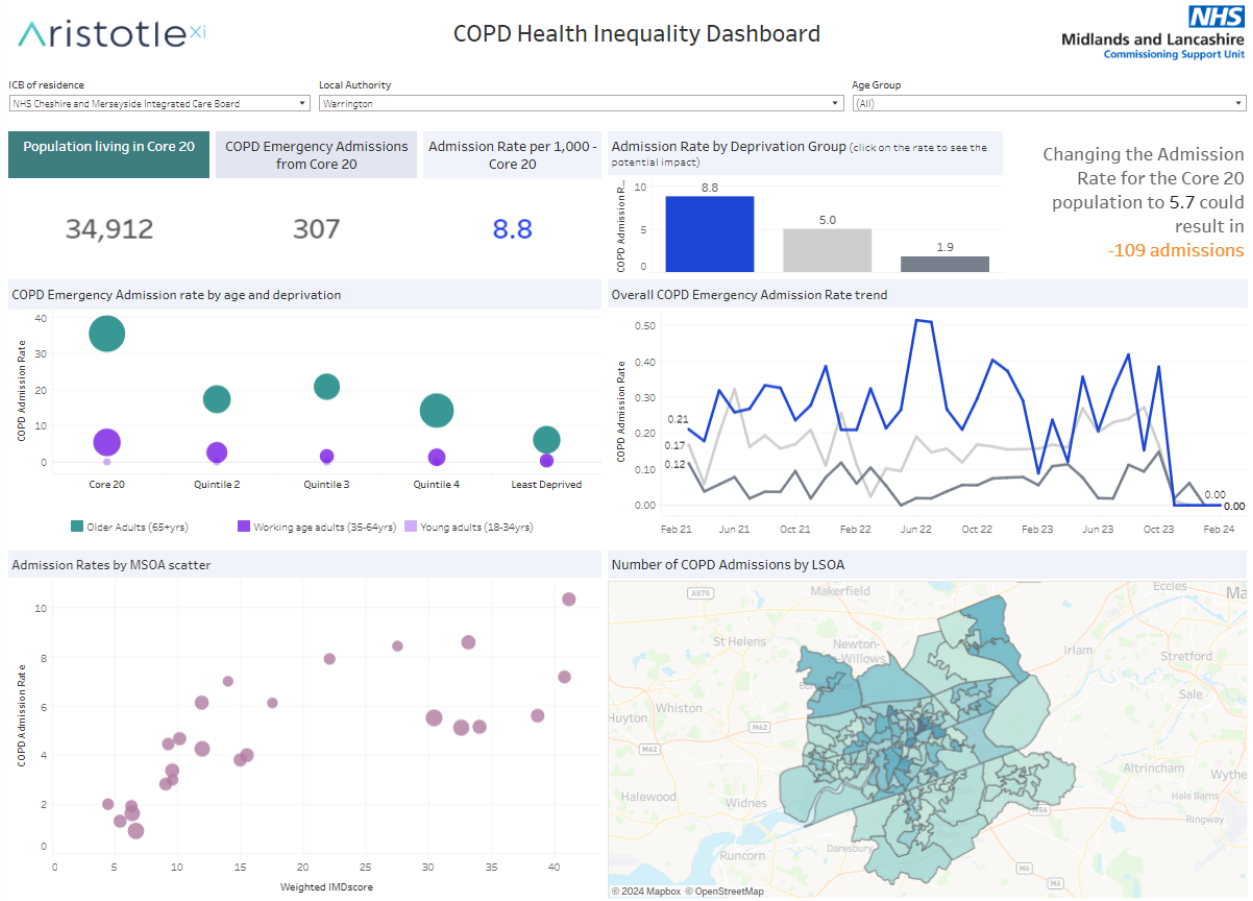


Source: Primary Care records

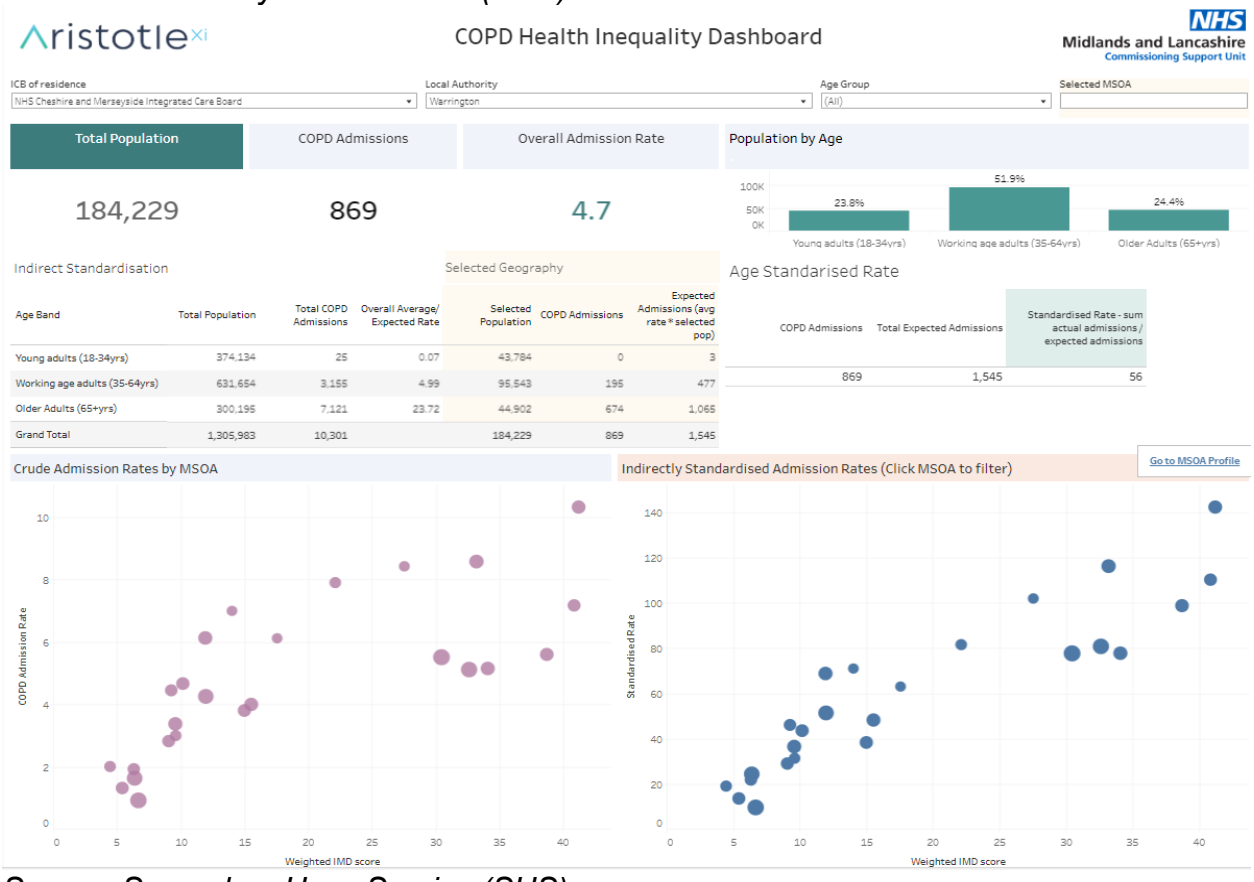
6.3. COPD inequalities dashboard – Warrington:



Source: Secondary Uses Service (SUS)



Source: Secondary Uses Service (SUS)



Source: Secondary Uses Service (SUS)

6.4. Respiratory Summary Actions

6.4.1. C&M continues to focus on delivery of the asthma bundle, and interventions are being delivered to address key areas that exacerbate asthma – this has an emphasis on the addressing the wider determinants of health inequalities.

6.4.2. Smoking Prevention Programmes are being provided across the ICS to "stop the start" of vaping / smoking and improve lung health. Schools have been prioritised based on proportion of CYP on free school meals (FSM) as a measure of level deprivation and those with the highest number of children accessing FSMs are prioritised. Training sessions have been delivered to schools, attended by 68 teachers with a further 12 schools completing self-led training. Recording sent to all 90 schools to support wider circulation.

6.4.3. The strategic development of our All Together Smoke free programme has commenced during 2023/24 with the ICB arranging LGA Sector Led improvement workshops with all of our Local Authority commissioners, Treating Tobacco dependency (TTD) providers, ASH, National leads and other ICS learning opportunities.

6.4.4. The work of our Maternity TTD services with supporting pregnant smokers to quit has seen prevalence rates substantially reduce from 10% to under 8%.

6.4.5. Completion of Indoor Air Quality Project including evaluation. This was in partnership with a Social Housing Landlord in a ward with high levels of deprivation. There was a focus on primary aged children to improve outcomes for those families within the highest areas of deprivation. 202 air quality monitors were installed, with 148 families receiving the full support offer. The model of delivery enabled a broader offer of support with access to benefits support, neighbourhood nuisance teams, referrals for mental / physical support providing a focus on wider determinants of health for CYP and their families.

6.4.6. Data on inequality of access to transport has been used to determine the best places to site mobile vaccination units in areas the most disadvantaged populations can access easily.

6.4.7. In July 2023 – during the COVID-19 vaccine inter-seasonal period – our roving Live Well outreach service undertook a proof-of-concept programme to expand its clinical offer to provide routine vaccinations to adults and children within migrant hotels and initial accommodation settings to improve vaccination access and engagement for migrant health purposes. The project started initially concentrating on settings in Liverpool and St Helens. This was then extended to Cheshire East, Halton and Knowsley. Over 760 vaccines were delivered over the 3-month period ending on 30th September.

6.4.8. Due to the success of this proof-of-concept Phase 2 covid Vaccination programme started in Q3 and Q4. The offer was extended to all migrant accommodations in Cheshire and Merseyside (excluding Liverpool where a

contracted provider for this service is already in place). The service ran from 5th February – 11th April (2024), 285 vaccines were delivered to 141 individuals including 112 MMR vaccinations.

6.4.9. In response to the surge in measles cases and the national Measles incident announced by UKHSA on the 19th of January 2024, it was agreed that the offer of routine immunisations would be extended to all future living well clinics with the focus on increasing the MMR uptake.

6.4.10. Over this period the living well service also worked alongside Liverpool inclusion groups to help drive uptake in low uptake areas which had a high population of Romanian, Slovak, Czech Republic, Hungarian and Lithuanian Nationalities. Many of the individuals of the aforementioned nationalities in Liverpool identify as Roma. In the UK, Roma experience inequalities in standards of living, education, employment and health. Vaccination uptake has been reported as lower in Roma communities compared to non-Roma communities across Europe. Roma communities in the UK have particularly been found to experience language and literacy, and discrimination, as barriers to vaccination and health service access.

6.4.11. The Live Well service also provides a range of targeted health checks, helping promote prevention and support across a range of CVD and Cancer risk factors

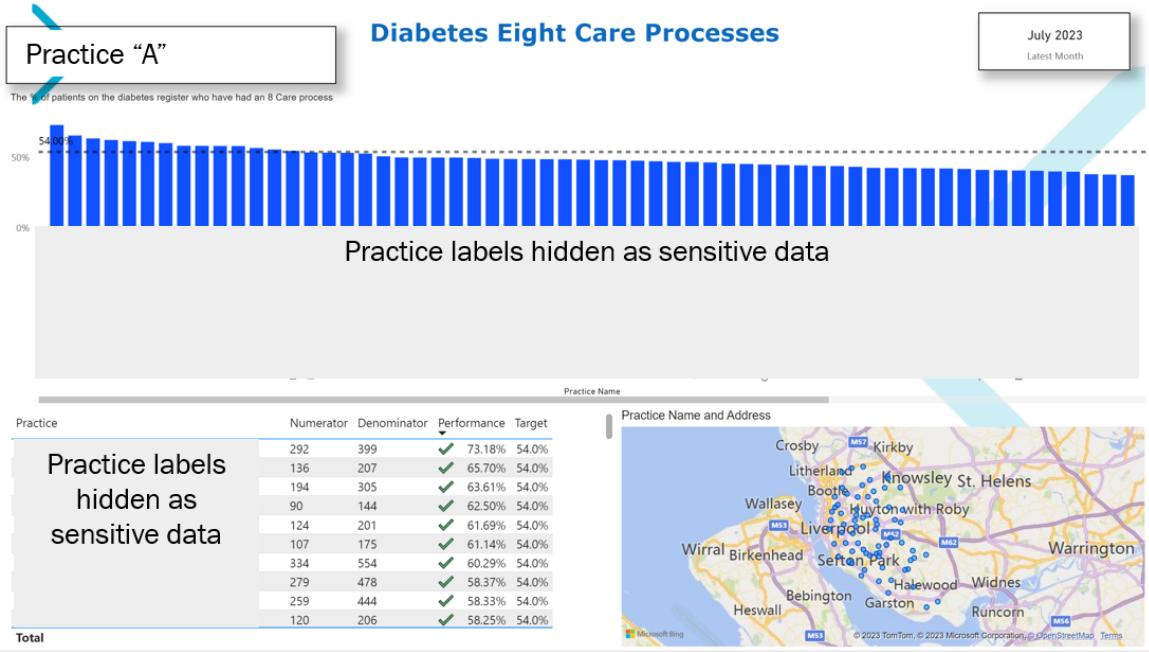
6.4.12. We continue to enhance the Live Well outreach offer to increase accessibility and engagement in our areas of highest inequality. We utilise inequalities data to target these areas and populations and work alongside local public health teams to identify the most appropriate ways in which to remain visible, engage and build trust with these communities to improve vaccine confidence and deliver them when required.

7. Diabetes

7.1. Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile.

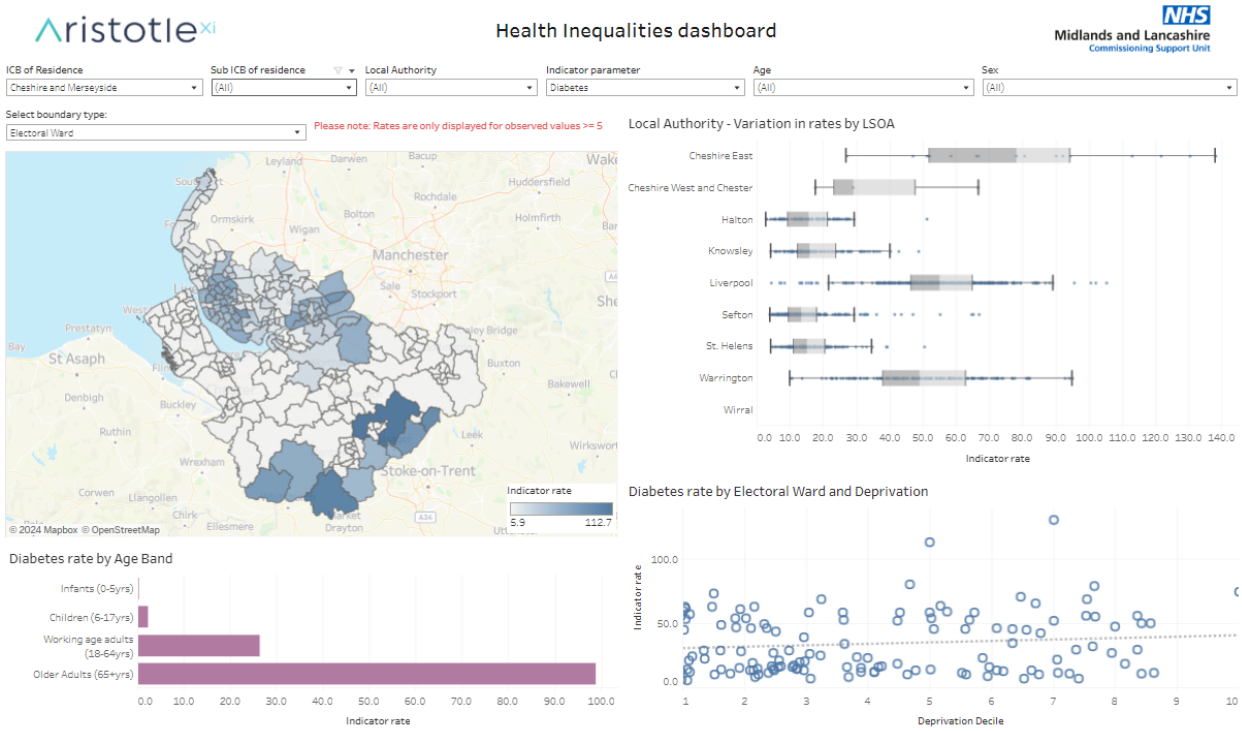
7.2. Variation in the proportion of patients with Type 1 and Type 2 diabetes receiving all 8 care processes

Source: National Diabetes Audit Microsoft Power BI



Source: Primary Care records

7.3. Health Inequalities Dashboard: Diabetes, LA level:



Source: Quality & Outcomes Framework (QoF)

7.4. **<u>Diabetes Summary Actions</u>**

7.4.1. Priority actions relate to increasing use of CGM / pumps and annual health checks for Children and young people with Type 2 diabetes have included:

- NHSE Diabetes CGM pilot has concluded with 174 patients started on new tech as a result of this project, 88 (50%) were from CORE 20 populations. This pilot was targeted to trusts with lowest numbers of tech use within the most deprived populations.

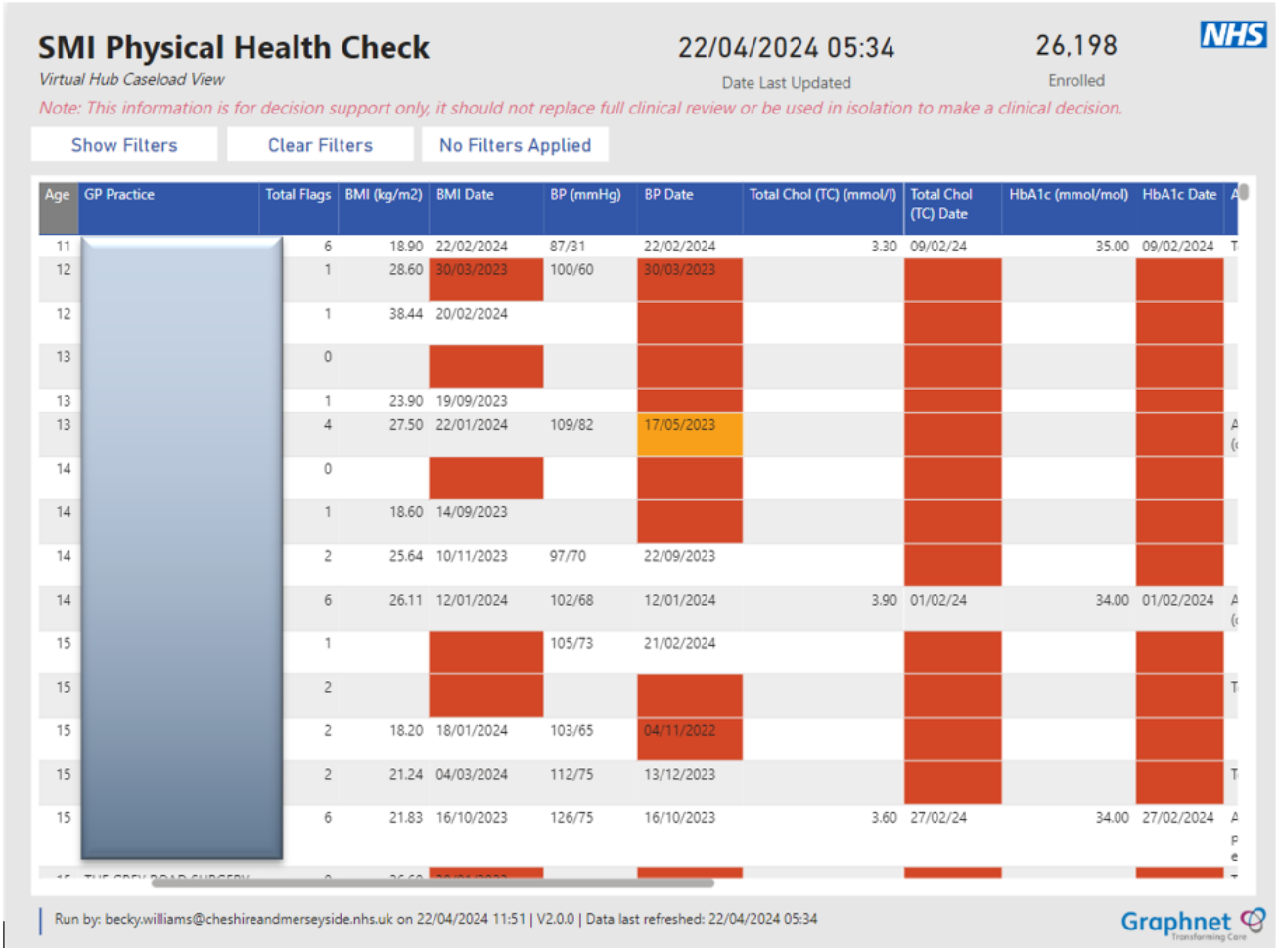
- 'Phase 2' of the technology pilot commenced with Mersey and West Lancashire Teaching Hospitals NHS Trust (Whiston), to be delivered Feb 24-Aug 24. This focuses on families in areas of highest deprivation and BAME populations. Since January 2024, 40 Children and young people have commenced on technology.

- Diabetes and Healthy Weight & Obesity leads working on plan of action to move forward plans of linking type 2 diabetes and obesity. Joint SBRI Funding application submitted (with Alder Hey CEW/Innovation) to support T2 early intervention/ prevention.

8. Mental Health

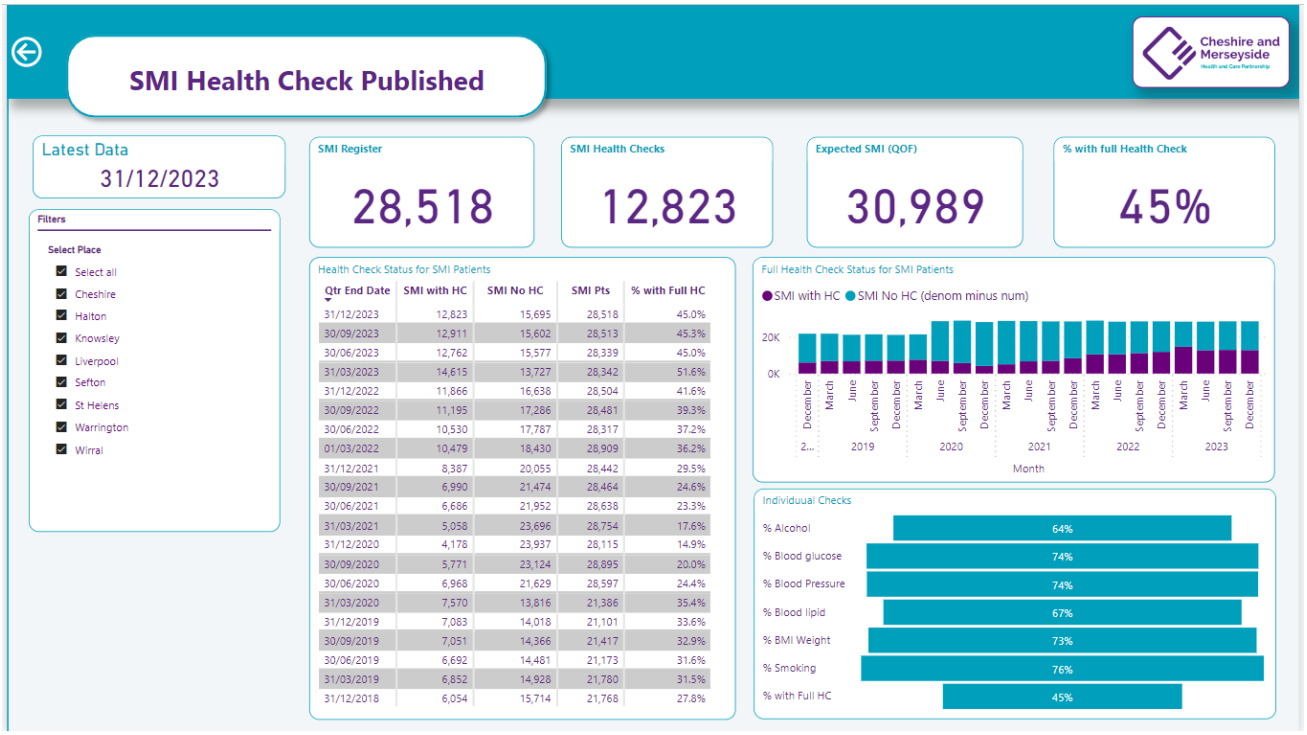
8.1. Physical Health Checks for people with Severe Mental Illness

Patient level tool to filter and select patients key risk factors (age, vaccination status, health check type)



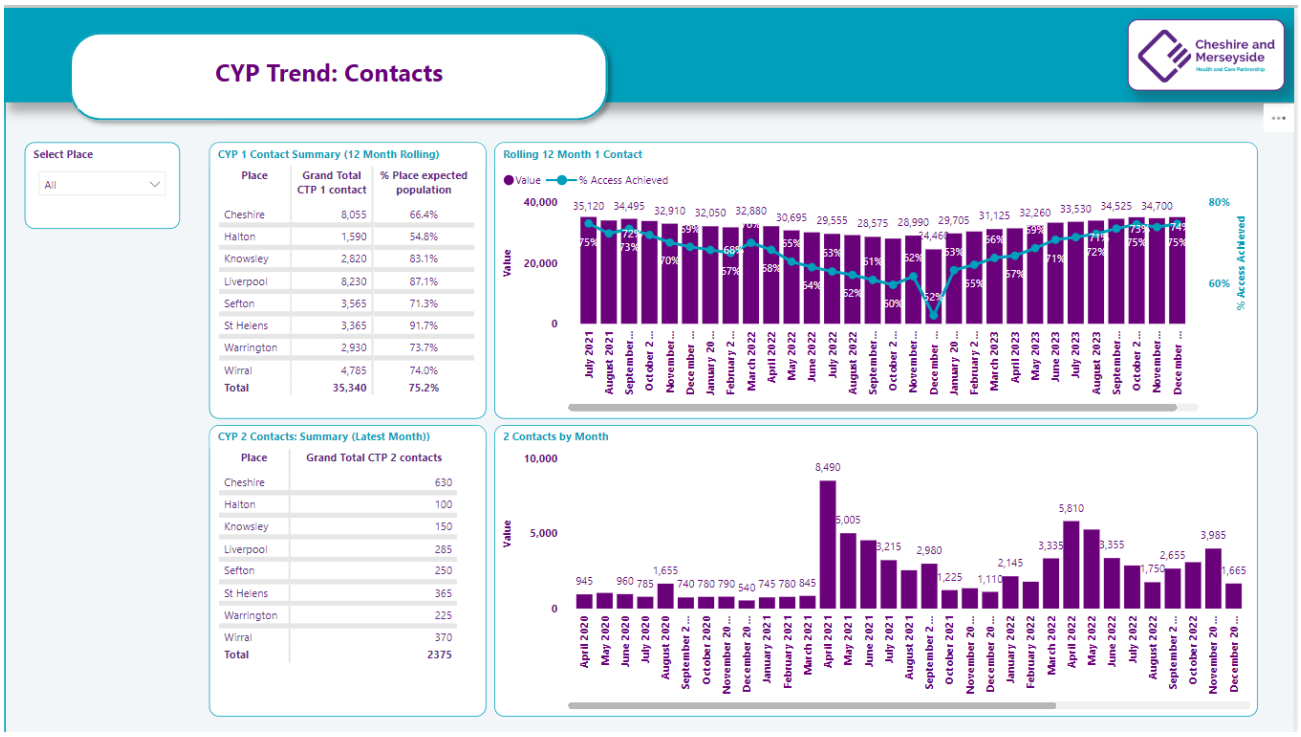
Age	GP Practice	Total Flags	BMI (kg/m2)	BMI Date	BP (mmHg)	BP Date	Total Chol (TC) (mmol/l)	Total Chol (TC) Date	HbA1c (mmol/mol)	HbA1c Date
11		6	18.90	22/02/2024	87/31	22/02/2024	3.30	09/02/24	35.00	09/02/2024
12		1	28.60	30/03/2023	100/60	30/03/2023				
12		1	38.44	20/02/2024						
13		0								
13		1	23.90	19/09/2023						
13		4	27.50	22/01/2024	109/82	17/05/2023				
14		0								
14		1	18.60	14/09/2023						
14		2	25.64	10/11/2023	97/70	22/09/2023				
14		6	26.11	12/01/2024	102/68	12/01/2024	3.90	01/02/24	34.00	01/02/2024
15		1			105/73	21/02/2024				
15		2								
15		2	18.20	18/01/2024	103/65	04/11/2022				
15		2	21.24	04/03/2024	112/75	13/12/2023				
15		6	21.83	16/10/2023	126/75	16/10/2023	3.60	27/02/24	34.00	27/02/2024

Source: Primary Care records



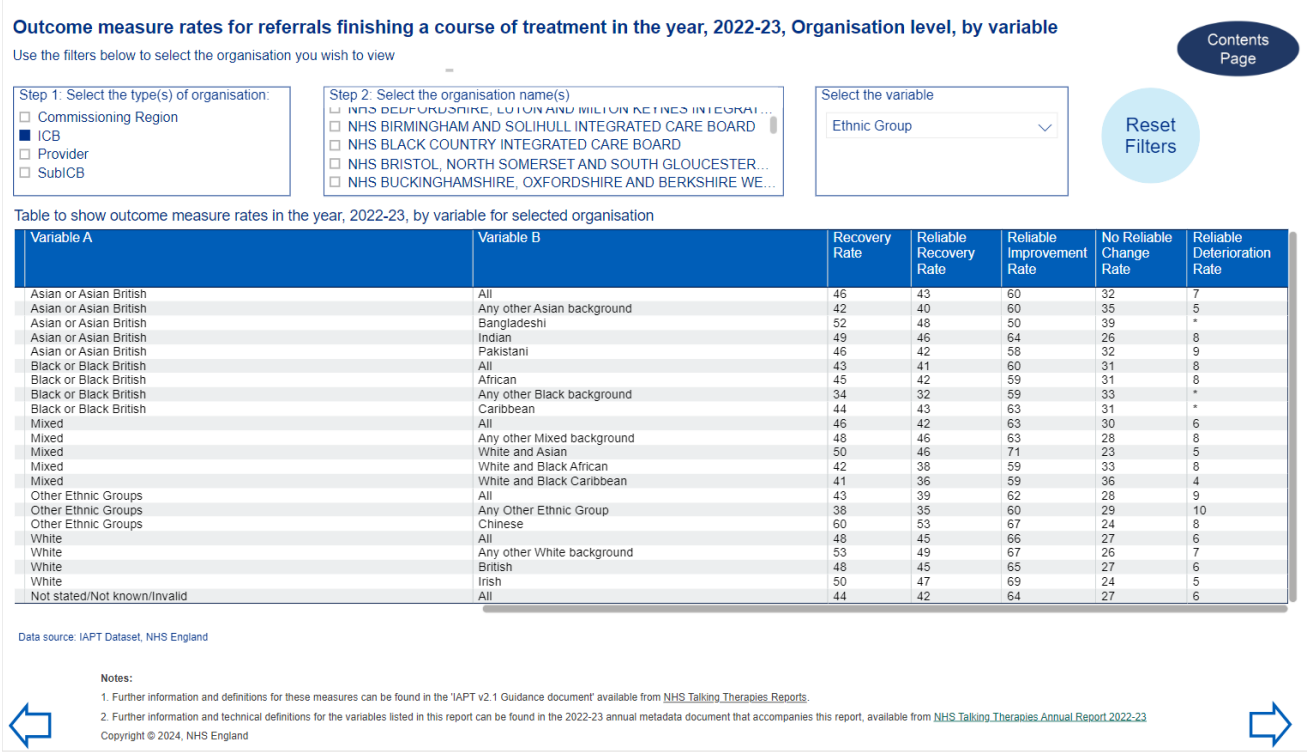
Source: NHS Digital

8.2. Children and young people's mental health access



Source: NHS Digital

8.3. NHS Talking Therapies (formerly IAPT) recovery



Outcome measure rates for referrals finishing a course of treatment in the year, 2022-23, Organisation level, by variable

Use the filters below to select the organisation you wish to view

Contents Page

Step 1: Select the type(s) of organisation:
- Commissioning Region
- ICB
- Provider
- SubICB

Step 2: Select the organisation name(s)
- NHS BIRMINGHAM AND SOLIHULL INTEGRATED CARE BOARD
- NHS BLACK COUNTRY INTEGRATED CARE BOARD
- NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTER...
- NHS BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WE...

Select the variable: Ethnic Group

Reset Filters

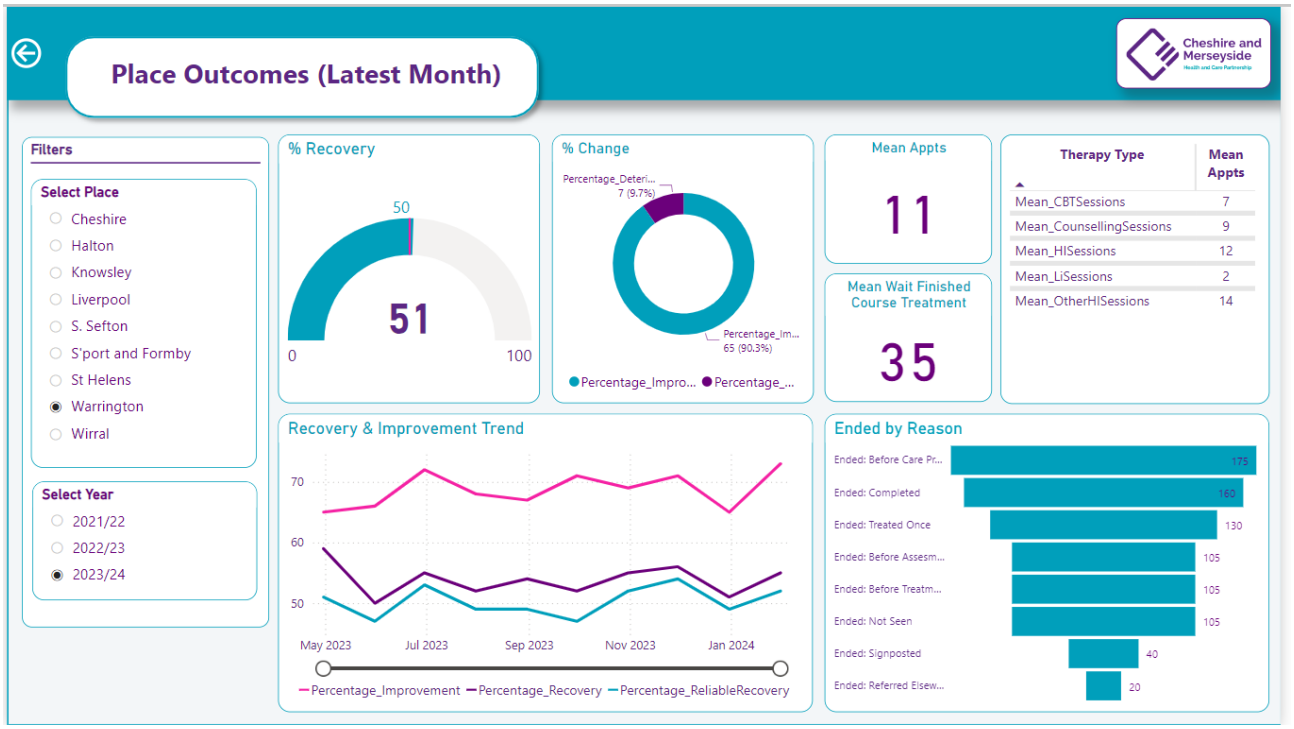
Table to show outcome measure rates in the year, 2022-23, by variable for selected organisation

Variable A	Variable B	Recovery Rate	Reliable Recovery Rate	Reliable Improvement Rate	No Reliable Change Rate	Reliable Deterioration Rate
Asian or Asian British	All	46	43	60	32	7
Asian or Asian British	Any other Asian background	42	40	60	35	5
Asian or Asian British	Bangladeshi	52	48	50	39	*
Asian or Asian British	Indian	49	46	64	26	8
Asian or Asian British	Pakistani	46	42	58	32	9
Black or Black British	All	43	41	60	31	8
Black or Black British	African	45	42	59	31	8
Black or Black British	Any other Black background	34	32	59	33	*
Black or Black British	Caribbean	44	43	63	31	*
Mixed	All	46	42	63	30	6
Mixed	Any other Mixed background	48	46	63	28	8
Mixed	White and Asian	50	46	71	23	5
Mixed	White and Black African	42	38	59	33	8
Mixed	White and Black Caribbean	41	36	59	36	4
Other Ethnic Groups	All	43	39	62	28	9
Other Ethnic Groups	Any Other Ethnic Group	38	35	60	29	10
Other Ethnic Groups	Chinese	60	53	67	24	8
White	All	48	45	66	27	6
White	Any other White background	53	49	67	26	7
White	British	48	45	65	27	6
White	Irish	50	47	69	24	5
Not stated/Not known/Invalid	All	44	42	64	27	6

Data source: IAPT Dataset, NHS England

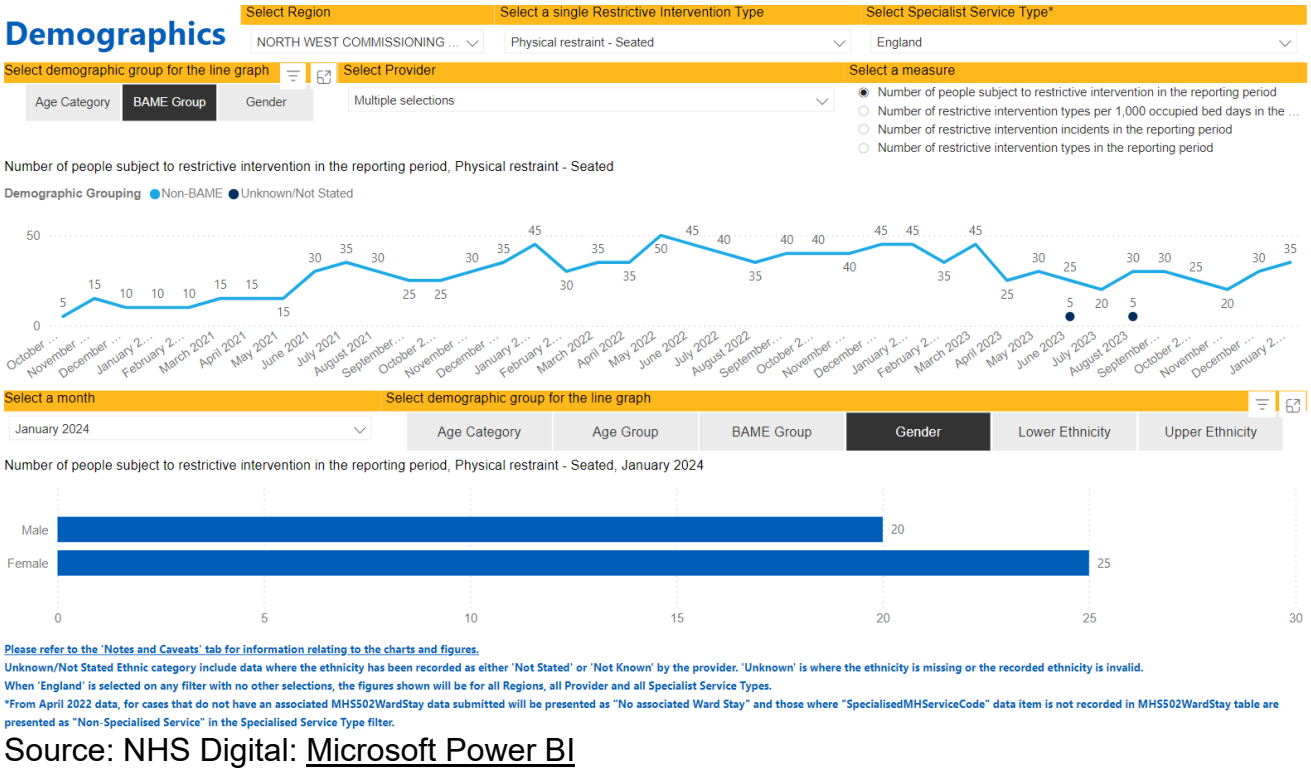
Notes:
1. Further information and definitions for these measures can be found in the 'IAPT v2.1 Guidance document' available from NHS Talking Therapies Reports.
2. Further information and technical definitions for the variables listed in this report can be found in the 2022-23 annual metadata document that accompanies this report, available from NHS Talking Therapies Annual Report 2022-23

Source: NHS Digital Microsoft Power BI



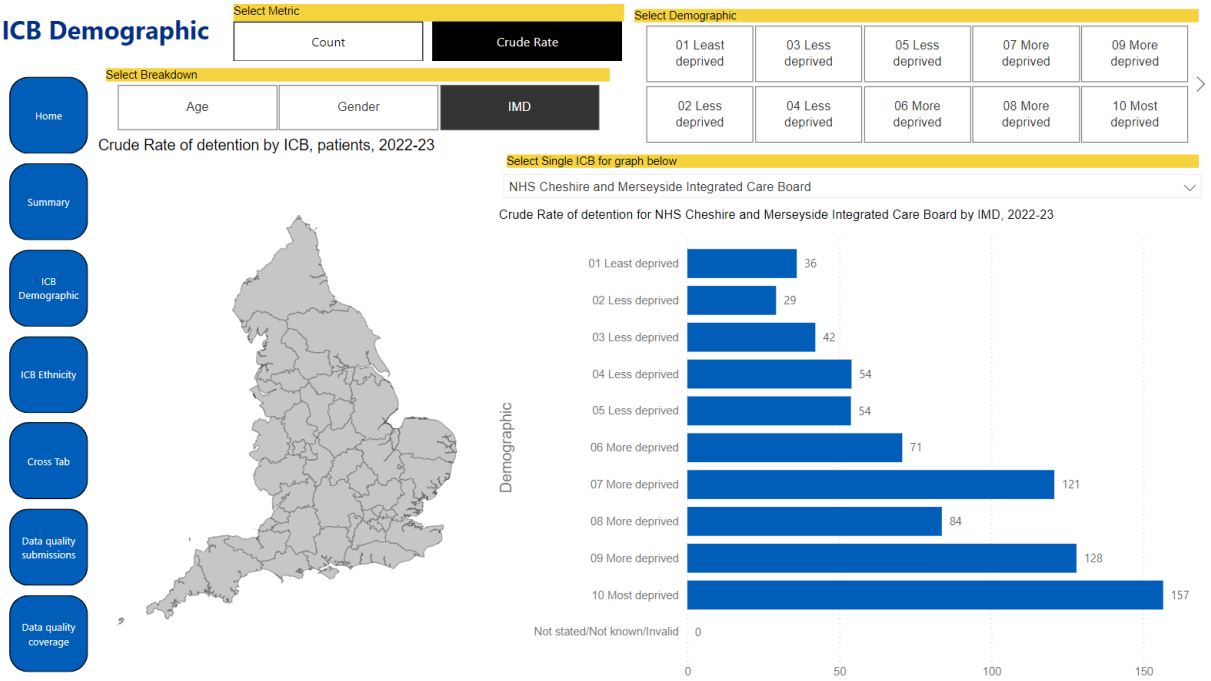
Source: NHS Digital

8.4. Rates of restrictive interventions

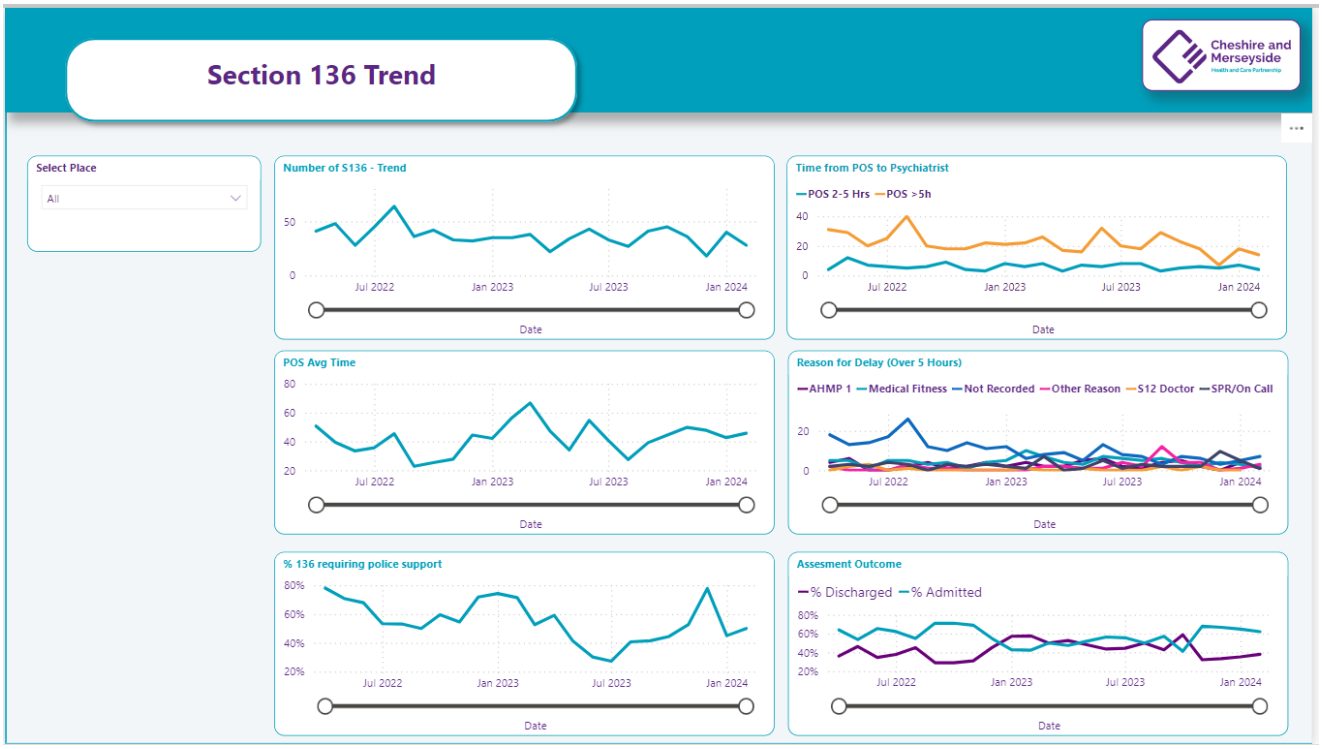


Source: NHS Digital: Microsoft Power BI

8.5. Rates of total Mental Health Act detentions

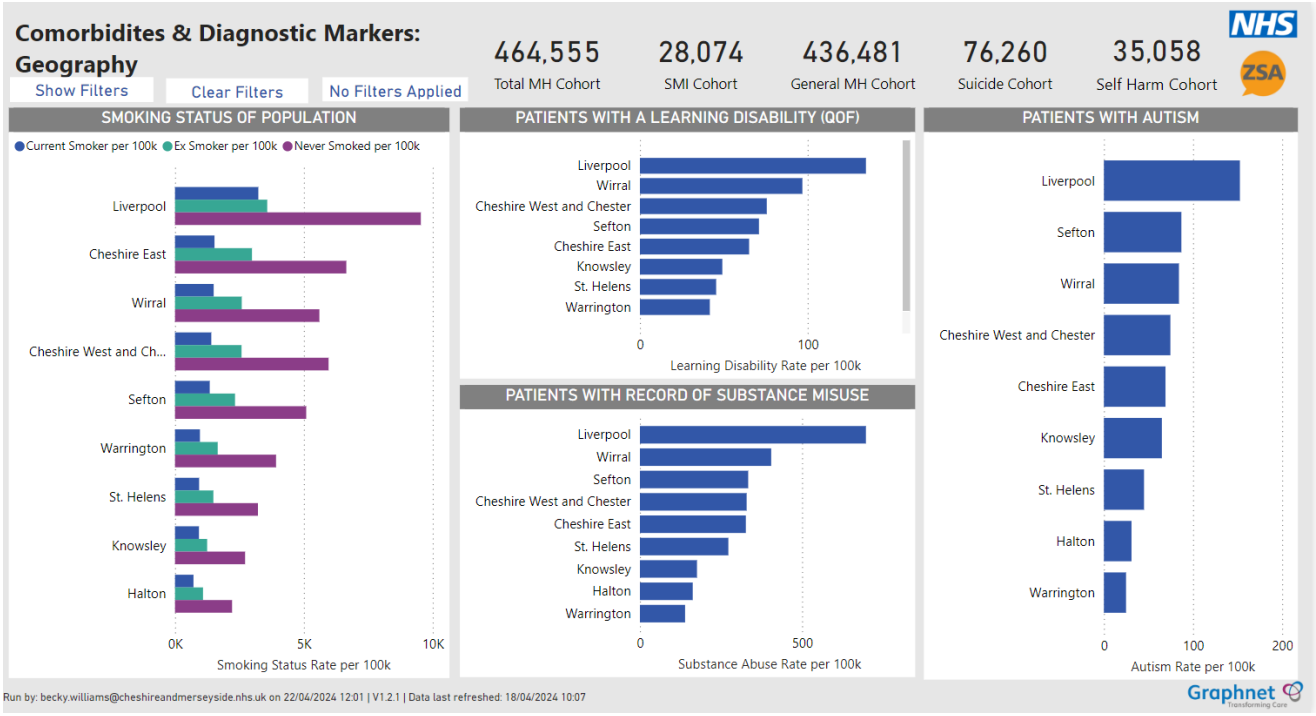


Source: MHSDS collection, NHS Digital Microsoft Power BI



Source: Local contract monitoring information.

8.6. Mental Health Population Health Explorer:



Source: General Practice data

8.7. Mental Health Summary Actions

8.7.1. Significant inequalities in life expectancy for mental health patients are well known, with people in contact with mental health services nearly five times more likely to die prematurely than those not in contact with mental health services. The metric on delivery of health checks reflects a key intervention the NHS can provide to identify where support for a patient's physical health needs is required. National data is used alongside local demographic data through the CIPHA platform to allow clinicians to assess the need for targeted outreach to support people to access the health checks and follow-up interventions. Securely held data can be accessed by clinicians and using easy to use filters, cohorts of patients can be identified and called in to practice to conduct checks.

8.7.2. More people received an SMI health check in Q3 of 2023/24 than on equivalent quarter in previous years. This demonstrates a sustained improvement in performance from previous years with 12, 823 SMI health checks conducted during the year. Data is now being utilised at system level, to inform a strategic approach to offering the full 6 aspects of the SMI check. In particular, Cheshire have contracted with VCSFE provider to provide a consistent model and approach across all of Cheshire and Wirral for improving health outcomes for people with SMI. It is anticipated that this approach will lead to improvements in the delivery of health checks for people with SMI.

8.7.3. The C&M Mental Health Programme led a Mental Health Support Teams (schools) Wave 11 funding panel this quarter which will increase access rates for CYP. The panel met to consider where 5 additional new MHST's would be placed in order to improve MH Access Rates. The panel made the wave 11 decision based on health inequality and levelling up coverage.

8.7.4. ICB agreement to continue to develop a single digital point of access for MH support to increase access to self-help resources, and to simplify referral routes

8.7.5. It is known from the data that people from more deprived backgrounds and ethnic minorities are more likely to receive the most restrictive forms of mental health provision. The metrics in relation to Mental Health Act detentions are used to identify and deliver progress on the recommendations of the Independent Review of the Mental Health Act and the principles of the government's White Paper, Reforming the Mental Health Act, with patients treated in the least restrictive way and setting possible with the maximum therapeutic benefit.

8.7.6. With the introduction of the Advancing mental health equalities strategy, health organisations are taking steps to fight stigma and inequalities, with the Patient and carers race equalities framework (PCREF) being a core part of delivering the strategy by NHS mental health trusts and mental health service providers.

8.7.7. The ICB is embedding the principles of the PCREF in the actions taken. Improving the quality of data based on protected characteristics is key to

addressing the underlying determinants of health inequalities and overcome inequalities in access, experience and outcomes via partnership working.

8.7.8. A new clause has been included in the NHS Standard Contract for 2024/25 which requires all mental health providers to have implemented the Patient and carer race equality framework (PCREF), by March 2025. The PCREF will support improvement in three main domains in Cheshire and Merseyside:

- Leadership and governance: trusts' boards will be leading on establishing and monitoring concrete plans of action to reduce health inequalities;
- Data: new data set on improvements in reducing health inequalities will need to be published, as well as details on ethnicity in all existing core data sets; and
- Feedback mechanisms: visible and effective ways for patients and carers to feedback will be established, as well as clear processes to act and report on that feedback.

8.7.9. Partnership working, especially within the ICS context, is critical in addressing the underlying determinants of health inequalities across all mental health services. Cheshire & Merseyside expect to continue to improve the capture and flow of data to national datasets to help identify and overcome inequalities in access, experience and outcomes in line with the Advancing Mental Health Equalities Strategy and the five priority areas highlighted in the Operational Planning Guidance.

8.7.10. Providers are expected to improve the quality of data based on protected characteristics including age, disability, gender, marriage/civil partnership, ethnicity, religion/belief, sexual orientation, deprivation, accommodation status, looked after child status, and ex-British armed forces status. Data items whose quality should be improved as a matter of priority include sexual orientation, disability, ethnicity, accommodation status (homelessness and rough sleeping). Performance against this improvement standard will be measured across providers in 2024/25 and reported.

8.7.11. The ICB has shared actions that providers can take to improve quality of protected characteristics:

- Ensuring that clinicians and healthcare workers are collecting data on protected characteristics as part of assessments and admissions and ensuring that data is accurate.
- Electronic Patient Record systems should be designed to ensure and enforce routine collection of data on protected characteristics.
- Data Quality reports should be designed to feedback data on protected characteristics to teams, so that they have visibility of data quality issues and can take action to redress them.
- Ensuring that service users are aware of how their data is used, and the importance of accurate data on protected characteristics for service design and improvement.

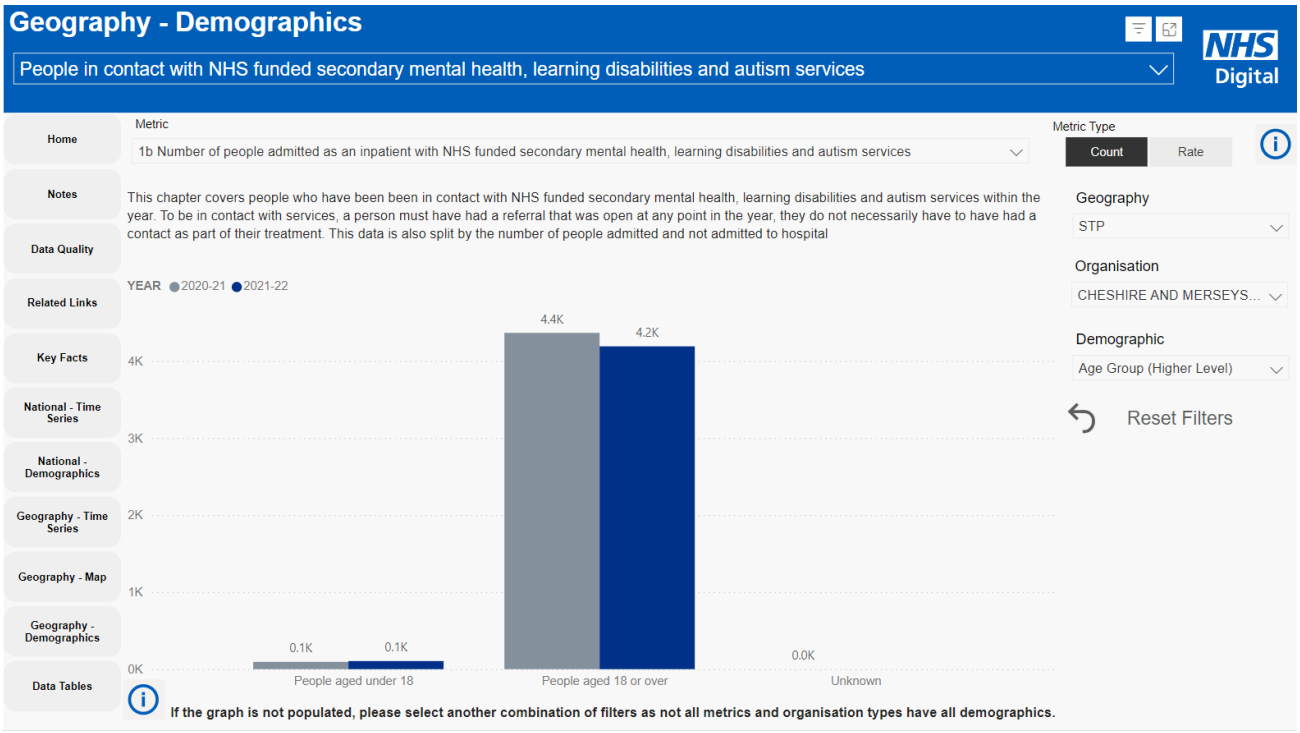
8.7.12 Providers are expected to report progress to the ICB Mental Health programme and seek support to impact on priority areas. Priority areas for improvement will be determined through data and community engagement.

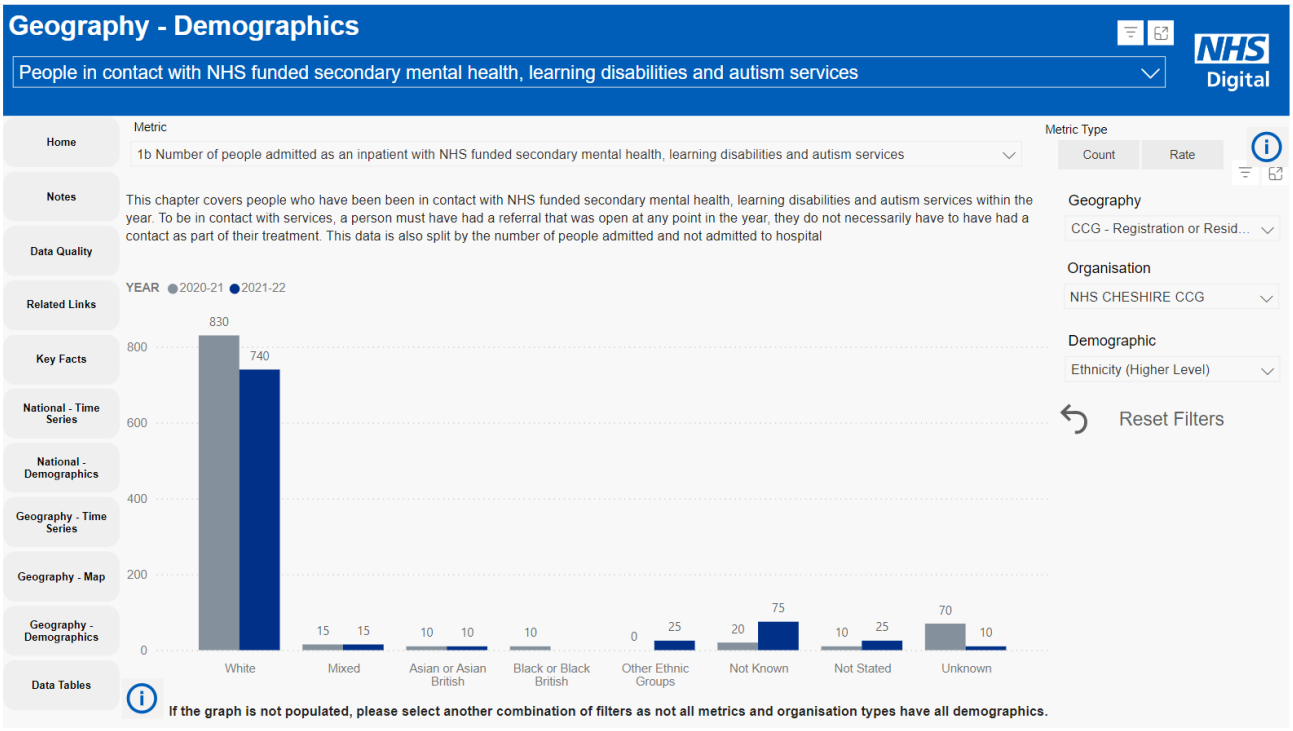
8.7.13 Coverage, validity and accuracy scores for each of the three mental health trusts in Cheshire and Merseyside in relation to ethnicity recording are monitored regularly and reported to the Mental Health programme leads. A summary of performance is described in the mental health programme annual report.

8.7.14 Improved data quality will support Cheshire & Merseyside Trusts to embed anti-racism through the patient and carer race equality framework (PCREF).

9. Learning Disability and Autistic People

9.1. Adult mental health inpatient rates for people with a learning disability and autistic people





Source: NHS Digital Microsoft Power BI

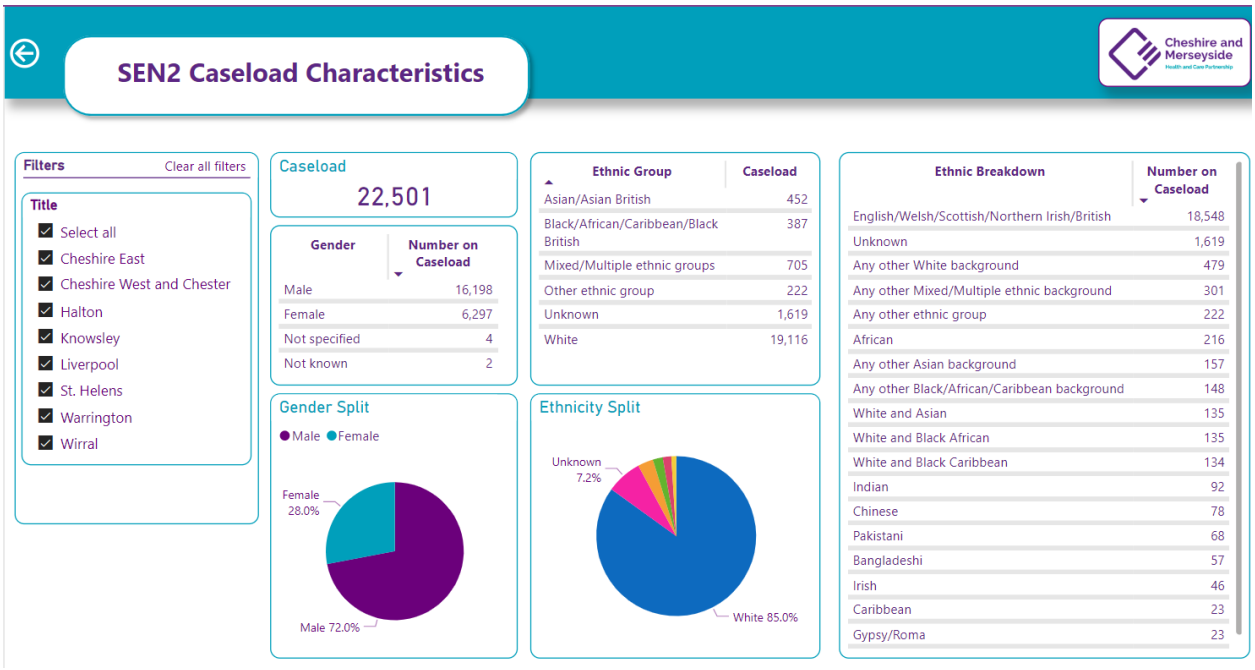
9.2. Learning Disability Annual Health Check

Learning Disability Annual Health Checks and Health Action Plans - November 2023

	Previous Month						*Latest Month*							*Previous Year Comparison*			
	October 2023						November 2023							November 2022			
ICB or TCP Name	Total LD Register (age 14+)	Completed health checks	Health Checks Declined	% Completed health checks	Completed Health Action Plans	% Completed Health Action Plans	Total LD Register (age 14+)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks	Completed Health Action Plans	% Completed Health Action Plans	Total LD Register (age 14+)	Completed health checks (age 14+)	Health Checks Declined	% Completed health checks
ENGLAND	**320,823**	**110,805**	**2,281**	**34.5%**	**99,799**	**31.1%**	**347,263**	**137,149**	**3,202**	**206,912**	**39.5%**	**124,949**	**36.0%**	**310,199**	**131,301**	**3,178**	**42.3%**
NHS CHESHIRE AND MERSEYSIDE ICB	14,525	4,966	132	34.2%	4,356	30.0%	15,656	6,194	209	9,253	39.6%	5,478	35.0%	14,229	5,683	210	39.9%
NHS GREATER MANCHESTER ICB	17,581	6,621	83	37.7%	5,926	33.7%	18,956	8,217	107	10,632	43.3%	7,539	39.8%	17,197	7,488	153	43.5%
NHS LANCASHIRE AND SOUTH CUMBRIA	9,299	2,987	99	32.1%	2,688	28.9%	10,057	3,778	125	6,154	37.6%	3,439	34.2%	9,098	3,503	93	38.5%

Data is not available nationally by key demographics of ethnicity, or deprivation. Reports are being developed locally exploring using data from General Practice. This will allow the data to be viewed by key demographic groups.

Local data on Special Educational Needs population characteristics:



Source: Local Authority data supplied locally to ICB

9.3. **Learning Disability and Autism actions**

9.4. As part of our Data into Action programme, we have developed a range of population health management tools to help prioritise and enhance our approach to supporting 'Complex Households'. For example. the largest area of spend in Complex Households is for children's social care – accounting for 49%. In addition to this, there is a huge amount of activity for children in community and mental health settings. Much of this is fragmented and not centred around the needs of the child and/or the family.

9.5. From our analysis, we have shown children in these families have a much higher rate of respiratory disease, mental health issues, but also learning disabilities/autism. For example, asthma is 6% in the general population but 21% in Complex Households. LD inc. autism stands at 12% in Complex Households which is 10% higher than the general population. These children are living in complex households where adults have a range of mental and physical health challenges, alongside other factors such as deprivation, substance misuse etc. We cannot manage these conditions in isolation. We need a co-ordinated system response, which is responsive not prescriptive.

9.6. These families exist across C&M not just in urban areas – we will draw upon collective knowledge and work together to try and adopt new approaches. Linked data enables us to do this in a way we have not been able to before. Previously we have had strategic planning data, but with the creation of this new tool we will have data in a format which can be practically used by a range of services.

9.7. During 2023/24 our HCP also ran a system wide workshop that focused on Housing and Health, with a particular focus on housing for residents with Mental health and LD needs. This can have a significant impact on delayed discharges, work has been undertaken with Northwest Housing Lead and analysts to map those individuals clinically ready for discharge with housing difficulties, with the C&M Housing Strategy in development. A new Health and Housing Collaborative between ICB, Housing providers and Local Authorities is due to be established during 2024/25

9.8. Our new Population Health Academy has been developed during 2023, and launches in Q1 of 2024, which will focus on providing knowledge and skills in utilising data tools to help support our inclusion health groups.

9.9. Significant system wide planning has commenced during 2023, to establish plans for a whole system pathway redesign programme for Neurodiversity in our Children and Young People. Our ambition across our Health and Care Partnership (NHS and Local Authorities) is to view neurodiversity as a difference from a strengths-based perspective rather than a disability, whilst recognising the challenges associated with lifelong neurodevelopmental conditions. Our focus is on effectively and consistently supporting each child's needs, with easier access to early support and empowering them and their families to maximise potential, rather than focusing only on diagnosis to support have been developed that will be implemented during 2024.

10. Maternity and Neonatal

10.1. Preterm births under 37 weeks

Cheshire & Merseyside WhaM Programme Metrics - ICB & Providers - Latest Period Summary

		Metric Name	Latest Period	Unit of measurement	Direction	England	ICB C&M	ICB GM	ICB L&SC	Providers: Countess Of Chester Hospital NHS Foundation Trust	East Cheshire NHS Trust	Liverpool Women's NHS Foundation Trust	Mid Cheshire Hospitals NHS Foundation Trust	Mersey & West Lancashire NHS Teaching Trust	Warrington and Halton Hospitals NHS Foundation Trust	Wirral University Teaching Hospital NHS Foundation Trust
LMNS Outcome Measures	Maternal mortality	Number of maternal deaths	2020-22	Rate per 1,000 pop	Lower	13.41	-	-	-	-	-	-	-	-	-	-
	Stillbirths	Number of stillbirths (MBRACE)	2021	Rate per 1,000 pop	Lower	3.6	3.3	4.0	4.1	2.9	-	4.5	4.6	S&O - 3.5 StH&K - 1.5	2.3	3.2
		Number of stillbirths (SUS)	Year to Oct 23	Rate per 1,000 pop	Lower	3.7	3.0	5.1	3.5	2.1	3.9	2.5	4.5	2.9	2.9	3.8
	Neonatal mortality	Number of neonatal deaths occurring at or after 24 weeks gestational age	2021	Rate per 1,000 pop	Lower	1.6	2.1	1.6	1.7	1.2	-	4.0	1.8	S&O - 0.9 StH&K - 0.8	0.8	1.3
	Brain injury during or soon after birth	Infants with a brain injury occurring during or soon after birth	Eng 2019, ICB 2017	Rate per 1,000 pop	Lower	4.3	5.2	5.1	4.1	-	-	-	-	-	-	-
	Safe, Personalised and Equitable Care (Theme 4 - 3 Year Plan)	Of women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care	Q3 - 23/24	Percentage	Higher	Target 85%	92.0%	87.0%	100.0%	-	-	-	-	-	-	-
		Proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal	Year to Sept 2023	Percentage			-	-	-	-	-	-	-	-	-	-
	Preterm Birth	Every provider has a preterm birth clinic														
		Deliveries under 27 weeks	Oct-23	Percentage	Lower	0.4%	0.3%	0.6%	0.7%	0.0%	0.0%	0.9%	0.0%	0.0%	0.0%	2.0%
		Deliveries under 34 weeks	Oct-23	Percentage	Lower	1.9%	2.1%	1.8%	2.2%	3.1%	0.0%	2.6%	1.9%	1.1%	2.6%	2.0%
		Deliveries under 37 weeks	Oct-23	Percentage	Lower	7.1%	6.7%	8.3%	7.6%	9.4%	4.2%	8.5%	3.8%	6.4%	10.5%	6.1%

Source: Local provider data flows to ICB

10.2. **<u>Preterm Birth Summary Actions</u>**

10.2.1 C&M have made significant progress towards tackling preterm births and risk factors associated with deprivation and inequalities. Use is being made of the national Maternity Services Data Set (MSDS) to identify key population cohorts to target. However, a data quality improvement programme is being undertaken to ensure data is robust before it can be used as there are some known data quality issues from recent interrogation of the data.

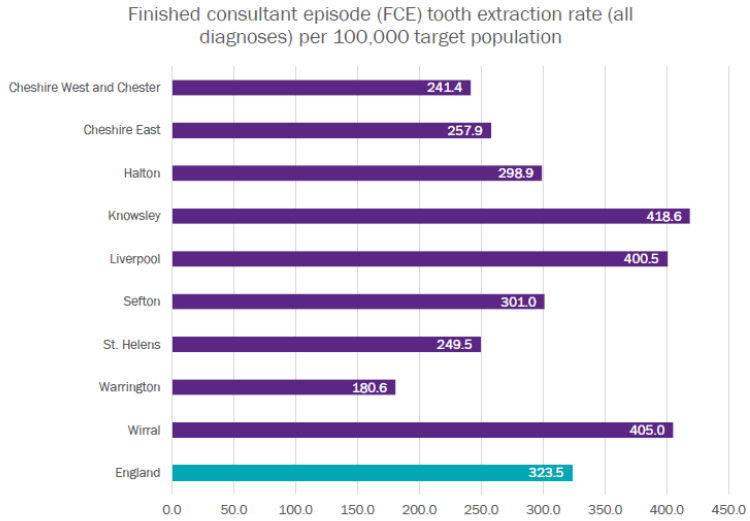
10.2.2 Progress has been made during the year and included targeted interventions such as tackling smoking and impact of deprivation and poverty in some of our communities, (having reduced smoking at the time of delivery to 7.2% from over 10% at the same point in 2023), with targeted enhanced engagement work with our most at risk expectant mothers.

10.2.3 Our ICB has an established and successful pre-term birth network with clinics and specialist clinicians in every maternity provider that builds on the vital relationships with our Local Authority commissioned healthy child programmes. Based on most up to date data available, in December 2023, the national average for preterm birth was 6.6% and the average for our Cheshire and Merseyside providers during this same period is at or below 6%. C&M is doing progressing well for births less than 34 weeks and hosted the UK Preterm Birth Conference in January 2024.

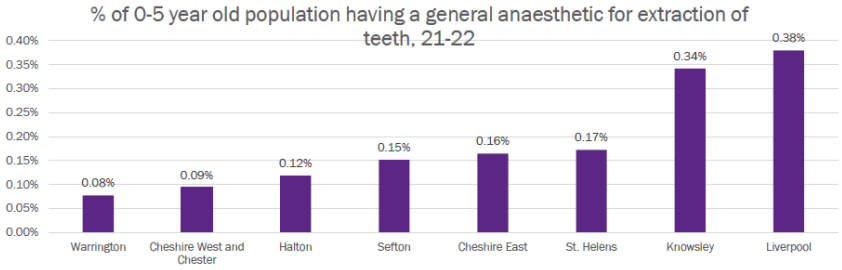
11. Oral Health

11.1. Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions not number of teeth extracted)

Cheshire and Merseyside Dental insight packs:

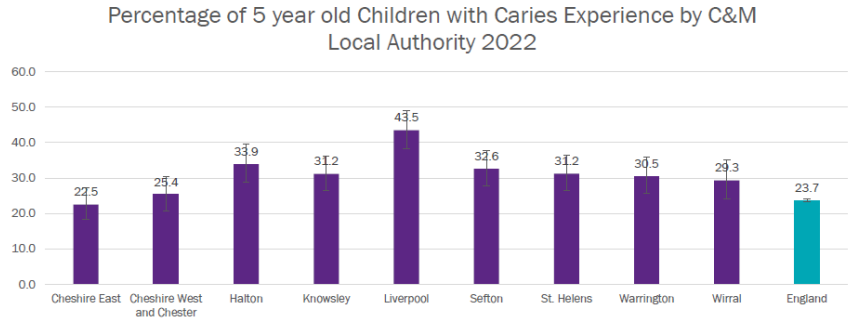


- The extraction rate for Wirral, Liverpool and Knowsley was higher than the England rate.
- Knowsley had the highest rate of all the local authorities, followed by Wirral and Liverpool



Cheshire and Merseyside Health and Care Partnership

- Liverpool and Knowsley have the biggest percentage of 0–5-year-old population who had a general anaesthetic for extraction of teeth when compared to the other local authorities



- Liverpool has the biggest percentage of 0–5-year-old population with caries experience when compared to the other local authorities
- All local authorities except Cheshire East have a bigger percentage of children with caries experience when compared to England

Graphs produced by Y Dailey & R Keat , Dental Public Health, Healthcare Public Health Directorate NHS E NorthWest

Source: PHE Fingertips

Sources: NHS Dental Statistics for England, 2022-23, Annual Report - NHS Digital
Public health profiles - OHID (phe.org.uk)
National Dental Epidemiology Programme (NDEP) for England: oral health survey of 5 year old children 2022 - GOV.UK (www.gov.uk)
English indices of deprivation 2019 - GOV.UK (www.gov.uk)

Cheshire and Merseyside Health and Care Partnership

Please note that for some indicators a RAG rating was used to compare the different areas.
Red indicates a worse position, Amber indicates a middle position and Green indicates a better position.

	Access (% of population seen)						Investment		Disease			Deprivation				Public Health - wider determinants	Workforce		
	Jun-20	Jun-20	Jun-20	Jun-23	Jun-23	Jun-23	23/24 £PP (AVG across LA)	Contracted UDAs	Child DMFT 2022 (% of examined population)	Hospital admissions for dental caries (0 to 5 years) (Crude rate, England = 220.8)	General Anaesthesia (0-19 years old)	AVG IMD Decile (1 is most deprived)	IMD Score (England = 21.7, ICB = 28.1)	Children in Poverty (IDACI)	Older adults in below average income households	Older adults with a long-standing health condition (ICB = 59.1%, England = 54.6%)	Leavers	Joiners	Dentists per 100,000 population
Area	Children 0-17 (06/20)	Adult 18-64 (06/20)	65 and over (06/20)	Children 0-17 (06/23)	Adult 18-64 (06/23)	65 and over (06/23)				Period: 2018/19 - 2020/21	FCE tooth extraction rate (all diagnoses) per 100,000 target population		Period: 2019	Period: 2019	Period: 2019	Period: 2023	% of total dentists 21/22	% of total dentists 22/23	
Cheshire East	48%	54%	52%	69%	49%	49%	£29.12	604,815	22.53	115.54	298.9	7.1	14.5	11%	9%	57.0%	8.7	6.1	70
Cheshire West and Chester	48%	56%	55%	65%	49%	51%	£29.52	628,063	25.35	67.34	180.6	6.2	18	14%	11%				
Halton	33%	45%	46%	49%	51%	50%	£34.36	226,959	33.9	126.94	257.9	3.8	32.3	24%	18%	63.5%	4.9	1.9	80
Knowsley	35%	50%	49%	56%	42%	48%	£31.80	294,523	31.23	371.38	241.4	2.6	43	30%	29%	59.6%	6.4	1.1	62
Liverpool	36%	42%	47%	52%	34%	44%	£29.74	846,929	43.52	559.9	418.6	2.8	42.4	30%	30%	57.7%	8.9	4.4	55
Sefton	41%	61%	59%	53%	50%	54%	£34.50	542,565	32.58	280.81	400.5	4.8	27	19%	17%	61.3%	5.5	5.1	65
St. Helens	42%	57%	57%	59%	51%	55%	£28.77	377,783	31.24	205.33	249.5	4	31.5	24%	17%	62.9%	10.4	4.1	67
Warrington	41%	51%	51%	54%	41%	46%	£32.88	348,216	30.51	106.07	301	6.2	18.9	13%	12%	56.0%	5.7	6.1	63
Wirral	40%	55%	56%	55%	50%	54%	£33.50	569,000	29.34	46.75	405	4.7	29.6	22%	17%	62.0%	7.8	9.5	62
	NHS BSA & ONS						C&M Dental Practice list	C&M Dental Practice list	NDEP survey	Fingertips (2018/19-2020/21)	NHS D	ONS	Fingertips	Fingertips/Poppi/Pansi	Fingertips/Poppi/Pansi	Fingertips/Poppi/Pansi	NHS Dental Statistics		

11.2. Oral Health Summary Actions

11.2.1. ICB has agreed a significant 3-year supervised toothbrushing programme, with the provision of toothbrushing packs, targeted at CORE 20 populations across all 9 places within our sub region and particularly at the 67, 000 2–7-year-olds in those most deprived communities. The business case for the oral health improvement programme was approved in Q3 2023/24, and mobilisation and procurement of oral health packs had commenced by Q4. Full scale implementation with our Local Authority and VCFSE sector partners will be achieved throughout 2024/25.

11.2.2. The roll out of HENRY workshops across C&M with focus on Healthy Teeth and Healthy Drinks to support Oral Health Agenda. Two HENRY (Healthy Teeth, Healthy Drinks) workshops delivered at Kensington nursery, an area of high deprivation, to support Oral Health concerns.

11.2.3. Early Intervention funds have also been used to target and deliver Oral Health Parent Champions Project in Liverpool. This was identified as the area with the highest level of deprivation within the region and the area with the highest level of dental caries.

11. Smoking Cessation

11.1 Proportion of adult acute inpatient settings offering smoking cessation services

This is a new national data collection Individual person level data is required to monitor activity and outcomes and to identify the anticipated impact on addressing health inequalities. Data quality is still being addressed before this data set may be considered reliable for routine use.

11.2 Proportion of maternity inpatient settings offering smoking cessation services:

Cheshire & Merseyside WhaM Programme Metrics - ICB & Providers - Latest Period Summary

					ICB			Providers						
MetricName	Latest Period	Unit of measurement	Direction	England	C&M	GM	L&SC	Countess Of Chester Hospital NHS Foundation Trust	East Cheshire NHS Trust	Liverpool Women's NHS Foundation Trust	Mid Cheshire Hospitals NHS Foundation Trust	Mersey & West Lancashire NHS Teaching Trust	Warrington and Halton Hospitals NHS Foundation Trust	Wirral University Teaching Hospital NHS Foundation Trust
% of women with recorded smoking status at booking appointment	Oct 23	Percentage	Lower	11.2%	11.5%	9.8%	12.7%	11.8%	6.3%	11.5%	12.7%	14.4%	9.1%	10.2%
% of mothers known to be smokers at time of delivery	Sep 23	Percentage	Lower	8.1%	8.3%	8.8%	12.4%	7.4%	5.9%	7.3%	7.9%	10.6%	5.7%	11.4%
% of mothers known to be smokers at time of delivery (qtly)	Q2 23/24	Percentage	Lower	7.5%	8.1%	7.7%	10.5%	.	.	.	.	.	.	.

Source: Local provider data flows to ICB

11.3. <u>All Together Smokefree Summary Actions</u>

11.3.1. A co-produced and system-owned CM Smokefree Framework and plan is now under development with our Vision: All Together Smokefree. Ending Smoking. Everywhere. For Everyone. Interim target: to deliver a Smokefree 2030 in a way that is fair and equitable for our adult population and a tobacco free future for every child.

11.3.2. Smoking kills two in three smokers and is the leading modifiable risk factor responsible for health inequalities, accounting for half the difference in life expectancy between the richest and poorest costing the C&M sub-region £1.9bn. Costs to healthcare Is £73.2m. C&M smoking rates have fallen to 11.7% in 2022, below England 12.7%. One in four patients in a hospital bed is a person who smokes, contributing 500k admission each year and smokers also see GPs over a third more than none smokers.

11.3.3. System engagement has been ongoing during Q3/Q4 during 2023/24 through meetings and briefings to support co-production of the draft blueprint for a 3–5-year programme of work subject to funding with the opportunity to publicly launch the programme at the end of 2024 and move into full delivery in early 2025.

11.3.4. Sector-led improvement (SLI). Delivery of system wide engagement in successful Champs Public Health Collaborative/Local Government Association SLI Event on 8 March attended by 61 participants as part of process to support development of the Framework and local tobacco control priorities, including event report to participants.

11.3.5. Advocacy. Engagement in advocacy for the Smokefree Generation and Vapes Bill included social media and PR in Feb and March and a letter to all CM MPs in March. Participation in the All-Party Parliamentary Group on Smoking and Health No Smoking Day Event with 17-year-old CM youth parliament advocate attending Parliament and delivering additional advocacy to CM MPs via social media. Full participation in national partnerships and forums including the Smokefree Action Coalition.

11.3.6. Communications and social marketing. System engagement through articles in Collaborate in January and March and Champs Public Health Collaborative web resource to promote emergent programme. Amplification of March national No Smoking Day campaigns at CM and local level supporting community activation.

11.3.7. The NHS Tobacco Treatment Dependency Programme has seen significant progress made during 2023/24 across our large number of NHS providers, all 8 Maternity Trust implemented a service contributing to reduction in smoking at pregnancy rates to below 8%. Nine of our Acute Trusts implemented a service – 1 trust has a go live date of 8 April 2024; and two mental health services are working with a specialist TTD provider to implement the proposal for a pilot programme for hospitalised people.

11.3.8. To support the implementation of the programme and development for all TTD providers and stakeholders, a CM TTD Forum was established by the ICB. Clinical Leaders and External partners have continued towards sharing best practise and emerging evidence base to help support TTD providers and establish stronger collaborative working with community smoking cessation providers.

11.3.9. The ICB also commissioned and provided four 2-day educational sessions (two for midwifery and two for acute service TDAs).

12. Additional Population Health and Inequalities Tools Developed

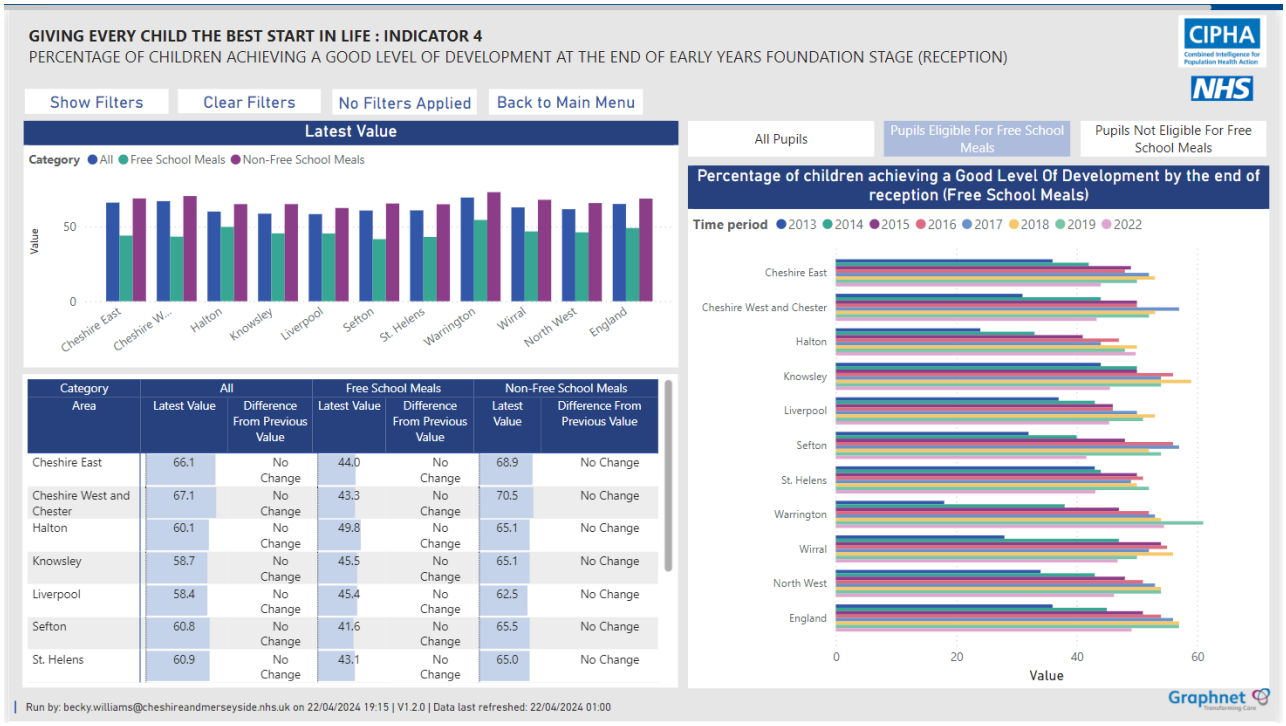
12.1. All Together Fairer Marmot Dashboard of Beacon Indicators: The All Together Fairer Programme exists to support development and delivery of a strategic approach to improve population health and address inequalities in health and the social determinants of health across Cheshire and Merseyside. It facilitates collaborative engagement and action to support whole system implementation of appropriate policies and initiatives in line with our All Together Fairer strategy.

12.2. Nine Marmot Place Leads & C&M Marmot Community Leads have been established to lead priority programmes locally. These are accountable to the C&M

Marmot Community Advisory Board which reports to C&M Population Health Board.

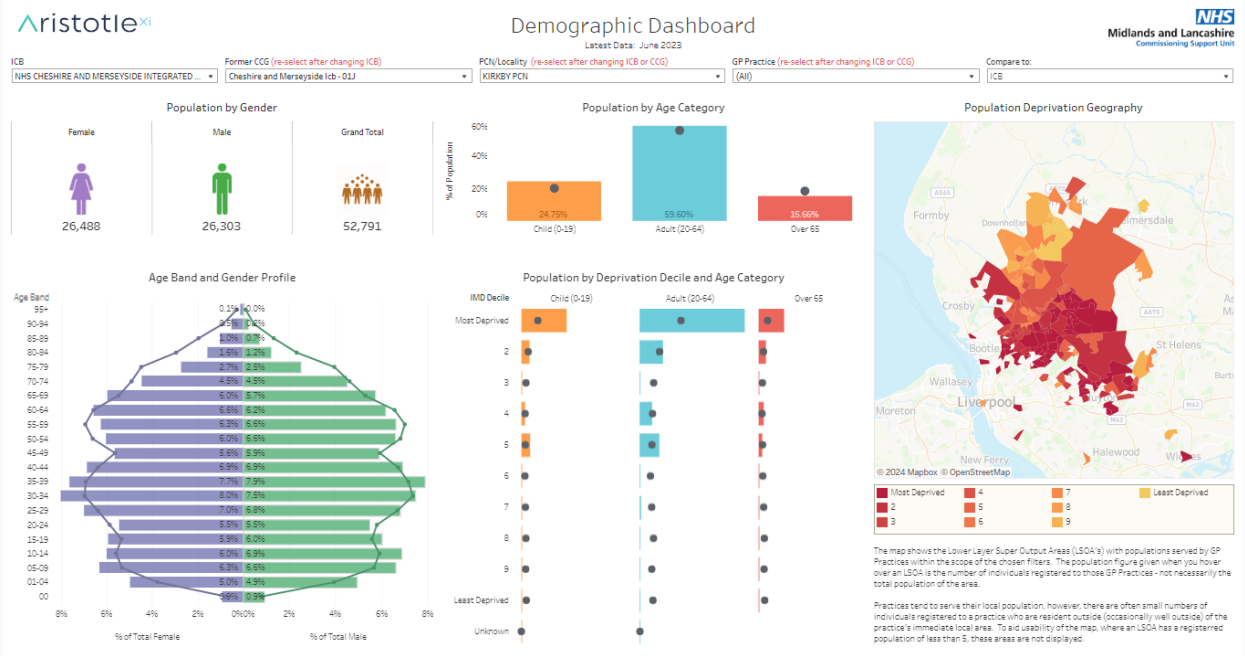
12.3. The Beacon Indicator Set was developed during the preparation of the All Together Fairer report launched in May 2022. A total of 22 indicators were chosen to measure progress in action on the social determinants of health and this is key to programme implementation and is accessible to leads within each place.

12.4. It is possible to view indicators stratified by the population eligible for free school meals, age, and gender to understand inequalities.



Category / Area	All – Latest Value	All – Difference From Previous Value	Free School Meals – Latest Value	Free School Meals – Difference From Previous Value	Non-Free School Meals – Latest Value	Non-Free School Meals – Difference From Previous Value
Cheshire East	66.1	No Change	44.0	No Change	68.9	No Change
Cheshire West and Chester	67.1	No Change	43.3	No Change	70.5	No Change
Halton	60.1	No Change	49.8	No Change	65.1	No Change
Knowsley	58.7	No Change	45.5	No Change	65.1	No Change
Liverpool	58.4	No Change	45.4	No Change	62.5	No Change
Sefton	60.8	No Change	41.6	No Change	65.5	No Change
St. Helens	60.9	No Change	43.1	No Change	65.0	No Change

12.1 Understanding demography at small area level (General Practice)



Source: NHS Digital

Dashboard reports such as the one above can be used at a local level by PCNs to understand their populations in greater detail and identify potential opportunities to work differently within the constituent practices in a PCN to work more effectively for disadvantaged populations.

12.5. **NHS Cheshire and Merseyside ICB Prevention Pledge.** Our NHS Prevention Pledge [4] is a framework developed for NHS provider trusts that is underpinned by 14 'core commitments' promoting healthier settings (in particular those promoting physical activity, healthier catering, tobacco-free environments), social value and wider 'anchor practices', workforce development, MECC, quality assurance, workplace wellbeing, and health inequalities.

12.6. The commitments were developed through extensive consultation with representatives from Provider Trusts, NHS England, local authority public health teams, OHID, NICE, academic researchers and third sector organisations. Read more about the 14 core commitments.

12.7. The pledge has been included in a recent NHS Confederation Health toolkit [5] in how to embed action on health inequalities into integrated care systems.

12.8. **Ethnicity recording**- A Northwest Improving Ethnicity recording round table event was held in November with representation from C&M ICB. This identified a number of recommendations that will inform a regional action plan for improving ethnicity recording. C&M are exploring approaches with NHS Trust contracts for improving Ethnicity recording.

[4] https://www.preventionpledge.org.uk/
[5] https://www.nhsconfed.org/toolkits/how-embed-action-health-inequalities-integrated-care-systems

12.9. **Primary Care Recovery Programme:** Equality, Diversity and Inclusion (EDI) and Health Impact Assessment Phase 1 completed as part of the primary care recovery programme presented to ICB in November. EDI phase 2 programme now working with our individual places to take forward EDI assessment recommendations and accounting for local inclusion group needs both in digital and access of health services.

12.10. **ICB Contracting guidance tool** – An NHS Cheshire & Merseyside Health Inequalities Schedule and Toolkit has been established to support the delivery, and assurance on the prevention and health care inequalities work being undertaken across all our NHS Trusts. This will be in place for 2024/25 and includes specific guidance about Health Inequalities and Prevention tools and resources to inform contract schedules and system transformation approaches an our quarterly stocktake and assurance meetings with NHSE. The tool also includes asks of NHS trusts to implement the North West Black, Asian and Minority Ethnic Assembly Framework.