CABINET

13TH SEPTEMBER 2022

Proposals for the allocation of the Public Health ring-fenced grant reserve to reduce health inequalities

Report of: Liz Morgan, Interim Executive Director of Public Health and Community Services

Report of Cabinet Member: Cllr Wendy Pattison, Adults' Wellbeing

Purpose of report

This report describes the process undertaken to agree proposals for additional investment in public health interventions from the ring-fenced public health grant to reduce health inequalities; and to make recommendations.

Recommendations

Cabinet is recommended to:

- Approve the allocation of funding from the Public Health reserve as proposed in this report.
- Delegate to the Director of Public Health the precise expenditure of the funding set aside to address issues around poverty.

Link to Corporate Plan

This report is particularly relevant to one of the two overarching themes of the NCC Corporate Plan 2021-2024: Tackling inequalities within our communities, supporting our residents to be healthier and happier. It is also relevant to the Living, Learning and Enjoying priorities.

Key issues

- There is a requirement when using any funds from underspend to comply with the conditions of the use of the annual public health grant, which means that the funds must be spent on public health functions (1).
- This report describes a prioritisation exercise undertaken for allocation of part of the public health reserve that has accumulated from underspend. Criteria were developed and weighted to score bids that were sought from within the public health team and from other teams across the council. Criteria with the highest weighting were: 'aim to reduce inequalities' (20%); and 'local need', 'evidence of impact/ effectiveness', and 'prevention' (each 15%). A higher score was given if the goal was *primary* prevention (preventing illness or maintaining health), in line with public health principles.
- A total of 13 projects costing £2,543,000 were provisionally approved by the senior team assessing and scoring bids, pending Cabinet approval. These ranged from

£1,500 to £1 million in individual cost. Four proposals of relatively low value individually (£23,000 in total) were approved as business as usual. Supported bids with the highest cost were for: poverty (£1 million); a selective licensing scheme for privately rented homes (£710,000); NHS Health Checks programme redesign (£300,000); Children and Young People's Emotional & Mental Health Support (£210,000); and the evaluation of integration of services for children, young people and families in Northumberland (£150,000).

Background

Conditions of the public health grant

Northumberland County Council receives a public health grant from the Department of Health and Social Care. There are conditions for the use of this grant, which is ringfenced for use on public health functions. The grant must be used only for meeting eligible expenditure incurred or to be incurred by local authorities for the purposes of their public health functions as specified in Section 73B(2) of the National Health Service Act 2006. If payments are made out of the fund towards expenditure on other functions of a local authority or the functions of an NHS body, other public body, or a private sector or civil society organisation, the authority must be prepared to demonstrate that those functions have a significant effect on public health (1). If at the end of the financial year there is any underspend, local authorities may carry these over, as part of a public health grant reserve, into the next financial year. In using those funds in following years, local authorities still need to comply with the grant conditions.

A public health reserve has accumulated from underspend over recent years which at the end of 2021/22 totalled £5,149,659. This has largely arisen from a very precautionary approach being taken to committing recurrent or large-scale one-off expenditure in the light of uncertainty about future funding. Up until 2020/21, the grant had been reducing year on year since its inception and information on the envelope of funding for any year was usually only made available in the last few weeks of the preceding year which hampered the financial planning process. For the first time, the Treasury has committed funding for the next three years (2022/23 - 2024/25) which provides some confidence in committing the reserve, knowing that there is less of a risk of a significant reduction in the grant value and therefore a potential gap in planned expenditure and income that the reserve would need to fill to enable an orderly decommissioning of services.

We are now therefore able to commit significant expenditure of the public health reserve in a way which ensures it is not only spent in a timely manner but spent in accordance with the grant conditions whilst ensuring transparency and value for money, improving the health of the population of Northumberland and reducing health inequalities. A prioritisation exercise was therefore undertaken to determine what services and interventions should be funded (and by how much) within this fixed, non-recurrent budget to achieve maximum benefit (referred to as 'allocative efficiency' in economic terms).

Reducing inequalities

In some parts of Northumberland, residents are dying up to 12 years earlier than those in other areas, and spending longer living in poor health. There is a common purpose and ambition to reduce health, social and economic inequalities in Northumberland. To achieve this ambition, the Northumberland system has come together to develop a system-wide Inequalities Plan. This plan will focus on a few key enablers which will support an improvement in a focused collection of short, medium and longer-term indicators which will

demonstrate that inequalities are narrowing and outcomes for our residents are improving. Northumberland County Council has committed to supporting the development and implementation of the Inequalities Plan.

Reducing inequalities has been a key criterion in determining how to propose allocation of funding from the Public Health reserve. Each of the recommended bids can be expected to contribute to reducing inequalities in Northumberland.

Prioritisation process and outcome

In undertaking a prioritisation exercise, the health economic principle of 'opportunity cost' has been paramount. The opportunity cost is the loss of (health) benefits from not investing in a more cost-effective intervention. Building on a previous prioritisation exercise for the entire annual public health budget, a business case template was developed that incorporated and weighted key criteria on which to assess potential bids (see Table 1), similar to multi-criteria decision analysis (MCDA). Bids were requested from the public health and community services, children's services, adults' services and NCT teams . These bids were scored by a team of five assessors within the public health team against the weighted criteria to inform decision making.

Cabinet may also wish to note that £100,000 has already been committed from the Public Health reserve to part-fund a strategic Creative Health Manager. This was agreed at a System Transformation Board meeting earlier in the year; is aimed at supporting the delivery of the recommendations in the 2019 Director of Public Health Annual Report (Creative Health); and supports the Northumberland cultural strategy. The post, which has matched CCG funding, will be working across NHS, local authority, VCSE, communities and cultural organisations over 3 years to increase our capacity to use creativity to improve health and wellbeing and reduce inequalities.

Following scoring and discussion, Cabinet is asked to approve allocation of funding to nine projects or interventions (Table 2), described here in more detail. An example of a completed business case is attached at Appendix 1. A further four projects totalling £23,000 will be supported as business as usual.

Children and Young People's Emotional & Mental Health Support (£210,000)

This funding will provide an additional £210,000 within Northumberland over the next 3 years to help support children and young people with low level emotional wellbeing and mental health needs. The emphasis is on developing resilience and coping in children and young people as we learn to live with COVID-19. NCC will work closely with partners to identify appropriate evidence-based resources.

All services in Northumberland which provide emotional wellbeing and mental health support to children and young people are reporting unprecedented increases in demand. A similar picture is seen across the UK and COVID-19 is a contributory factor. There is evidence that COVID-19 has disproportionately impacted the mental health and wellbeing of children and young people experiencing other forms of disadvantage, those with

existing mental health difficulties, those with special educational needs and disabilities (SEND), and girls and young women.

Providing additional resources will directly contribute to the Northumberland Joint Health and Wellbeing Strategy, helping to give children and young people the best start in life and supporting the cross-cutting theme of improving mental wellbeing and resilience.

Evaluation of integration of services for Children, Young People and families in Northumberland (£150,000)

This initiative will enable NCC to work with local universities to design and undertake an evaluation of the integration of children's services in Northumberland, including the new Family Hubs model. NCC has embarked on a two to three-year programme of integration of services for children and young people. This is innovative, collaborative work which is being undertaken at a system level in Northumberland which recognises that services exist within a complex system and that delivering at the front line and into key settings such as education is where we can achieve the biggest difference in quality and efficiency. The emphasis of this work is on making the best use of our collective resources, addressing health and social inequalities while supporting the development of resilience and resourcefulness of children and families.

The purpose of this evaluation is to identify and share learning about the process of integration and to understand the impact of this work, particularly from the perspective of children, young people and their families. Working with academic partners will enable us to develop a high-quality evaluation, share learning widely, and highlight the innovative work that is being done with partners across the county.

NHS Health Checks transformation (£300,000)

NHS Health Checks aim to reduce the chance of a heart attack, stroke or developing some forms of dementia in people aged 40-74 years. The provision of NHS Health Checks is a condition of the Public Health grant. They are currently delivered exclusively in General Practice based on a tariff per completed health check. However, there is evidence that fewer people from more deprived areas who are most likely to benefit have an NHS Health Check, thus increasing health inequalities.

One-off funding would be used to support a major redesign of the NHS Health Check programme to enable direct delivery by health trainers (and potentially other staff) in community settings outside of General Practice in order to target those most at risk of

premature mortality and reduce socioeconomic inequalities in uptake. Funding will be needed for the following:

- Procurement of point of care testing devices.
- Staff training.
- Procurement of third party to manage the identification and invitation of eligible population (if needed).
- Procurement of electronic health record to record data with interoperability with local GP practice systems.
- COVID-19 cohort catch up: to pay for additional costs owing to the need for the programme to catch up for those eligible who missed a health check during the pandemic.
- Development of a digital offer (if needed).

A hybrid arrangement may be developed whereby General Practices continue to undertake NHS Health Checks for their eligible patients, and this is supplemented by Health Trainers undertaking NHS Health Checks in community settings using an outreach model to reduce inequalities in uptake (funded for 3 years from the Public Health reserve). This will be decided by option appraisal following confirmation of Cabinet approval for funding.

Poverty (£1 million)

It is proposed to contribute £1 million from the Public Health reserve to support the implementation of the NCC Poverty Action Plan (part of the system-wide Inequalities Plan) over 18 months.

It is anticipated that many local households will face considerable financial hardship over the coming winter months. Annual inflation rate is the UK highest since March of 1992, with rising costs of energy, food, and transport having particular impact. Many households will struggle to afford basic necessities. This will have significant long-term health implications on many people in Northumberland, and contribute to increased health inequalities because people on low income will be worst affected.

Several gaps in support available have been identified:

- Central Government funding for the replacement of any condensing gas boilers will cease in July 2022.
- The Warmer Homes Scheme is NCC's new in-house scheme for the delivery of government funding for the retrofit of domestic dwellings. It is targeted at households with an income below £30K/year in low energy rated properties. The total number of properties that the scheme will support is limited to 400.
- The Household Support Fund (managed by Northumberland Communities Together) is primarily used to support households in the most need. The current funding is from 1st April to 30th September 2022, with no confirmation of continuation at this stage.
- Northumberland Emergency Transition Support provides grants or loans to people in a crisis. Awards are limited to two per year of £1000 whichever comes first, the average transition award is £509.
- There is a lack of capacity across the VCS and NCC teams/ organisations to appropriately support individuals to navigate the systems and support in place to help them. Support needs to be tailored, and vulnerable groups require increased

support to help identify bona fide contractors, practical structural help such as loft clearance, accessing proof of benefits.

Final decisions on specific funding will be made once the Poverty Action Plan is developed but the recommendation is that the public health grant contribution will be towards longer term sustainable and upstream interventions rather than short term emergency funding.

Selective Licensing of Rental Properties (£710,000)

Selective licensing is a tool available to local authorities to address the impact of poor-quality housing, management, and anti-social behaviour associated with tenants. It has primarily been developed with the need to tackle these problems in areas of low housing demand that suffer from significant and persistent anti-social behaviour. As well as improving housing standards, selective licensing can create sustainable neighbourhoods providing tenants with a greater choice of safe, good quality and well managed accommodation.

Improvement in health is achieved by preventing exposures to hazards that cause disease or injury and the chronic (housing related) stress which leads to ill health, as well as improving the health of people with chronic disease.

The proposal is to designate the area of Cowpen Quay as an area for selective licensing. Funding is sought for 5 years to meet the costs that cannot be met from the income from the scheme. Evaluation will be built in, the evidence from which will inform a decision about continuing the scheme through the normal NCC budget or PH grant budget setting process.

Table 1. Criteria, definitions and weighting for informing prioritisation exercise for allocation of the Public Health reserve

Criterion	Definition	Weighting
1. Local need	The level of need that is strategically aligned to existing objectives. This is expressed need as well as any predicted need based on intelligence available.	15%
2. Aim to reduce inequalities	The programme aims to close the gap in healthy life expectancy both to England average and within Northumberland.	20%
3. Evidence of impact/ effectiveness	Quality of the evidence available which includes theoretical underpinning of programmes as well as evidence in outcomes: credibility of source, generalisability to real world applicability.	15%
4. Prevention	To what extent is the programme area focused on primary prevention (maintaining people's health before they become ill); the earliest possible intervention	15%
5. Building Community Strengths	The degree to which the programme is community centred. Community-centred approaches are not just community-based, they are about mobilising assets within communities, promoting equity and increasing people's control over their health and lives.	5%
6. Value for money	Extent to which evidence is available that shows that costs and harms are outweighed by the benefits. (This is not higher because published evidence is not always available for public health interventions.)	5%
7. System benefits and inter-dependencies	The impact and level of connectedness between this programme for common outcomes with other services/ partners (including co-commissioning and/ or delivery, quality, flexibility and availability) in the local public and voluntary sector system; reflecting the level of risk to the wider system if this programme was not in place.	5%
8. Outputs / outcomes to demonstrate impact	Reasonable outputs (quantitative and qualitative) that can be tracked and measured to report benefit in spend.	10%
9. Sustainability / exit plan	A well-considered exit strategy given that this is one-off, non-recurrent funding.	10%

Table 2. Projects recommended for funding

Name and brief description	Funding	Average weighted score
1. **Children and Young People's Emotional & Mental Health Support**: see text	£210,000	72%
2. **Evaluation of integration of services for Children, Young People and families in Northumberland**: see text	£150,000	75%
3. **HENRY (Health, Exercise, Nutrition for the Really Young) training for Early Help staff**: evidence-based programme working with families with children from conception to 12 years to promote healthy weight.	£20,000	76%
4. **Lung Cancer Health Checks**: contribution to early adoption of early identification of treatable lung cancer by offering low-dose CT scan to people aged 55-74 years with chronic obstructive pulmonary disease and smoking history in SE Northumberland where incidence is almost twice the national average.	£30,000	67%
5. **Making Every Contact Count (MECC) training grants to voluntary and community sector (VCS) groups**: to cover costs such as backfill, travel, and room hire for training in brief conversations and signposting to improve health and wellbeing (MECC), and community activities to put MECC into practice.	£50,000	71%
6. **NHS Health Checks programme redesign**: see text	£300,000	75%
7. **Poverty**: see text.	£1M	74%
8. **Selective Licensing of Rental Properties**: see text.	£710,000	81%
9. **Vaccination midwife**: short-term funding to promote COVID and other vaccination among pregnant women in Northumberland	£50,000	75%
TOTAL	**£2.52M**	

Implications

Policy	All of the proposed projects are intended to improve health and reduce inequalities in health. Impact on health inequalities is a key criterion on which projects were assessed. The Northumberland Corporate Plan 2021-2024 identifies addressing inequalities as one of two overarching priorities.
Finance and value for money	Funding will be met entirely from the Public Health reserve. The extent to which published evidence is available on value for money of the proposed intervention was a criterion in the prioritisation of projects.
Legal	Funding must meet the conditions for use of the Public Health grant (1). The Local Authorities (Functions and Responsibilities) (England) Regulations 2000 confirm that the matters within this report are not functions reserved to Full Council
Procurement	Several projects will require procurements. Procurement advice will be obtained to ensure that any commissioning or contractual arrangements entered into are compliant.
Human Resources	Several projects will require training of existing staff or recruitment of new staff.
Property	None identified
Equalities (Impact Assessment attached) Yes ☐ No x N/A ☐	Impact on health inequalities was a key criterion of the prioritisation exercise and so has been considered and scored for each project.
Risk Assessment	Risks have been identified in business case templates and project leaders are expected to produce a detailed project plan and risk assessment for projects with a higher value.
Crime & Disorder	Selective licensing of rental properties is expected to have a positive impact on anti-social behaviour.
Customer Consideration	Many of the projects can be expected to improve customer or resident satisfaction e.g. NHS Health Checks, Poverty interventions, Health Trainer website.
Carbon reduction	Carbon reduction has not been specifically assessed within business case templates. None of the projects proposed are expected to increase the release of greenhouse gases that contribute to global heating. Some interventions which may be considered as part of the poverty reduction plan may contribute

	to carbon reduction. Having completed the carbon impact assessment, the overall impact assessment for this proposal is: 0.57 which includes: Policy score: 1 Partnerships and Engagement score: 1 Heating score: 1 Transport score: 0 Renewable Energy Generation score: 1 Carbon Sequestration: 0 Waste score: 0
Health and Wellbeing	All projects are explicitly intended to improve health and wellbeing of Northumberland residents, and reduce health inequalities.
Wards	Most projects are Northumberland-wide, but some cover specific areas e.g. Selective Licensing of Rental Properties covers Cowpen Quay; Lung Cancer Health Checks will initially be in SE Northumberland. All projects are intended to reduce socio-economic inequalities in health and so will be expected to have greater impact in more deprived areas.

Background papers:

1. **Department of Health and Social Care.** Public health ringfenced grant 2022 to 2023: local authority circular. [Online] February 07, 2022 https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2022-to-2023/public-health-ringfenced-grant-2022-to-2023-local-authority-circular

Report sign off.

Authors must ensure that officers and members have agreed the content of the report:

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Appendix 1: Provisionally approved Public Health reserves funding bids

1. Children and Young People's Emotional & Mental Health Support
2. Evaluation of integration of services for Children, Young People and families in Northumberland
3. HENRY (Health, Exercise, Nutrition for the Really Young) training for Early Help staff
4. Lung Cancer Health Checks
5. Making Every Contact Count (MECC) training grants to voluntary and community sector (VCS) groups
6. NHS Health Checks programme redesign
7. Poverty
8. Selective Licensing of Rental Properties
9. Vaccination midwife

1.

Children and Young People's Emotional & Mental Health Support

Public Health Reserves Funding Bid Request

Name of scheme:	**Additional emotional wellbeing and mental health support for children and young people**
1. Brief summary of programme/intervention covering: A. **Local need** B. **How will it reduce inequalities?** C. **Evidence of effectiveness** D. **Scale of prevention (primary, secondary, tertiary)** E. **How will it build on community strengths?** F. **Value for money**	This case is for funding to commission additional resource within Northumberland to support the emotional wellbeing and mental health needs of children and young people during the next 2-3 years. Working with partners, additional, evidence-based resources would be commissioned to strengthen the offer to CYP with low level emotional wellbeing and mental health problems: i. To strengthen the prevention offer and develop resilience in CYP ii. To provide additional time-limited capacity to manage increased demand on current services Further work with multiagency stakeholders is required to identify the specific resources / interventions that would have greatest impact. It is anticipated that where possible these would build on existing provision (e.g. expanding offer provided by current VCS partners). Resources / interventions would be child and family focused. Examples of potential interventions include i. Specific programmes such as RelaxKids, or extending provision of Incredible Years ii. Extension of existing VCS provision (e.g. increasing 1:1 counselling support for children, young people and their families) iii. Group approaches for children, young people and families. iv. Fixed term contracts for specific roles (e.g. emotional resilience support workers within school nursing)

	Local need: All services in Northumberland which provide emotional wellbeing and mental health support to children and young people are reporting unprecedented increases in demand. This includes school nursing, the Northumberland Inclusive Education Service, the Primary Mental Health Work (PMHW) Team, Children and Young People's services and voluntary and community services. There is a graduated approach to emotional wellbeing and mental health support to children and young people in Northumberland; support for those with low level needs includes school nursing (including Chat Health), voluntary sector support (mainly in Trailblazer areas of Ashington, Bedlington, Blyth and Hexham) and online resources (Kooth). Referrals to school nursing have doubled compared to pre-pandemic levels. Much of the increase is for emotional and psychosocial advice and support which accounted for 42% of face to face contacts with a school nurse in 2021/22 compared to 19% in 2018/19. This has contributed to sustained increases in waiting times to see a school nurse in Northumberland. All referrals are triaged within 48hrs. Following triage, the maximum waiting time for an intervention is 26 weeks, with the longest waiting times in the Central and South East localities. COVID-19 has disrupted the implementation of whole school approaches to emotional wellbeing and mental health across Northumberland. Inequalities: There is evidence, summarised by OHID, that COVID-19 has disproportionately impacted the mental health and wellbeing of children and young people experiencing other forms of disadvantage, those with existing mental health difficulties, those with SEND and girls and young women. The localities with the longest waiting times and largest number of children waiting for school nursing interventions include the most disadvantaged communities in Northumberland. Prevention levels: This will potentially have an impact on all levels of prevention. The main impacts will be on primary prevention by promoting good mental health and secondary prevention by supporting children and young people who may be at higher risk

	of experiencing mental health problems. Some interventions / resources may support children, young people and families who have existing mental health problems to stay well. Community strengths: Opportunities for utilising community resources would be explored with partners. Strengthening resilience in children, young people and their families will contribute to developing community resilience.
2. Outputs / outcomes expected to be achieved and by when	The expected outputs / outcomes are: • An increased offer of support for children, young people with low level emotional wellbeing and mental health needs (specific resources to be determined by key stakeholders) • Uptake of this offer and positive feedback from children, young people, families and other stakeholders • Reduced referrals to services, particularly school nursing from schools and primary care with low grade EWMH problems • Impact on other services - reduced waiting times will potentially prevent worsening of symptoms and escalation of issues to other services (eg PMHWs)
3. System benefits and interdependencies e.g. • **Health in all policies** • **Joint Health & Wellbeing Strategy** • **Part of PCN inequalities plan** • **Links to Covid inequalities HIA**	The increasing need for emotional wellbeing and mental health support affects the whole system. • This directly supports the Joint Health and Wellbeing Strategy, two of the key themes of which are giving children and young people the best start in life and empowering people and communities. Priority areas in this theme include providing the best quality education and ensuring that all children and young people feel safe and supported in all areas of their lives. Improving mental wellbeing and resilience is a cross cutting theme across all key themes of the JHWS. • The socio-economic determinants that adversely affect outcomes for children and young people are also associated with disproportionate impacts from COVID-19. • PCNs will be involved in Family Hubs and integration; a number have identified children and young people in their priorities

	• Mental health has been identified as the top priority of the North East and North Cumbria's Child Health and Wellbeing Network.
4. Do you anticipate that a procurement will be required?	Procurement may be required but this depends on the specific interventions / resources identified by stakeholders. It is more likely that several smaller commissions would be undertaken which would not require procurement.
5. Funding A. **Total amount requested and over how long** B. **Forecast spend over duration of programme e.g.:** • **All up front (e.g. a purchase)** • **Monthly (staffing costs)** • **Procurement timeline to be worked up** • **Delay and then spend back end of programme** C. **Match funding opportunities?**	• To be confirmed, depending on additional resources identified but estimate £210k over 3 years (e.g. approx. £70k per year). This amount would enable funding of fixed term contracts if required. • This may involve some upfront spending (e.g. purchase of training package / resources) • It is possible that there may be some match funding opportunities from other commissioners.
6. Exit strategy / sustainability plan	This case is to commission additional resource for a fixed period. The intention is to provide additional capacity to help manage immediate levels of unprecedented demand. This would provide some "breathing space" to enable services to collaboratively review and plan a sustainable longer term system-wide response.

7. Risks to be managed e.g. • **Workforce available to recruit** • **Procurement delivers to time** • **Financial risks** • **Safeguarding** • **Risks to credibility, relationships or reputation**	• Securing agreement with partners regarding interventions which will have the most impact • There are challenges in recruiting some specialist roles. However, interventions for those with low level emotional / mental health need may be delivered by non-qualified staff • Existing services, e.g Early Help and schools may not have capacity to implement interventions / programmes if training/resources are provided. VCS organisations may not have capacity or be able to obtain additional resources to expand their offer • Risk of temporary funding: This programme needs to be concurrent with the development of a sustainable longer term multiagency response which will require effective systems leadership. Introduction of additional funding may raise future expectations which need to be managed.

2.

Evaluation of integration of services for Children, Young People and families in Northumberland

Public Health Reserves Funding Bid Request

Name of scheme:	**Academic evaluation of integration of services for Children, Young People and families in Northumberland**
A. **Brief summary of programme/intervention covering:** A. **Local need** B. **How will it reduce inequalities?** C. **Evidence of effectiveness** D. **Scale of prevention (primary, secondary, tertiary)** E. **How will it build on community strengths?** F. **Value for money**	This case is for funding to commission academic partners to design and undertake an evaluation of the integration of children's services in Northumberland, including the new Family Hubs model. Innovative, collaborative work is being undertaken at a system level in Northumberland. The purpose of this evaluation is i) to identify and share learning about the process of integration and ii) to understand the impact of this work, and obtain the perspective of children, young people and their families. There is limited capacity and skills within NCC to design and undertake the robust academic evaluation that a programme of this size warrant. Given the scope and duration of the integration programme it is anticipated that embedded researcher(s) will be required. An initial meeting with academic partners and OHID has been arranged for Friday 17th June. Integration of children's services: Northumberland County Council has embarked on a two to three year programme of integration of services for children and young people. This recognises that services exist within a complex system and delivering at the front line and into key settings such as education is where the difference in quality and efficiency can be maximised. A focus is on making the best use of collective resources, addressing health and social inequalities while supporting the development of resilience and resourcefulness of children and families.

	Two recent major developments have prompted work on integration: • The section 75 partnership agreement between NCC and Harrogate and District Foundation Trust to provide health visiting and school nursing (0-19) services. The developing model for school nursing and health visiting in Northumberland will include a strengthened emphasis on community assets • Family Hubs – Northumberland is one of 75 local authorities eligible for funding to develop Family Hubs which are a way of joining up services locally to improve access, connections between families, professionals, services and providers, with relationships at the heart of family help. An asset-based community approach is integral to the Family Hubs model. <u>Inequalities:</u> Children's services include universal provision (e.g. health visiting and school nursing an education) and targeted interventions (e.g. Early Help, SEND education). Wider determinants including poverty, parental income, quality of housing and access to social networks influence outcomes for children and young people. Reducing inequalities and improving health and social outcomes are primary goals of the Northumberland Children and Young People's Strategic Partnership. <u>The evidence for integration:</u> Health and social care integration has been in progress for adult / elderly care services for a number of years, but the evidence base is limited. There is much potential benefit in exploring what a collaborative delivery model for conception to 19 years (25 years for SEND and care leavers) could look like and how that would work differently. We are not aware of examples of integration of children and young people's services. Central government funding for family hubs will be conditional on undertaking a local evaluation.
B. **Outputs / outcomes expected to be achieved and by when**	The expected outputs / outcomes are to engage academic partners to: • Collaboratively design an evaluation • The research to actively inform the development and implementation of integration • Complete and publish the evaluation, with interim updates as appropriate • Collaboratively produce and submit papers for publication

C. **System benefits and interdependencies e.g.** • **Health in all policies** • **Joint Health & Wellbeing Strategy** • **Part of PCN inequalities plan** • **Links to Covid inequalities HIA**	System benefits have been described in section 1. Key interdependencies include: • Giving children and young people the best start in life and empowering people and communities are key themes of the Joint Health and Wellbeing Strategy. • Wider determinants and associated impact on outcomes for children and young people will be considered in the Northumberland Inequalities Plan • The socio-economic determinants that adversely affect outcomes for children and young people are also associated with disproportionate impacts from COVID-19. • PCNs will be involved in Family Hubs and integration; a number have identified children and young people in their priorities
D. **Do you anticipate that a procurement will be required?**	It is possible that procurement may be required, depending on the total cost and how this is distributed over study period.
E. **Funding** 1. **Total amount requested and over how long** 2. **Forecast spend over duration of programme e.g.:** • **All up front (e.g. a purchase)** • **Monthly (staffing costs)** • **Procurement timeline to be worked up** • **Delay and then spend back end of programme** 3. **Match funding opportunities?**	A. Total amount to be confirmed but very approximate estimate based on experience from other evaluations is £150k over 3 years B. Forecast of spend over duration of programme: To be determined. • There is potential for additional funding from alternative sources eg PHIRST

F. **Exit strategy / sustainability plan**	Not applicable – This is a time limited programme
G. **Risks to be managed e.g.** • **Workforce available to recruit** • **Procurement delivers to time** • **Financial risks** • **Safeguarding** • **Risks to credibility, relationships or reputation**	Potential risks to be managed include: • Suitable academic partner cannot be found • Integration programme does not progress (however, evaluation would still have benefit in this eventuality) • Integration programme takes longer than expected, extending beyond anticipated funding period • Delay in commencing evaluation process. There is time pressure for the family hub evaluation to commence as work on family hubs is progressing. • The government has not yet published guidance for evaluation of family hubs in those local authorities eligible for funding. The amount of funding available for Northumberland is to be determined. Evaluation of Northumberland family hubs will need to meet any national criteria.

3.

HENRY (Health, Exercise, Nutrition for the Really Young) training for Early Help staff

Public Health Reserves Funding Bid Request

Name of scheme:	**HENRY (Health, exercise, nutrition for the really young)** **Training for Practitioners**
1. **Brief summary of programme/intervention covering:** A. **Local need** B. **How will it reduce inequalities?** C. **Evidence of effectiveness** D. **Scale of prevention (primary, secondary, tertiary)** E. **How will it build on community strengths?** F. **Value for money**	The HENRY programme is a core part of the Early Help; Prevention and Intervention Pathway. It is a recognised evidenced based intervention. The programme works with parents to address: • Healthy weight data informs of areas of concern. • behaviour change strategies • parenting skills • improved knowledge about food and activity for under 5s and the whole family During covid we have not had ready access to families, particularly during the periods of isolation, to get the healthy messages embedded or indeed to provide these sessions. Some families have become 'sedentary' to a degree, so exercise and nutrition messaging is vital. Since the start of the Covid pandemic in March 2020 and the procedures and restrictions put in place to limit its spread, we have seen or had reported to us an increase in: • the weight of both children and adults, leading to many more becoming overweight or obese. • Number of parents reporting a negative impact on their mental wellbeing, and an increase in the challenging behaviours of their children, as well as issues around sleep routines.

	• HV teams and childcare settings are reporting that more children are being identified with speech/language/communication and social and emotional developmental delays. The HENRY suite of programmes is targeted at families with babies and children, from conception to 12 years of age. It is a proven approach (Bridge & Willis 2019), which was developed in response to an identified gap for a practical intervention that would deliver the key evidenced based messages contained in *'Tacking obesity through the Healthy child programme – a framework for action'*. The HENRY approach focusses on both the message and messenger to create the conditions for change and to support families to adopt healthier lifestyles, using integrated evidence-based behaviour change models. Research shows that information alone is unlikely to achieve sustained lifestyle change. The HENRY approach enables practitioners to create the conditions for change where parents can put the messages into practice as part of their everyday life. Support from HENRY trained practitioners explicitly builds family resilience through strength-based solution focused partnership approach that supports families to take control of their everyday life. This approach will be able to mitigate some of the effect of Covid, mentioned above, as it would provide parents with the messages, tools and support for both them and their families to live healthier lifestyles. And the changes supported by attendance in the training will: • Enhance their parenting skills • Help them to provide Healthy family routines and a balanced diet. • Lead to increased physical activity and better sleep routines • Improve Emotional well-being for the whole of the family (adults and children). If we were successful in our funding bid we would be able to train more HENRY practitioners covering all 3 HENRY programmes (Anti-natal, 0 – 5 years and 5-12 years). This would allow us to provide more HENRY courses, both face to face and virtual, enabling access to a HENRY programme to families living throughout Northumberland, referred onto this programme, no matter where in the county they life.

	In order to deliver any HENRY programmes, participants need to complete the HENRY Core training, plus face to face facilitators training. This allows them to deliver the 0-5 programme (Healthy families right from the start). Once they have achieved this, they can go on to train to deliver the HENRY 5+ (Healthy families growing up) and/or HENRY anti-natal (Healthy families in the making) If staff did the facilitators training virtually during covid they need to do a face-to-face conversion training to deliver face to face. **Identified need:** We currently have the following requests from our Early Help providers and partners across Northumberland requesting HENRY training for their workers and a commitment for them to deliver the programmes once trained: • 9 for Core training • 10 for facilitators • 10 for HENRY 5+ • 12 for anti-natal HENRY • 4 for conversion to face to face
2. **Outputs / outcomes expected to be achieved and by when**	**Outputs**: 5 training courses to be delivered within Northumberland by HENRY for each of the following programmes within the 2022 –2023 financial year: • Core training, 2 days for up to 16 participants • Facilitator training, 2 days for up to 12 participants • HENRY 5+ half day training for up to 12 participants • HENRY anti-natal, half day training for up to 12 participants • Conversion to face to face from virtual for up to 12 participants **Outcomes:**

	• Increase in the number of HENRY facilitators able to deliver within Northumberland. An increase in 12+ new facilitators. • Increase in the number of courses offered across Northumberland to families from conception to age 12 years. • Families attending will gain an improved awareness/understanding of behaviour change strategies, parenting skills and improved knowledge about food and activity for the whole family • Leeds LA who have adopted the HENRY programmes have found that this has supported improvement in children's healthy weight measure results.
3. **System benefits and interdependencies e.g.** • **Health in all policies** • **Joint Health & Wellbeing Strategy** • **Part of PCN inequalities plan** • **Links to Covid inequalities HIA**	This funding request meets the criteria of: Community-based support for those disproportionately impacted such as the BAME population e.g. early intervention, prevention, and MH support for CYP; domestic abuse interventions. We are also aware that Public Health would like to use the HENRY Programmes as part of their Healthy Weight initiatives, especially following the outcomes from the Healthy Child weight measurement programme within schools
4. **Do you anticipate that a procurement will be required?**	Yes. All training will be purchased from HENRY. HENRY have informed us that if we book training now, they can provide training from October 2022 within Northumberland.
5. **Funding** A. **Total amount requested and over how long**	**£20,000 over 1 year** **Breakdown of duration and costs for delivery of HENRY facilitator training within Northumberland by HENRY:** • Core training, 2 days for up to 16 participants £5000 • Facilitator training, 2 days for up to 12 participants £5000 • HENRY 5+ half day training for up to 12 participants £1500

B. **Forecast spend over duration of programme e.g.:** • **All up front (e.g. a purchase)** • **Monthly (staffing costs)** • **Procurement timeline to be worked up** • **Delay and then spend back end of programme** C. **Match funding opportunities?**	• HENRY anti-natal, half day training for up to 12 participants £1500 • Conversion to face to face from virtual for up to 12 participants £2000 **Total training costs: £15,000** Community venues, and subsistence costs for training: **total costs £700** Refreshments for courses: • £3 per person per day: £96 • Facilitator training (2 days) £72 • HENRY 5+ (half day) £18 • HENRY anti natal (half day) £18 • Conversion (1 day) £36 **Total refreshment costs £240** Contribution towards coordination and admin support **total cost £1,000** stationary/printing etc: **Total resource costs for courses £50** Resources (course packs) for families attending programmes delivered by NCC trained HENRY facilitators: **£3,000**
6. **Exit strategy / sustainability plan**	The increased capacity of trained facilitators will allow us to sustain HENRY provision. It will provide us with the facilitator resources to be able to offer both face to face and virtual programmes which are accessible to families throughout Northumberland.

	The NCC Childrens Centre HENRY lead will link with locality HENRY leads throughout Northumberland to develop and promote the training package for local families, both face to face and virtually. HENRY C.C. lead will proactively seek additional funding from both funding opportunities and partners to be able to refresh facilitators training as and when required. The NCC HENRY Children's Centre leads time will be funded through the Childrens Centre/Early Help budget.
7. **Risks to be managed e.g.** • **Workforce available to recruit** • **Procurement delivers to time** • **Financial risks** • **Safeguarding** • **Risks to credibility, relationships or reputation**	We already have a list of practitioners who require training and a commitment from HENRY to deliver in Northumberland, post October 2022.

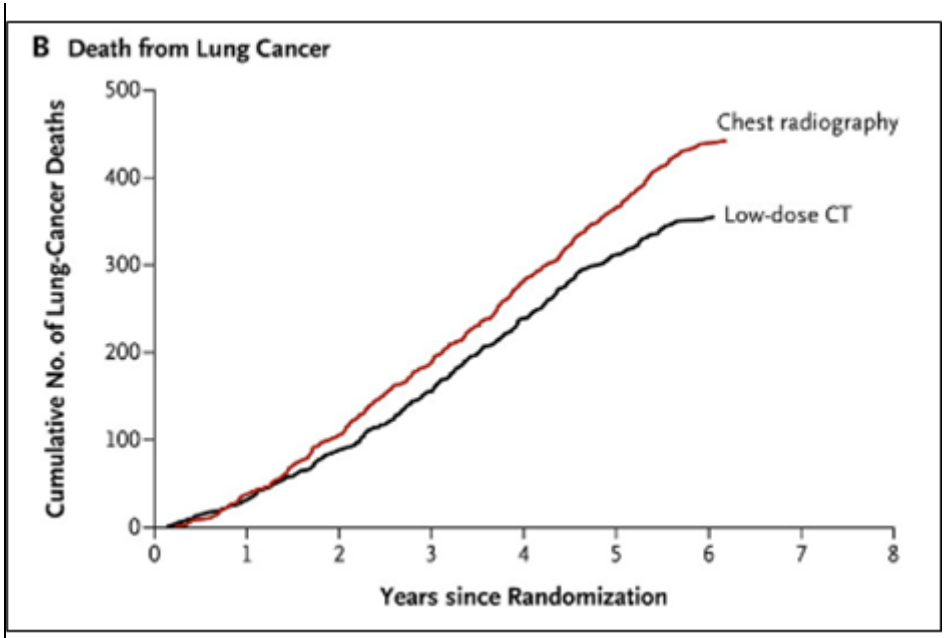
4.

Lung Cancer Health Checks

Public Health Reserves Funding Bid Request

Name of scheme:	Lung cancer case finding / targeted screening
1. **Brief summary of programme/intervention covering:** A. **Local need** B. **How will it reduce inequalities?** C. **Evidence of effectiveness** D. **Scale of prevention (primary, secondary, tertiary)** E. **How will it build on community strengths?** F. **Value for money**	**Brief summary of programme** Lung cancer is the most common cause of cancer death in the UK, accounting for 21% of all cancer deaths in 2018. Around 3 in 20 (16.2%) of people diagnosed with lung cancer in England survive their disease for five years or more (2013-2017). More than 75% of people with lung cancer present with advanced disease; yet lung cancer is potentially curable if found at an early stage. Although there is no national programme in the UK, there have been a number of pilots locally and nationally. The USA and Canada have approved screening programmes for lung cancer. [CRUK] This proposal builds on work undertaken across the region, including North Tyneside, to improve early identification of people with lung cancer. People registered with COPD in SE Northumberland (practices TBC), aged 55-74 years with a >10 pack year smoking history and no CT in the previous 6 months will be offered referral to NHCT during their annual COPD review for a low dose CT scan provided they do not meet 2WW criteria. If lung cancer is suspected, patients will enter the 2-week wait suspected cancer pathway. Incidental findings will be investigated by NHCT through direct referral to the relevant specialty, or referred back to primary care to manage. Patients not diagnosed with a new or changed condition will be referred for life-style advice: primarily this will be Stop Smoking but may include weight loss. A. **Local need** While incidence and mortality from cancer for the whole of Northumberland (all persons) are similar to the England average, there are 10 wards in south east and coastal

	Northumberland that have incidence of lung cancer more than 50% (significantly) higher than the England average. [Local Health, 2014-2018]. Mortality from lung cancer was significantly higher in Northumberland for women in 2017-19. [Fingertips] When diagnosed at its earliest stage, almost 9 in 10 (88%) people with lung cancer will survive their disease for one year or more, compared with around 1 in 5 (19%) people when the disease is diagnosed at the latest stage. And when diagnosed at its earliest stage, 57% of people with lung cancer will survive their disease for five years or more, compared to 3% of people when the disease is diagnosed at the latest stage. [CRUK] Although smoking rates have come down in recent years, because of the lag between smoking and lung cancer diagnosis, early diagnosis and intervention are key for reducing mortality from lung cancer in the short term. B. **Inequalities** Lung cancer incidence rates in England in females were 174% higher in the most deprived quintile compared with the least, and in males were 168% higher in the most deprived quintile compared with the least (2013-2017). [CRUK] Around 14,300 cases of lung cancer each year in England are linked with deprivation (around 6,600 in females and around 7,800 in males). The programme would be provided for patients with COPD registered at practices in areas of higher deprivation and high lung cancer incidence. C. **Evidence of effectiveness** The US National Lung Screening Trial (NLST; n=53,454 people at high risk; 59% male) showed around a 20% reduction in the number of lung cancer deaths in the group monitored annually for 3 years with low-dose CT scans compared to x-rays (see figure)[i]. There was a 3% detection rate. There were a number of limitations: there was no unscreened group; around 4 in 10 people had CT scans that warranted further investigation, but more than 9 in 10 of these cases (96%) turned out not to be cancer and there were a small number of very serious complications from invasive tests; and around 1 in 5 lung cancers detected by low dose CT were overdiagnosed.



Two subsequent trials are the UK Lung Screening Trial (UKLST) and the NELSON trial (based in Belgium and Holland). The UKLST showed that around 85% of the lung cancers picked up through screening were early stage.[ii] But as a pilot – with 2027 people receiving a CT scan and 2028 people receiving no screening – the study wasn't large enough to tell if lung screening reduces the number of people dying from lung cancer.

The NELSON trial, which included more than 15,000 people, showed that offering men at high risk of lung cancer low-dose CT scans reduced lung cancer deaths by 26% after 10 years for men (p=0.0003), and 39% for women (p=0.0054)[iii]. The results of the NELSON trial also suggested there was a favourable balance of benefits and harms. After 10 years, there was around a 20% excess of new lung cancer cases (i.e. cancers that may have been overdiagnosed) in the screening group, but this decreased to around 9% by 11 years.

	In the North Tyneside pilot, 320 patients were screened between January 2021 and February 2022. Lung cancer was detected in 12 people (4%) including 10 people with potentially curative early stage disease. Nodules were identified in 14% of those screened, and other findings were identified in 16%. An additional benefit is that the lung cancer health check appears to encourage people to access stop smoking services.[iv] G. **Scale of prevention (primary, secondary, tertiary)** This is secondary prevention i.e. early identification of disease so as to improve outcomes. H. **How will it build on community strengths?** Nil specific. I. **Value for money** As funding for subsequent investigations will be made by the NHS, and Public Health funding will only be for initial investigation and subsequent lifestyle advice (e.g. stop smoking), this represents a good return on investment from a PH budget perspective in terms of lives saved and improved quality of life. Cost utility adopting an NHS perspective is uncertain. A HTA published in 2018 prior to the results of the NELSON trial found that a single round of screening could be considered cost-effective at conventional thresholds, but there is significant uncertainty about the effect on costs and the magnitude of benefits.[v] A recent (unpublished) update incorporating the results of the NELSON trial has found that all variations of targeted screening are cost-effective: less than £5000 per QALY gained (compared to no screening or the next less costly option) but did not consider lifetime costs for positive cases or follow up of incidental findings.
2. **Outputs / outcomes expected to be achieved and by when**	The following outcomes can be expected for the areas taking part in the programme: • Increased proportion of people diagnosed with lung cancer in stages 1 or 2 – likely within first year • Improved survival from lung cancer – would only be measured after 2 years (for one-year survival) • Reduction in age-standardised mortality rate from lung cancer – likely within first year

3. **System benefits and interdependencies e.g.** • **Health in all policies** • **Joint Health & Wellbeing Strategy** • **Part of PCN inequalities plan** • **Links to Covid inequalities HIA**	This programme links to the **Joint Health & Wellbeing Strategy** cross-cutting theme 'Adopting a whole system approach to health and care'. Not only does it help to refocus the system on prevention, it is an example of integration and pooling of budgets for a common purpose. It will also contribute to smoking cessation by having a clear pathway into specialist stop smoking services, and help to reduce inequalities by focusing on areas with highest deprivation and lung cancer incidence. During COVID, many cancers were detected later. This programme links to the **COVID inequalities HIA** by helping to address late detection of lung cancer.
4. **Do you anticipate that a procurement will be required?**	No
5. **Funding** A. **Total amount requested and over how long** B. **Forecast spend over duration of programme e.g.:** • **All up front (e.g. a purchase)** • **Monthly (staffing costs)** • **Procurement timeline to be worked up** • **Delay and then spend back end of programme** C. **Match funding opportunities?**	A. The total amount requested is £30K. This would contribute to the costs of the first year of the programme. B. The spend would be over 1 year. C. There is funding already secured from the Trusts Bright Charity of £100K. This will support the Project Manager post and analyst support in the first year. The CCG and NHCT are also considering what funding they can contribute, with funding from the Northern Cancer Alliance expected for long-term funding.

6.	**Exit strategy / sustainability plan**	The Northern Cancer Alliance has indicated that funding will be available in the future for areas with higher lung cancer incidence. From 2023/24, NCA will be looking to start delivering on their Targeted Lung Health Checks (TLHC) expansion plans. They have to invite 40% of the Cancer Alliance's eligible population to a TLHC by the end of 2023/24, 60% by end of 2024/2,5 and so on until we reach full coverage by the end of 2026/27. Newcastle Gateshead and the Tees Valley project only cover 28%, so they will be looking to invite an additional 52,000 patients from North Cumbria, North Tyneside, Northumberland, County Durham and South Tyneside and Sunderland in 2023/24 and in each subsequent year. Rollout will be based on lung cancer mortality, targeting the areas most affected first, but they are also mindful of not overwhelming local services so would be looking for as equal a split as possible across the CCG areas. It will be crucial that any plans developed locally dovetail with the NCA's plans for roll-out. The National Screening Committee is currently reviewing evidence on lung cancer screening, and it is likely that targeted screening will become available in the near future.
7.	**Risks to be managed e.g.** • **Workforce available to recruit** • **Procurement delivers to time** • **Financial risks** • **Safeguarding** • **Risks to credibility, relationships or reputation**	The main risk is capacity of radiology services to be able to provide CT scans. Discussions at the NHCT Health Inequalities Programme Board and Lung Cancer Screening Group suggest that this will be resolved and will not impact on existing services or waiting times. Whilst Primary Care appear to be in favour, there may yet be some resistance. It is also likely that this programme will increase referrals into the IWS specialist stop smoking service. As part of the work-up of the project plan, we will negotiate whether some funding should be earmarked for the stop smoking service. There are clear pathways and communications already developed to manage 'false positives' and incidental findings, as well as false reassurance about risk owing to a negative screening result.

5.

Making Every Contact Count (MECC) training grants to voluntary and community sector (VCS) groups

Public Health Reserves Funding Bid Request

Name of scheme:	**Making Every Contact Count: supporting a VCS MECC Movement**
1. **Brief summary of programme/intervention covering:** A. **Local need** B. **How will it reduce inequalities?** C. **Evidence of effectiveness** D. **Scale of prevention (primary, secondary, tertiary)** E. **How will it build on community strengths?** F. **Value for money**	**Provide resources to build capacity for the MECC approach within VCS organisations that support Northumberland residents.** **Building a MECC trained workforce with skills, confidence and resources to enable increased opportunities for healthy conversations across our communities.** A. **Local need** The local need for building and strengthening our local MECC movement is evident from the broad range of conversations that are recognised within the MECC approach: Affordable Warmth, Alcohol, Carers, COVID-19, Crime and Community Safety, Dementia, Domestic Abuse, Employment, Falls & Frailty, Finances, Fire Safety, Green & Blue Spaces, Healthy Diet & Weight, Housing, Library & Digital Services, Long Term Conditions, Mental Health, Oral Health, Physical Activity, Problem Gambling, Screening, Sexual Health & LGBTQ Plus, Smoking, Social Isolation & Loneliness, Substance Misuse, Suicide Awareness, Transport, Vaccines We reflect on local need in MECC training programmes, generating conversations by using PHE Fingertips health indicators and reflecting on priorities in our JSNA. MECC is also a useful tool to address the unique health and wellbeing needs in Northumberland, specifically the combination of urban, rural and coastal inequalities and the pockets of significant deprivation and poor health outcomes, that can often be

masked. Encouraging our wider Public Health Workforce to develop their role in Making Every Contact Count would have a widespread reach to our residents and communities.

I envisage that further local need will be defined by local partners, VCS and our local communities or residents during the series of Thriving Together locality conversations on local inequalities.

B. **How will it reduce inequalities?**

The Marmot Review highlighted a social gradient in health, where the less affluent a person's position, the worse his or her health and provided evidence for reducing health inequalities. It described the importance of measures to address the wider determinants of health as well as interventions to prevent ill health by improving health behaviours.

MECC and MECC plus approaches can help to tackle health inequalities by supporting individual behaviour change across a range of behaviours and addressing wider determinants of health at the individual level.

For example, some local services are using the MECC plus approach to engage local populations in managing debt, action towards gaining employment or in tackling housing issues. The population level approach of MECC can also help address equity of access, by engaging those who will not have otherwise engaged in a 'healthy conversation' or considered accessing specialised local support services, such as for weight management.

C. **Evidence of effectiveness**

PHE Guidance on Making Every Contact Count: evaluation guide for MECC programmes states there is limited published formal research on MECC itself, with most of the evidence being from within policy papers or local evaluations of training.

They suggest that external evaluation is not required but programmes should consider the following:

a) MECC contributes to a cultural change of embedding prevention into organisational policy and strategy

b) the adoption of MECC enables wider workforces to see prevention as part of their role

c) MECC training increases the capability of workforces to undertake healthy conversations as part of their everyday practice

d) MECC motivates and prompts staff to adopt positive health behaviour changes

e) MECC brief interventions promote population health behaviour change

Develop an evaluation plan to measure progress and achievements, using either quantitative and or qualitative data.

See PHE Outcome Framework for MECC – pages 9-10

D. **Scale of prevention (primary, secondary, tertiary)**

The broad scope of the MECC approach gives the potential to reach across the full scale of prevention by using the 3A's of Ask, Assist and Act – traditionally; raising awareness of the issue, benefits of change, choices or opportunities available and signposting people to support, information or services:

Primary in terms of preventing development of illness or disease and focus on interventions to maintain a healthy life (for example, unhealthy or unsafe behaviours) and increasing resistance to disease or illness in relation to exposure (for example, immunisations).

Secondary prevention in terms of reducing the impact of disease or illness by halting or slowing progress; encouraging and empowering people to develop personal strategies to enable people to return to their original health and prevent long-term problems (for example screening to detect disease in its earliest stages or accessing programmes that can support an improvement or 'return to optimum health' in physical and/or mental wellbeing).

Tertiary prevention in terms of alleviating the impact of an ongoing illness or disease by helping people to manage their condition; increasing ability to function, increasing their quality of life and their life expectancy.

Furthermore, MECC provides a platform for conversations around the wider determinants impacting on health, which often supports preventative actions to avoid reaching a point of crisis, for example financial wellbeing.

	E. **How will it build on community strengths?** The MECC approach focuses on empowerment; building self-awareness, self-confidence and self-esteem; enabling people to more aware of their choices and opportunities and retain the autonomy to make their own decisions on their own health and wellbeing. To enable people to have more choice and control, our system wide MECC approach needs to harness the existing expertise, capacity and potential of our community assets, which includes local people and communities. Building our local community capacity – by working with communities to embed MECC - is an approach to supporting people to stay well and build community resilience by enabling people to make informed choices. F. **Value for money** The MECC approach is an established national initiative which is both simple and cost effective. There is limited published formal research on MECC itself, but there is good evidence for the cost effectiveness of brief interventions for alcohol and smoking.
2. Outputs / outcomes expected to be achieved and by when	Outcomes: • To provide resource to enable VCS organisations to access MECC training and other relevant Health Improvement training to develop the skills of their employees and volunteers • To use this training as a foundation from which to develop and deliver a consistent MECC approach within the organisations • To incorporate MECC interactions into day to day business to provide a sustainable approach applied at scale for the benefit of the populations The proposal involves a number of options or opportunities which would require further discussion with key partners, including VCS partners.

	Building on the learning of a similar programme delivered in Gateshead, this would provide resources to build capacity for the MECC approach within VCS organisations that support Northumberland residents. Initially a workshop for interested VCS organisations would be offered to gain further understanding of Making Every Contact Count and co-design the VCS MECC approach; an opportunity to apply for a grant for capacity building and implementation of MECC would follow. The aim would be to build a MECC trained workforce with skills, confidence and resources to enable or increase opportunities for healthy conversations across our communities. It would lead to an increase of a MECC trained workforce and pool of VCS MECC trainers in Northumberland. VCS organisations working with Northumberland residents will be able to access funds to help support them in building capacity for the MECC approach. Identifying staff who can attend Train the Trainer MECC training and ability to cascade this to others in their setting and/or community. As part of the implementation, they would be invited to recruit or host a Community Health Champion/s as volunteer/s who, with further training and support, can help improve the health and wellbeing of their families, communities or workplaces. For any VCS organisations who recruit Community Health Champions, it will be integral to the IWS led programme and signed up to the Northumberland County Council volunteer programme. Following MECC training, the MECC trained workforce, including the VCS leads, will be encouraged to participate in further training modules offered by the Health Improvement Team, via Learning Together, to support healthy conversations linked to health behaviours. For example, key topic sessions on health and wellbeing in relation to alcohol, nutrition and physical activity, tobacco, and mental wellbeing. There would be a single application process across two stages:

	Stage 1: capacity building / access training e.g. cover the cost of attendance at training, for example backfill for staff time. Other reasonable costs associated with attendance at training e.g. travel, childcare, room hire, refreshments etc. Stage 2: funding to put MECC into practice e.g. MECC conversation cafés and/or other activities to enable co-ordinated delivery of health activities with communities - championing health some of which could be linked to Public Health Campaigns Network. The VCS MECC leads along with their Community Health Champions will motivate and empower people to get involved in health-promoting activities, create groups to meet local needs guided by other local partners such as the Health Trainer Service, Communities Together. The 'implementation' or 2 stage of the fund would enable these activities to take place. Associated costs that the grant could be used for would include, as examples: Costs of attending training and developing local programme and an investment of their local expertise e.g. time, transport, Further funding may also cover the development or provision of: • An information/resources assistant to enable regular communication with our MECC Community of Practice – to update the MECC trained workforce on key and current messaging opportunities – but to also manage the sharing of good practice • Series of solution focused workshops focusing on MECC Plus conversations • A toolkit and a suite of resources will be developed for our MECC Community of Practice • Alignment to the Inequalities Plan – workshops to enable the MECC VCS leads to contribute to the development of the Northumberland System Inequalities Plan. Providing insight into community needs, and collaboration, working in partnership and having shared decision-making power in the planning, design, implementation and evaluation of services.

3. System benefits and interdependencies e.g. • **Health in all policies** • **Joint Health & Wellbeing Strategy** • **Part of PCN inequalities plan** • **Links to Covid inequalities HIA**	Expected Benefits: • Increased level of understanding of MECC within VCS organisations in Northumberland which will be determined by a range of formal and periodic evaluations • Increased number of VCS organisations engaged in the MECC approach • Development of innovative/creative approaches to MECC which support sustainability and consistency of MECC principles • Effective delivery of MECC approach with Northumberland residents which organisations are working with • Increased confidence among existing staff in the VCS through enhanced competence to deliver consistent and concise healthy lifestyle messages • Improved staff ability to direct residents to local services that can support them Contributes to issues/priorities identified by the Northumberland Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy.
4. Do you anticipate that a procurement will be required?	No
5. Funding A. **Total amount requested and over how long** B. **Forecast spend over duration of programme e.g.:** • **All up front (e.g. a purchase)** • **Monthly (staffing costs)**	£50,000 over 2 years Single application process across two stages: Stage 1 funding: grant scheme for organisations to access to enable capacity building and access to MECC training delivery. Stage 2 funding: MECC implementation funds to enable VCS organisations to deliver MECC in their settings and/or within their communities

• **Procurement timeline to be worked up** • **Delay and then spend back end of programme** C. **Match funding opportunities?**	Potential to align this with Thriving Communities, further discussion with key partners need to take place e.g. MECC System-wide Steering Group, Thriving Communities, Public Health Team e.g. Health in all Polices, Wider Determinants leads. Further conversations are also planned with MECC lead at Gateshead Public Health and the regional MECC at Scale Co-ordinator.
6. Exit strategy / sustainability plan	The funding is time-limited, therefore requiring clarity of purpose and expectations for all parties. The purpose is to build capacity and provide a resource from which to develop and deliver a consistent MECC approach within the organisation, it will provide a sustainable approach applied at scale for the benefit of the population. Moving towards a sustainability plan, over the two years we will have connected multi-sector partners to form a MECC Community of Practice, which would be continued to be co-ordinated by the MECC Public Health lead along with support from the MECC System-wide Steering Group.
7. Risks to be managed e.g. • **Workforce available to recruit** • **Procurement delivers to time** • **Financial risks** • **Safeguarding** • **Risks to credibility, relationships or reputation**	Workforce available to recruit: - Buy-in, commitment and capacity of VCS organisations to deliver Risks to credibility, relationships or reputation: - Relationships with VCS organisations; risk assess any negative impacts of the proposed delivery - Management of expectations of/for VCS organisations Financial risks: - Risk of failure of delivery of grant recipients - Risk of misuse of public funds e.g. fraud Safeguarding:

	- Ensure understanding of the boundaries and expectations of MECC and assessing level of risk of an individual (and their role in safeguarding)

Making Every Contact Count: evaluation guide for MECC programmes - GOV.UK (www.gov.uk)

Table 1: Outcomes Framework for MECC

Organisational Culture	Extent that prevention is embedded within the organisation	• leadership: buy-in demonstrated for example by managers taking part in MECC training; MECC presentations to managers/Board • MECC on the agenda of team meetings • awareness of MECC amongst staff: MECC publicity in bulletins; MECC workshops • a local MECC brand • MECC written into organisational policies • MECC written into annual reports • having a designated MECC champion • MECC being part of induction and/or mandatory training • MECC principles in job descriptions and personal development plans/workforce appraisal systems • health and social care professionals can deliver a healthy conversation (brief or very brief intervention) • MECC incorporated into relevant service pathways • all public service sites are able to support opportunities for a healthy conversation, for example a suitable room or space for one-to- one conversation, or access to internet for information on sources of local support/referral
Prevention as part of all roles	A shift in recognition for staff (outside of health improvement) of their contribution to preventing ill-health	• the number of healthy conversations (incl. topic discussed) and where these took place , for example outpatients clinic, community service, housing office • the number of referrals and signposting undertaken and the setting where these took place • the use of evidence and information from robust sources, for example All Our Health or MECC

Staff knowledge and skills	The capability of staff to engage people in and conduct 'healthy conversations', also known as VBIs	• the number of training sessions delivered, and which staff groups took part in these • reported levels of workforce satisfaction and confidence following training • number of staff completing training who are then delivering VBIs • refresher courses are made available and follow up conducted on how training is put into practice • use of a consistent training model developed using MECC training quality markers • all relevant health and social care professionals have achieved level 1 of MECC competence (possibly through e-learning) and a proportion achieve level 2 competence
Improvement in staff health and wellbeing	Impact on workforce wellbeing from the MECC approach to address behavioural risk factors ‡	• development of staff wellbeing and health initiatives • staff uptake of services to support behaviour change • staff sickness absence rates • reported staff behavioural risk factor changes, such as stopping smoking, or starting an exercise activity or joining a wellbeing group
Population health improvement	Reduction in behavioural risk factors	• reported behaviour change by individuals or reported contemplation of making change/or planning for change • reported satisfaction from individuals who have been engaged in a MECC intervention • uptake of services enabling behaviour change, for example smoking cessation, weight management • longer term reduction in behavioural risk factors, for example reduced levels of smoking, obesity, or alcohol consumption at increasing or higher risk levels, amongst the population the programme serves

6.

NHS Health Checks programme redesign

Public Health Reserves Funding Bid Request

Name of scheme:	Redesign and delivery of NHS Health Checks
1. **Brief summary of programme/intervention covering:** A. **Local need** B. **How will it reduce inequalities?** C. **Evidence of effectiveness** D. **Scale of prevention (primary, secondary, tertiary)** E. **How will it build on community strengths?** F. **Value for money**	NHS Health Checks (NHSHCs) are currently delivered exclusively in general practice based on a tariff per completed health check. It is proposed that one-off funding is secured to support a major redesign of the NHS Health Check programme to enable direct delivery by health trainers (and potentially other staff) in community settings outside of General Practice in order to target those most at risk of premature mortality and reduce socioeconomic inequalities in uptake. The details are currently being worked up, and an option appraisal will be presented to SMT. It is likely that delivery will be either exclusively or partly delivered outside of General Practices. Funding will be needed for the following: • Procurement of point of care testing devices • Staff training • Procurement of third party to manage the identification and invitation of eligible population • Procurement of electronic health record to record data with interoperability with local GP practice systems • COVID-19 cohort catch up: to pay for additional costs owing to the need for the programme to catch up for those eligible who missed a health check during the pandemic. • Digital offer. A large proportion of the eligible population have missed out on an NHS Health Check due to COVID-19. Evidence states that people with cardiovascular disease, diabetes and obesity are more likely to experience severe outcomes from COVID-19 (2; 3). This highlights the importance of systematically identifying people at risk of such conditions through the NHSHC programme thereby avoiding further exacerbation of health inequalities. The low number of NHS Health Checks completed in 2021/22 means

	that significantly fewer people have been identified as high risk of developing cardiovascular disease therefore it is more important than ever that these people are identified through the NHSHC programme. **Local need** In 2017, a Health Equity Audit of the NHSHC programme across Northumberland found that there was less uptake than expected in people living in more deprived areas. In this way, NHSHCs were potentially contributing towards health inequalities. To address this, a revised service specification has been implemented since April 2018 where payment is weighted by deprivation. However, a Health Equity re-Audit found that although the number of health checks received by those living in more deprived areas had increased, people living in these areas were still less likely to have an NHS Health Check than people living in less deprived areas. Over the last two years, the COVID-19 pandemic has crystallised the challenge of ensuring that equity is at the heart of the NHSHC local delivery model. The LGA advises that as a result of the pandemic, there is greater awareness of health inequalities and the ways in which they impact on individuals' lives. Therefore, it is vital to drive forward work programmes that reduce inequalities, prevent poor health and improve people's opportunities for better health (1). Furthermore, suspension of the programme for other priorities and a vast reduction in uptake during the COVID-19 pandemic has demonstrated that capacity to deliver the programme in general practice is limited. An increase in the programme's capacity will also be required in the first 3 years in order to meet the increased demand anticipated due to the 20/21 and 21/22 cohorts requiring catch up after COVID-19. **How will it reduce inequalities?** It is anticipated that delivery in community settings and involving an outreach approach will increase the uptake of NHS Health Check by people living in more deprived areas of Northumberland, who are more likely to develop heart disease, stroke, dementia, type 2 diabetes and dementia at younger ages, and are more likely to die younger. **Evidence of effectiveness**

A literature review was undertaken by Kathryn Bush (PH Registrar) to understand the how other NHSHC delivery models can improve equity.

In a mixed method pilot review performed in County Durham (4), 'lay health trainers' offered a mini-health MOT opportunistically in community settings. This included height, weight, BP and screening questions. Those eligible were then offered a full health check.

774 people underwent the mini-health MOT, and of those 239 were eligible for the full health check. 101 people (42%) returned for the full health check advised. Those living in the most deprived areas were more likely to engage than those in the least deprived areas. 449 individuals (60.5%) came from the first and second deprivation quintiles combined, compared with 183 individuals (24.7%) from the fourth and fifth quintiles. However, those in the most deprived areas were less likely to return for the full check than those in the least deprived areas (32.7% vs 44.4%).

Multiple qualitative studies (4; 5; 6; 7; 8; 9; 10) have addressed the acceptability of community based NHSHC in areas of high deprivation (4; 5; 6; 7; 9) or areas with underserved groups', such as low levels of English speaking or specific ethnic minority groups (6; 8). These have shown that community outreach (including telephone outreach (6)) is acceptable and generally welcomed positively (4; 6; 8; 9), although the logistics of service delivery and the associated costs were often more complex than initially estimated (5; 7; 8; 10).

The physical location of the NHSHC had a clear impact upon who was most likely to attend (4; 6; 8; 9; 10), as did the language skills and cultural knowledge of the person performing the outreach (6; 8).

Scale of prevention

Cardiovascular disease (CVD) is a major contributor to health inequalities accounting for the differences in premature mortality between areas in Northumberland and the national average.

	The NHSHC programme contributes to the primary prevention of CVD and type 2 diabetes through the early detection and treatment/ advice of key risk factors such as smoking, hypertension, hypercholesterolaemia, increased levels of blood glucose, reduced physical exercise etc. **How will it build on community strengths?** The involvement of community-based providers to support the delivery of the NHSHC builds on the assets that are available in the communities, such as the IWS team, their community insights and those of partners, community settings such as social clubs and groups, and the communities themselves. The strength of involving the IWS health trainers (or a similar approach) is to build on the local knowledge and partnerships that the health trainers have built with communities to ensure individuals have access to networks and activities which will support their health and wellbeing. **Value for money** It is anticipated that total costs per health check will in the longer term be similar to current costs after adjusting for inflation. Point of care testing will increase costs because, currently GP practices take venous blood samples to check cholesterol and HbA1c levels which are not paid for by the local authority. There is also an additional cost for inviting the eligible population. However, this increase in costs will be offset by lower staff costs because staff are already employed within the IWS with only a small increase in number of staff needed. Furthermore, the value per health check will increase if NHS Health Checks are taken up by people at highest risk.
2. Outputs / outcomes expected to be achieved and by when	• Increased equity: increased number and proportion of health checks taken up by people living in most deprived areas. • Increased quality of the programme delivered. • Increased referrals into local smoking cessation services, and weight management services. • Decreased premature mortality from cardiovascular disease.

<table>
<tr><td>3. System benefits and interdependencies e.g.
Health in all policies
Joint Health & Wellbeing Strategy
Part of PCN inequalities plan
Links to Covid inequalities HIA</td><td>This work aligns with the Northumberland Joint Health and Wellbeing Strategy by:
Empowering people and communities through asset based community development
Taking a whole system approach through primary prevention and health promotion
Ensuring access to services that contribute to health and wellbeing are fair and equitable
Furthermore, this work aligns with the forthcoming Health Inequalities action plan which will seek to ensure all projects are delivered through an ‘inequalities lens’ to ensure that services (at the least) do not drive/ widen inequalities and (where possible) support a reduction in health inequalities.</td></tr>
<tr><td>4. Do you anticipate that a procurement will be required?</td><td>Yes / ~~No~~ [please delete as necessary]</td></tr>
<tr><td>5. Funding
A. amount requested and over how long
B. Forecast spend over duration of programme e.g.:
All up front (e.g. a purchase)
Monthly (staffing costs)
Procurement timeline to be worked up</td><td>Capital costs are required for the redesign and implementation of a new NHS Health Checks Delivery model with anticipated increased demand as the 20/21 cohort are caught up.
<table>
<tr><td></td><td rowspan="2">Estimated baseline costs</td><td>Set up</td><td>Implementation</td><td rowspan="2">Total</td></tr>
<tr><td></td><td>2022/2023</td><td>2023/2024</td></tr>
<tr><td>Staff training</td><td>The procurement of a training provider will be required to ensure staff feel confident and competent to deliver a good quality NHSHC and provide high quality advice & guidance</td><td></td><td>£20,000</td><td>£20,000</td></tr>
<tr><td>Procurement of point of care testing devices</td><td>In 2017, a study reported the cost of a</td><td>£70,000</td><td></td><td>£70,000</td></tr>
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• **Delay and then spend back end of programme** C. **Match funding opportunities?**		POCT device was £950 - £1500 (11) With inflation, it is estimated that this cost is likely to be approx. £1100 - £1700/device	(£1700 x 40 devices) • 1 device/ GP practice signed up • Further devices for IWS/ community provider		
	Procurement of third party to manage the identification and invitation of eligible population	Work is ongoing to understand how this has been achieved in other areas. Newcastle use NHS Digital to identify eligible and send offers.		£20,000	**£20,000**
	Procurement of electronic health record to record data with interoperability with local GP practice systems	Continued use of SystmOne or procurement of first year license of new system compatible with local GP practice systems	£20,000		**£20,000**
	COVID-19 cohort catch up It is anticipated that there will be an increase in demand	Increased demand will put additional strain on revenue costs earmarked for the NHSHC programme		**£150,000** £50,000/ year for the next 3 years of the NHSHC delivery	**£150,000**

	over the next 3 years due to eligible cohort not receiving NHSHS during COVID.	(such as increased POCT consumables)			
	Digital offer	This requires further working up. There is an intention for a digital offer to be available from 2025 pending the evaluation of current pilots.			**£20,000**
				Net total:	**£300,000**

6. Exit strategy / sustainability plan	There is a designated sum of money in the public health budget for the running of the NHSHC programme. Staffing costs, payments to incentivise GP practices/ providers (if needed), POCT consumables, software and recurrent costs associated with identification and invitation of eligible population will be covered within this budget (except for £50,000 per year for 3 years for catch up).
	
	The costs estimated above are either associated with the set-up and implementation of a new model of delivery or for the catch up required after the COVID-19 pandemic. Both of these are required for a specified period of time/ short term.
	
	The following outlines the plan for future spending/ exit strategy associated with each cost identified:
	• One-off costs:
	  ○ Staff training
	  ○ Procurement of POCT devices (over estimated to include possible need for replacements due to breakage etc.)
	  ○ COVID-19 cohort catch up
	• Funded from the designated NHSHC fund once the new delivery model has been implemented:
	  ○ Procurement of third party to manage the identification and invitation of eligible population
	  ○ Procurement of electronic health record to record data with interoperability with local GP practice systems
	  ○ Digital offer

7. Risks to be managed e.g. • **Workforce available to recruit** • **Procurement delivers to time** • **Financial risks** • **Safeguarding**	As part of the wider project plan for this work, a risk register is kept up to date and managed by the NHSHC Working Group. Anticipated risks include: • Recruitment of staff may be challenging as an IWS Senior Health Trainer role is both a council and an NHS band 4. The pay associated with this band differs between the health sector and Local Authority. It is higher in the NHS. • There is potential to harm relationships between the Local Authority and GP practices and a reputational risk is associated with this. This will be managed by effective stakeholder engagement.

• **Risks to credibility, relationships or reputation**	• A further reputational risk may also come if access to an NHS Health Check is not good, or the equity/ quality of the NHSHC programme is not improved as anticipated. • A financial risk may be that the overall cost of the running of the redesigned model is more expensive than anticipated. This would require an additional long-term funding appraisal and reprioritisation. • It may not be possible to complete procurement before April 2023. This could mean a delay to the start date until possibly April 2024.

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7.

Poverty

Public Health Reserves Funding Bid Request

Name of scheme:	Poverty and hardship support (Emma Wright, Liz Robinson & Emma Richardson)
1. **Brief summary of programme/intervention covering:** A. **Local need** B. **How will it reduce inequalities?** C. **Evidence of effectiveness** D. **Scale of prevention (primary, secondary, tertiary)** E. **How will it build on community strengths?** F. **Value for money**	It is anticipated that many local households will face financial hardship over the coming winter months at an unprecedented scale. This is likely to have real, long-term health implications for many. This proposal seeks to allocate a significant sum of the public health underspend to strategies addressing this unprecedented poverty and hardship burden locally. Annual inflation rate is the UK highest since March of 1992, as rising cost of energy and food continues to squeeze the living standards. Biggest price increases have been reported in transport (11.5% vs 11.3% in January); furniture and household equipment (9.1% vs 8.4%); clothing and footwear (8.9% vs 6.3%); housing and utilities (7.2% vs 7.1%) namely electricity, gas and other fuels; and food (5.1% vs 4.3%). On a monthly basis, consumer prices jumped 0.8%, the biggest increase since 2011, and reversing from a 0.1% drop in January. The cost of transport fuel is key for a large, rural county like Northumberland. **Relative low income:** • An individual is in relative low income (or relative poverty) if they are living in a household with income below 60% of median household income in that year (1) • Based on the latest ONS and DWP data from 2021, households will be in relative low income if their income is less than **£19,134.60/ year (approx. £368/ week)** (2)**.** • 2021 figures do not account for the rise in inflation and rise in energy bills in April 2022 and October 2022. Households now need more money for basic living costs. Data from the ONS (3) and the Resolution Foundation (4) was used for the following estimations.

April 2020

The ONS reported that households in the lowest 3 income deciles across the UK (on average) spent the following on items such as food, clothing, household goods/services, transport and fuel and power (22).

- **£298.40 per week spend**
- **approx. £15,516.80/ year spend**

April 2022

With 2022 inflation rate of 7.6%:

- **£321.08 per week** (298.40 + 7.6%)
- **£16,696.07/ year spend**

With additional £693 energy cost increase in April 2022:

- **£17,389.07/ year spend**

With additional £900 energy cost increase in October 2022:

- **£18,289.07/ year spend**
- **£351.71/ week**

A. **Local Need**

There are 32,844 Lower Layer Super Output Areas (LSOAs) in England (rank 1 being the most deprived). Northumberland has 23 LSOAs in the most deprived 10%, which represents a population of 38,178 people. A further 17 LSOAs sit in the 10-20% most deprived grouping.

The number of people living in the 10% most deprived decile has increased since 2015, when the population living in the 10% most deprives LSOAs was 23,877.

Of the 14,682 children living in relative low income in Northumberland 2019-20, 6,874 were in lone-parent families and 7,811 lived with a couple. 10,415 of the children were living in 'working families', 4,269 in non-working families. Northumberland has a higher number of children living in poverty in working families, than in non-working families.

This is true overall and for each individual ward in the region. There are 44,600 people who are economically inactive in Northumberland (16-64yr olds who are neither in employment nor unemployed) of these 11,500 people in Northumberland who are economically inactive and defined by the DWP as being 'long-term sick'.

In certain local wards (Isabella, Croft, Newbiggin Central and East, Cowpen, Hirst), over 45% of households have a household income at or below £20,000 (5). They are at risk of experiencing poverty if this is not already the case.

The health effects of living in poverty can be detrimental to health due to factors such as stress, limited choices and wider determinants of health including housing, living environment, meaningful work, relationships etc.

HES data shows that local hospital admissions for conditions exacerbated by cold homes such as acute bronchitis, asthma, COPD, pneumonia, acute respiratory tract infections in 2021 was greater in areas of deprivation. There are some similarities between the wards with the highest admissions and with the highest percentage of households with an income of < £20,000, these include: Croft, Newbiggin Central and East, Cowpen. This data is reported in the following Tableau dashboard: Fuel Poverty: Views - Tableau Server (northumberland.local)

The Benefits and Debt Advice Needs of Northumberland Residents Health Needs Assessment highlighted that benefits and debt advice were two of the top four reasons that people contacted advice services. Furthermore, Northumberland Communities Together (NCT) has received more than 14000 calls since April 2020; with the most frequent support required: 1. Food, 2. Financial support, 3. Utilities support.

Gaps or limitations in current support

The main local VCS organisations providing support include Citizen's Advice Northumberland, Community Action Northumberland, Age UK and within the council, the Housing team, Climate Change team and Northumberland Communities Together. These teams and organisations are all brought together to enhance collaborative action through the Warm Homes Group.

The Warm Homes Group has identified that the current demand for support may outweigh the support that is available. Due to the scale of the issue and an additional energy price rise forecasted for October, in the coming winter the demand will be overwhelming.

The current gaps in support available is described in the table below:

Support available	Gaps
Central Government funding through ECO/ Help to Heat for households with gross income <£30,000 or in receipt of housing benefit, council tax reduction, or the housing element of universal credit	ECO 4 (commencing in July 2022) will no longer fund the replacement of any condensing gas boilers. Starting to see cases no longer eligible, currently 3 - 4 households/ month in need. Households with old back boilers could be eligible but will be difficult to access because the numbers have been limited to 5000 across the whole of the UK. Gas central heating measures are also limited to homes that are already on gas. Some households due to have a new gas connection have now been told that this is no longer going ahead. LPG and oil installations can be similar to the cost of an ASHP (£5,000 to £10,000) but don't attract any grant support.
Foundations Independent Living Trust GAs Safe Charity Fund. Improves gas safety in privately owned homes of older, disabled and vulnerable people to prevent death, injury and illness caused by dangerous gas and work appliances.	Grants of up to £500 per intervention, and only one intervention per household per year. The average cost of replacement boiler is in the region of £3000.
Warmer Homes Scheme which is NCCs new inhouse delivery scheme for the delivery of government funding for the retrofit of domestic dwellings. It is targeted at households below	The total number of properties in the current scheme which can be supported is approximately 400. This scheme does not start until July 2022.

	£30k on low energy rated properties.	
	Boiler Upgrade Scheme (managed by the Climate Change team)	£5,000 towards the cost of an air source heat pump, biomass boiler or ground source heat pump installation. This amounts to somewhere around 50% of the actual cost.
	Citizen's Advice and Community Action Northumberland	The Benefits and Debt Advice Needs of Northumberland Residents Health Needs Assessment identified the increased demand on Citizens Advice. The short termism of existing funding streams means experienced staff are lost.
	Household support fund(managed by Northumberland Communities Together) is primarily used to support households in the most need. The current funding is from 1st April to 30th September 2022, with no confirmation of continuation at this stage.	Average award is £181. Whilst there is no upper limit, the scheme is intended as an emergency assistance payment and not intended to sustain loss of earnings, finances etc. and should reach as many people as possible i.e., high frequency, lower value. That ratio will be/ has been changing with fewer awards and higher payments with each grant allocation
	Northumberland Emergency Transition Support provides grants or loans to people in a crisis.	Awards are limited to two per year of £1000 whichever comes first, the average transition award is £509.
	All of the above	There is a lack of capacity across the VCS and NCC teams/ organisations to appropriately support individuals to navigate the systems and support in place to help them. Support needs to be tailored and vulnerable groups require increased support to help identify bona fide

		contractors, practical structural help such as loft clearance, accessing proof of benefits.

B. **How will it reduce inequalities?**

Rising energy and food prices particularly affect low-income households, because low-income households spend a larger proportion than average on food, transport, household, fuel/power (1). According to the Resolution Foundation, the poorest quarter of households are set to see their real incomes drop by 6% in 2022/23 (4).

Looking beyond the data, the Health Foundation highlights that as well as lacking basic material resources, poverty is also about exclusion and missed opportunities; the child who is singled out for having free school meals or the person who misses a job interview because they don't have the 'right' clothes (6).

When people are prevented from accessing resources and experiences, it can compromise their ability to participate and feel valued and included in society (6).

The Benefits and Debt Advice Needs of Northumberland Residents Health Needs Assessment highlighted the well-established association between low income and poor health:

- People on low income are less able to purchase goods and services that improve health.
- Due to financial restraints people make choices which may risk or directly damage their health.
- People with physical disabilities, mental health problems, caring responsibilities and single parent families are particularly at risk of low income.
- Children who grow up in poverty are more likely to be exposed to adverse life experiences and have poorer health and educational outcomes.
- Debt is associated with poor mental health
- Accessing the welfare system can be challenging, with some groups finding it more difficult than others

Furthermore, local HES data shows direct health effects of poverty, with increased hospital admissions in areas of higher deprivation. Targeting individuals within these areas to reduce hospital admissions serves to narrow this gap.

Strategies that reduce the carbon used/ emitted locally, while addressing the current climate crisis have the potential to exacerbate inequalities by limiting choice. Lower-income and other disadvantaged groups contribute least to causing climate change but are likely to be most negatively affected by it, they pay, as a proportion of income, the most towards certain policy responses and benefit least from these policies. For instance, a household

which can afford a new boiler is able to purchase and install a boiler, however current support schemes no longer offer to replace boilers. This creates an unjust transition.

C. **Evidence of effectiveness**

- Since the specific intervention is not yet known, below are examples of work undertaken nationally to support households at risk of poverty (and their effectiveness):

Reducing household energy costs through the provision of basic energy efficiency measures could be the most successful and progressive approach to protecting and compensating households who are significantly worse off due to Government energy policy (JRF 2014) The Joseph Rowntree Foundation Report on Solving Poverty shows that acting early and ensuring low income and at-risk households can access the best deals including energy efficiency programmes can be effective.

DfE's Holiday and Food Programme pilot evaluation showed that mental health improved when household financial pressures are eased, and family tensions decreased.

- Locally, the following outcomes have been achieved from support provided by Northumberland Communities Together:

Household Support Grant (previously Covid Support Grant) of £4,880,044 has been distributed between 01/12/20 to 31/03/22 through three 3 separate grant determinations. We have made £167k worth of NETS payments since April 2020. We have a further £2,480,330 until 30/09/22. Being able to make these discretionary payments for funerals, repairs, food, fuel, clothing, beds and may more items, combined with softer supports from the team and local communities working together has been life changing for some of our residents.

D. **Scale of prevention**

Primary prevention

E. **How will it build on community strengths?**

This work seeks to involve individuals/ communities and support them to maximise their wellbeing and health. We seek to build on the partnerships formed between communities and NCC teams and VCSE organisations (for example, The Covid-19 Pandemic Response, Warm Hubs within parish and village halls where CAN run cooking classes with slow cookers and Citizen's Advice provide energy advice to communities. The Thriving Together

	Network and Thematic Partnerships also brings community intelligence to enable solutions to be co-designed to complement existing schemes. By supporting a household in crisis, they are more able to work, learn, manage, stay well, be social, more likely to participate, and connect to the opportunities available in their community and beyond. We have seen much work where communities pull together once they are out of crisis mode, and by initiating conversations and shared actions we can build upon these strengths. We are leading with this emerging model that helps us shape how and what we fund and build provision in place. F. **Value for money** Cost-utility is difficult to assess. However, short-term funding is likely to have lasting impact on individuals', families' and communities' long-term mental and physical health.
2. Outputs / outcomes expected to be achieved and by when	Specific outputs are yet to be determined; this is because any outputs must be in line with the Poverty Action Plan (currently under development) as part of NCC larger inequalities plan. The broad outputs from this strategy include: i. **Reduce the financial pressure of local households** NCT is already delivering a payment system to individuals, partners, and organisations. Extending this is support is being explored with a focus on fuel, food, and prevention; as per Household support Grant - central heating fixes, fuel payments, laundry, eat, sleeping and learning furniture etc. (full and detailed reports on geography, theme, and household makeup system already in place). Clear communication of available support driven into communities where needed most with support of Thriving Together consortia, local schools, and groups. ii. **Use intelligence and data to identify households at risk of financial hardship** The development/ procurement of a data tool is being explored to bring council and policy data together to identify 'in crisis' and 'at risk' households, streets, and wards and demonstrate the financial impact of income intervention – Sept 22. Furthermore, GP practice disease registers could be a useful data source to identify individuals with conditions at risk of worsening with poverty/ fuel poverty.

	iii **Increase individual and household resilience to poverty** iiii **Explore strategies to remove barriers experienced by local households** Longer term outputs: Mitigation against increased financial hardship experienced by the most vulnerable residents in Northumberland following the pandemic and the cost of living crisis – within 1 year. Mitigation against worsening health of people living in the most deprived areas of Northumberland, with potential for lower premature mortality and slope of inequality in mortality in Northumberland compared to comparator LAs without similar intervention in next 10 years.
3. System benefits and interdependencies e.g. • **Health in all policies** • **Joint Health & Wellbeing Strategy** • **Part of PCN inequalities plan** • **Links to Covid inequalities HIA**	This work aligns with the Northumberland Joint Health and Wellbeing Strategy in that it 'tackles some of the wider determinants of health' by reducing poverty associated with ill health. Furthermore, this work aligns with the forthcoming Inequalities action plan which will seek to ensure all projects are delivered through an 'inequalities lens' to ensure that services (at the least) do not drive/ widen inequalities and (where possible) support a reduction in health inequalities. In the immediate term this work will support NCC poverty action plan which will clarify, develop, and strengthen the services, supports, and activities that we have in place to keep residents warm, safe and well during the cost-of-living crisis. Much of this work is driven though Northumberland Communities Together.
4. Do you anticipate that a procurement will be required?	Yes
5. Funding A. **Total amount requested and over how long**	Up to £1m over 18 month period. The NCC Poverty Action Plan will include strategic developments needed to build resilience and alleviate poverty. This funding/pathway to service could be co-designed and added to the NCT service, which is already able to issue payments, support and arrange services. This would ensure residents are also able to connect to the wider offers in place.

B. **Forecast spend over duration of programme e.g.:** • **All up front (e.g. a purchase)** • **Monthly (staffing costs)** • **Procurement timeline to be worked up** • **Delay and then spend back end of programme** C. **Match funding opportunities?**	The funding will be allocated and spent in line with the conditions of the Public Health Grant. (i.e., if payments are made out of the fund towards expenditure on other functions of a local authority or the functions of an NHS body, other public body, or a private sector or civil society organisation, the authority must be of the opinion that those functions have a significant effect on public health) (7).
6. Exit strategy / sustainability plan	This is a crisis response onto which we can better understand how to best use our combined resources – across the system. It will help support residents through winter 2022. Inflation is predicted to go down next year (around 4%), and then again, the year after (1.4%). We also expect the Government to extend the Household Support Grant to replace the old Welfare Assistance (currently no longer a LA requirement, but we have NETS), and that Universal Credit will be reviewed. Free School Meals, food insecurity, and Healthy Start are also likely to be reviewed by the government with the potential for a mini budget this summer.

7. Risks to be managed e.g. • **Workforce available to recruit** • **Procurement delivers to time** • **Financial risks** • **Safeguarding** • **Risks to credibility, relationships or reputation**	Existing workforce and load, strong triage as connected to Swift/EH and welfare rights. The ability to retain skilled, experienced staff. Need for a strong and clear referral pathway (simple for partners but solid for us) will reduce financial risk. Early discussions suggest that funding boilers (if this is a strategy supported by the Poverty Action Plan) which are powered by non-renewable sources will be compatible with our ambitions to carbon net zero if they can demonstrate they are to reduce inequalities and mitigate against unjust national energy policies. Financial risks should be addressed because there is already a robust system in place to use community insights to minimise the risk of fraud. However, there may be spending rules that need to be considered.

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8.

Selective Licensing of Rental Properties

Public Health Reserves Funding Bid Request

Name of scheme:	Selective Landlord Licensing Scheme
1. **Brief summary of programme/intervention covering:** A. **Local need** B. **How will it reduce inequalities?** C. **Evidence of effectiveness** D. **Scale of prevention (primary, secondary, tertiary)** E. **How will it build on community strengths?** F. **Value for money**	What is it?. Selective licensing is a tool available to local authorities to address the impact of poor-quality housing, management and anti-social behaviour associated with tenants. It has primarily been developed with the need to tackle these problems in areas of low housing demand that suffer from significant and persistent anti-social behaviour. As well as improving housing standards, selective licensing can create sustainable neighbourhoods providing tenants with a greater choice of safe, good quality and well managed accommodation. Licences contain conditions with which the applicant must comply over the life of the designation. Local authorities inspect properties in the area and enforce compliance with the conditions of the licence. The licence requires payment of a fee, one part of which covers processing of the application and the remainder supports the associated enforcement scheme. Non-compliance with the condition of a landlord licence is an offence, liable to a financial penalty of up to £5000 per breach, or a formal prosecution in the Magistrate's Court. Most LAs in the NE have a selective licensing scheme. Local need. The proposal is to designate the area of Cowpen Quay as an area for selective licensing, other ongoing projects to improve this area. The selective licensing scheme approach will provide a visible neighbourhood presence in the area in which it will be focused and will form part of the broader programme and integrated strategy for Blyth, helping to tackle areas of social deprivation. A selective licensing designation may only be made if the area satisfies one or more of a number of conditions and Cowpen Quay meets the following: poor property conditions, significant and persistent anti-social behaviour, high levels of socio-economic deprivation, high levels of crime, high levels of private rented accommodation.

	The proposed area for a selective licensing area runs south of Hodgson Road and is bounded on the west by Cowpen Road and Regent Street to the east, with the southern boundary including the town centre down to Waterloo Road. Most properties are terraced houses and flats dating back to the early 1900's. There are over 1000 residential properties in the area of which 55 are long term empty properties, around 420 are privately rented (therefore subject to selective licensing) with 398 owned by social housing providers. Northumberland County Council are the largest social housing provider in the area which will give further weight to the overall improvements in the area and support for the scheme. Private rented properties account for around 40% of all residential properties in Cowpen Quay; high for such a small area. Nationally, the private rented sector currently makes up 19% of the total housing stock in England. How will it reduce inequalities? Housing is a basic determinant of health, recognising the range of ways in which a lack of housing, or poor quality housing, can negatively affect health and wellbeing. Home can be the source of a wide range of hazards and it is the environment in which many people spend a majority of their time. The UK Housing Health and Safety Rating System (HHSRS) provides a health-based assessment of housing-related hazards, and this assessment forms part of the Selective Licensing process. The worse hazards are often found in unlicensed poorly managed properties; unlicensed rented properties are an indicator of the likelihood of Category 1 hazards. The wider local environment around the home is also important in terms of fear of crime and the introduction of a Selective Licensing scheme can have notable benefits in reducing anti-social behaviour. Improvements in any of the selective licensing conditions will reduce inequalities. Evidence of effectiveness. Proactive enforcement is more effective than reactive enforcement. An independent review of selective landlord licensing schemes in 2019 by MHCLG (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/833217/Selective_Licensing_Review_2019.pdf.) concluded that *'The research overall indicates that selective licensing can be an effective policy tool with many schemes achieving demonstrable positive outcomes. However, this study also indicates that when implemented in isolation, the effectiveness of selective licensing is often limited. Schemes appear to be more successful as part of a wider, well planned, coherent initiative with an associated commitment of*

	resources – a finding entirely consistent with the aims of the Housing Act.' and that *'There are a wide range of concrete examples of schemes achieving demonstrable positive outcomes.'* Research by the CIEH *f*ound that 69-84% of properties in licensed areas needed works to be done to bring the properties up to a decent standard (https://www.cieh.org/media/2552/a-licence-to-rent.pdf). Evaluation by Ashfield Town Council in 2021 is available here *(https://www.ashfield.gov.uk/media/ut3lf2wr/evaluation-report-selective-licensing-november-2021-v5.pdf.* This concluded that 'A significant number of tenants in need have been assisted and are now living in safe, warm homes. Thanks for this must be given to local landlords, the majority of whom have worked with the Council in a very positive way.' They recommended that the scheme continue for a further 5 years due to the demonstrable benefits that had been achieved. Scale of Prevention. Primary prevention achieved by preventing exposures to hazards that cause disease or injury and the chronic (housing related) stress which leads to ill health. Secondary prevention to reduce the impact of a disease or injury that has already occurred by identifying people with e.g. substance misuse disorder not in contact with services and supporting them into NRP; people with mental ill health, other physical and mental well being issues and who have a welfare and benefits advice need that could be supported via MECC approaches within the housing team and through signposting; identification of safeguarding issues e.g. DV, modern day slavery. Tertiary prevention e.g. helping people manage long-term, complex health problems and injuries through linking into social prescribing/support planners/self-help groups. Building on community strengths. Reduction in tenant turnover should support the development of sustainable community networks facilitated by the existing Heart of Blyth work. Value for money. Selective licensing schemes have not been subject to any formal cost-effectiveness analysis but leaving vulnerable people living in the poorest 15% of England's housing is costing the NHS some £1.4 billion per annum in first-year treatment costs. That is estimated to be only 40% of the costs to society as a whole. (see https://www.housinghealthcosts.org/res/hhcc.pdf). In view of the nature of the intervention, evidence comes from different Local Authorities who have implemented selective licensing schemes of differing scales and models.
2. Outputs / outcomes expected to be achieved and by when	Outputs expected to be positively impacted (some in the first 2 years) include: • Reduction in ASB incidents in licensed properties

	• Reduce Housing Hazards through assessment using the Housing Health and Safety Rating System • Improve licensing compliance rates and property standards. • Improved tenant welfare through referrals/signposting into NRP, falls prevention, welfare and benefits, MH and other statutory services • Reduced complaints about poor housing Outcomes expected to be positively impacted include: • A reduction in the fear of crime • Improved health and wellbeing • Increased community resilience • Increased social cohesion and capital
3. System benefits and interdependencies e.g. • **Health in all policies** • **Joint Health & Wellbeing Strategy** • **Part of PCN inequalities plan** • **Links to Covid inequalities HIA**	HiAPs – this is a policy focused on improving housing quality and ASB with associated impacts on health. JHWS – contributes to the priority to tackle fuel poverty by increasing the number of households with access to affordable warmth. Inequalities plans – will form a component of the NCC inequalities plan. Poverty action plan (early stages of development) – a future poverty action plan needs to recognise that people on low incomes will have limited housing options which are sometimes difficult to sustain (https://www.jrf.org.uk/report/links-between-housing-and-poverty) A side benefit of a selective licensing scheme is that there will be opportunities to prevent eviction due to financial issues.
4. Do you anticipate that a procurement will be required?	No. There is a statutory process which needs to be undertaken including formal consultation. This will be done by the housing team.
5. Funding	

	Set up	**Implementation**	**Totals**

A. **Total amount requested and over how long**

B. **Forecast spend over duration of programme e.g.:**
- **All up front (e.g. a purchase)**
- **Monthly (staffing costs)**
- **Procurement timeline to be worked up**
- **Delay and then spend back end of programme**

C. **Match funding opportunities?**

	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	
Salary & Oncosts	103,746	106,189	108,691	111,254	113,879	116,498	660,258
IT - Bespoke	10,000						10,000
Marketing & Other Costs	5,000	5,100	5,202	5,306	5,412	5,520	31,540
Legal Support	30,981	31,717	32,471	33,244	34,036	34,819	197,268
Total anticipated Income based on 90% take-up		-37,800	-37,800	-37,800	-37,800	-37,800	189,000
Net Cost	**149,727**	**105,206**	**108,565**	**112,004**	**115,527**	**119,037**	**710,066**
Balance met from Public Health Grant	-149,727	105,206	108,565	112,004	115,527	119,037	710,066

There are an estimated 420 privately rented properties in the Cowpen Quay proposed area for selective licensing. If all these properties were to become licensed this would generate an income of £210,000 during the statutory life of the scheme which is 5 years. Modelling is however based upon a 90% uptake of eligible owners / properties.

	There is anticipated to be political will to support this scheme (mentioned as something we should be pursuing at Communities OSC in the context of the Empty Homes report and Full Council meeting 4 May).
6. Exit strategy / sustainability plan	Evaluation early year 4 with a view to extending (or not) through NCC budget setting process or as part of PH grant budget setting process.
7. Risks to be managed e.g. • **Workforce available to recruit** • **Procurement delivers to time** • **Financial risks** • **Safeguarding** • **Risks to credibility, relationships or reputation**	All risks will be managed through the housing team. The Regional Director of Public Health supports the use of the PH grant for selective licensing schemes.

9.

Vaccination midwife

Public Health Reserves Funding Bid Request

Name of scheme:	Vaccination Midwife/Nurse
1. **Brief summary of programme/intervention covering:** A. **Local need** B. **How will it reduce inequalities?** C. **Evidence of effectiveness** D. **Scale of prevention (primary, secondary, tertiary)** E. **How will it build on community strengths?** F. **Value for money**	A: COVID vaccination is currently provided by bank staff alongside the Public Health Midwife. This has meant that the public health midwife has less time to focus on equally important priorities for improving the health of pregnant women and their unborn children. A dedicated vaccination nurse/midwife would provide a robust, sustainable service to pregnant women in Wansbeck General Hospital antenatal clinic and community settings (currently staffed by bank vaccinators). B: The vaccination nurse/midwife would also cover outreach clinics in areas of low vaccine uptake (data tracked weekly). Of those pregnant women residing in IMD 1; 66.6% have received a 1st dose COVID-19 vaccine, 55.8% 2nd dose and 55.6% booster, compared to IMD 10 (1st: 93.2%, 2nd : 87.7% and booster: 71.0%). C: The service is currently provided by bank staff alongside the Public Health Midwife. However, evidence shows and data supports that a midwife present in a vaccination setting increases women's confidence. Northumberland is consistently in the top 4 areas in the region for COVID vaccination – these numbers can be directly related to the increased presence of maternity staff in outreach areas. Recruitment and staff pressures within the regional maternity services mean that filling the post with a trained midwife may be a challenge. To mitigate this risk, the recruitment of a nurse, who would be supported to complete an enhanced training programme supported by the Public Health Midwife, wider maternity team and obstetricians, would add the value required to improve uptake by facilitating robust counselling and

	discussions with service users. This would be clearly outlined in the patient facing comms. The role can also support flu and pertussis vaccine uptake which are also relatively low, particularly in more deprived areas. This is in part because they are delivered by primary care staff or midwives within primary care settings, where there may not be the dedicated time to vaccinate. The vaccine coverage would increase if the service were able to offer vaccination at scale – almost every pregnant woman attends for a dating and an anomaly scan. There are approximately 3600 women having antenatal care and scans with the Trust each year. D: Primary/secondary E: Excellent collaboration with community services/pharmacy/primary care – this offer will reduce the pressure on primary care, increase women's choice and reduce barriers to vaccination. F: Vaccines are highly beneficial on a population level and cost effective - addressing low vaccine uptake is imperative to protect the health of women and babies. The vaccination midwife/nurse would provide an expert service, allowing maximum number of vaccines given to the target population within a clinic setting. A designated vaccination nurse/midwife would reduce overall costs to the wider system in reducing the need for additional clinics, clinical space, appointment times etc.
2. Outputs / outcomes expected to be achieved and by when	Increase uptake of all vaccinations for pregnant women in Northumberland – within months. There are no national targets for COVID/pertussis vaccination, however the national target for flu of 75% is an achievable benchmark. Reduced socioeconomic inequalities in uptake of all vaccinations for pregnant women in Northumberland – within months.
3. System benefits and interdependencies e.g. • **Health in all policies**	• JHWS – this funding would directly support the objectives of the 'Best start in life' domain of the JHWS. This is an opportunity to include flu and pertussis vaccination offer to seldom heard groups. Flu vaccination uptake in pregnancy was 10.3% lower this season compared to 2020/21 (55.8% v's 45.3%).

• **Joint Health & Wellbeing Strategy** • **Part of PCN inequalities plan** • **Links to Covid inequalities HIA**	• COVID inequalities HIA – the staff member would provide an outreach service to areas of low vaccine uptake/vaccine hesitancy
4. Do you anticipate that a procurement will be required?	Yes / No [please delete as necessary] No
5. Funding A. **Total amount requested and over how long** B. **Forecast spend over duration of programme e.g.:** • **All up front (e.g. a purchase)** • **Monthly (staffing costs)** • **Procurement timeline to be worked up** • **Delay and then spend back end of programme** C. **Match funding opportunities?**	A: £50,250 would provide all costs for a 1.0 WTE Band 5 (top point) for one year B: Annual cost C: Opportunity to seek match funds from North Tyneside Council to replicate offer in North Tyneside General Hospital Antenatal Clinic and community outreach clinics.
6. Exit strategy / sustainability plan	Funding is only sought until the end of March 2023. There is currently an organisational change process underway to move to a Maternity Support Worker (MSW) job description for all existing healthcare assistants in maternity. The additional funding to uplift the Band of this post has been agreed by the Trust. A funded apprenticeship programme has been commissioned to deliver the Level 3 MSW apprenticeship to ensure all staff will be able to fulfil the requirements of the new JD, which will include vaccination.

7. Risks to be managed e.g. • **Workforce available to recruit** • **Procurement delivers to time** • **Financial risks** • **Safeguarding** • **Risks to credibility, relationships or reputation**	The only risk of the money not being spent would be failure to recruit. However, the existing immunisations team contracts finish in May 2022, therefore staff availability and likely interest from this experienced cohort.