IMPACT
THE INTERNATIONAL HEALTH IMPACT ASSESSMENT CONSORTIUM

A rapid, concurrent Health Impact Assessment of the health impacts of Liverpool City Council (LCC) service changes on older people who are resident in Liverpool and who use LCH services.

Final Draft Report
January 2012

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Liverpool Community Health Trust HIA Working Group
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Executive Summary

Introduction

1. IMPACT, the International Health Impact Assessment Consortium at the University of Liverpool, was invited in March 2011 by Liverpool Community Health (LCH) Trust to undertake a Health Impact Assessment (HIA) of the Liverpool City Council (LCC) service changes on those Liverpool residents who use LCH services. Following further discussions and preliminary scoping work, the work was commissioned in August 2011. At the first steering group meeting in October 2011, the original scope was modified to look at how these service changes would impact upon Liverpool resident LCH service users aged 55 years and over.

2. HIA is concerned with improving health and reducing health inequalities. It is a systematic process, which aims to identify what the health effects of a new policy, strategy or project proposal might be on a particular group of people. HIA can be done at a national, regional, city or even ward level. It considers which key health determinants will be affected by the proposals and how these will in turn impact on the health and wellbeing of the population under consideration. By providing evidence to policy makers on the potential health effects of these proposals it helps to inform their decisions.

3. This HIA is a rapid concurrent assessment that took place between October 2011 and January 2012. It aims to assess the health effects of current and proposed future service changes made by Liverpool City Council on Liverpool residents aged 55 years and over who use LCH services, using a generic HIA methodology.

4. This report will describe the scope of the assessment, including the methods and process, the data collected and the evidence defined from these data. The potential health impacts emerging from the analysis of this evidence will then be described in broad, qualitative terms. Finally, conclusions and recommendations for Liverpool Community Health Trust will be presented.

5. A précis of the proposed council service changes was presented to the Steering Group in October and is shown in Section 2. This information was updated at the stakeholder workshop in January and will have gone to Council for approval prior to completion of this report. The Council is now considering the need for savings not of £141 million pounds over two years (2011/12 and 2012/13), but some £247 million over a five year period, 2012-17.

6. Liverpool Community Health Trust wanted to investigate the impacts of Liverpool City Council service changes upon the health and wellbeing of Liverpool residents, aged 55 years and over who use LCH services. It acknowledges that, along with the whole health service, it is making its own efficiencies and the impact of these are assessed internally. To this end, a rapid Health Impact Assessment was commissioned.

HIA Methodology

7. The Health Impact Assessment methods and procedure used were based on a validated generic HIA methodology (section 3, Figure 1). A Steering Group was formed and agreed the terms of reference for the HIA.

8. This HIA is described as a rapid concurrent HIA, reflecting the depth of assessment. In this HIA, data were collected from existing literature and some new data were collected at
a stakeholder workshop, from online contributions from staff and telephone interview with key informants; from this, the evidence was identified and impacts described.

9. The limitations of the assessment were its' concurrent nature and thus the impact of changes already made in light of the 2010 Emergency Budget and Spending Review across all sectors and partner organisations. Despite the modification of the scope agreed by the Steering Group, this HIA remained fairly complex in nature for several reasons. As a rapid HIA, it was not possible to examine the literature for the wide range of services offered by the Trust to the defined population. Stakeholder participation was minimal, not wholly unusual in rapid HIAs, but much lower than anticipated and is discussed in section 7.

Impact Analysis

10. Changes in national legislation and policy drivers likely to substantially reconfigure and reform health and social service provision, build uncertainty into predicting impacts. This is particularly so given projected demographic change in the population structure that is of continued overall growth and an ageing population.

11. Based on the evidence collected for this report which is primarily from a literature review (sections 4, 5, 6 and 7), positive and negative health impacts have been described not only upon the population under consideration, but also potentially on the Community Health Trust, both as an organisation and for its' staff.

12. The most significant positive impact for Liverpool Community Health Trust and users of their services will potentially result from providing a range of high quality health and self-care services, particularly health improvement and preventive services, which can be delivered in a patient-focussed and efficient manner.

13. The main negative impacts identified relate to access to services, particularly in light of increases in demand from an ageing population against an ongoing background of reductions in resources available for commissioning and providing services.

14. The net impact on future population health, particularly in reducing health inequalities and providing equitable access to services for population subgroups, will need to be carefully monitored by commissioners and providers. Based on the evidence presented, it is speculated that despite clear strategic commitment, local support and optimism from partner organisations and clear plans to develop innovative ways of working, the potential benefits of the service changes may be less than optimal due to factors beyond local control.

Recommendations

- The relationship between mental health services, self management programmes and primary care should be strengthened (Section 5 and 6).

- Trust staff should be trained in order to develop basic mental health skills (possibly by expert staff from MH Trusts) (Section 6).

- Trust staff should all have a greater awareness and training in providing basic debt advice. It may be appropriate to train some staff to a more specialised degree, as has been the case in the voluntary sector, in order to expand the support available elsewhere in the community (Section 6).
The Trust may wish to strengthen links to other not for profit debt advisory agents, such as those provided in association with the courts, to improve their capability for “signposting” to services (Section 6).

LCH should put robust systems in place and develop their capacity to analyse and closely monitor in detail referrals, demand for and utilisation of their services against projected need in the City (Section 5 and 6).

Information systems and audit trails should be established by the Community Health Trust, where possible shared with partner service providers, to monitor patient flows from and between services, particularly Acute and Care Trust services, to properly monitor population need, user demand and utilisation of services at an individual level. This might involve the use of segmentation techniques. Comprehensive analysis of work load and practice, for example by professional group and source of referral should enable the Trust to better target health improvement and health care services to members of the defined population (Section 5 and 6).

The Trust should seek to better understand, through data collection and stakeholder participation, the numbers, needs and preferences of the carers of service users, both child and adult, to inform new ways of working (Section 4, 5 and 6).

The Trust should seek to develop programmes such as the Liveability scheme, linking closely with similar initiatives that may be ongoing in the City, in order to better capitalise on “single gateway” contacts with particularly hard to reach groups of older people (Section 6).

The trust should engage in and develop asset-based approaches to living well, linking with activity in the city and elsewhere in the North West. This should include moving towards community asset mapping (not merely the development of directories), with a high degree of stakeholder input, in conjunction with partner organisations (Section 6).

The Trust, as part of the branding initiative currently in train, should more actively market it’s activity and unique selling point (high quality local services to local people by local people who provide continuity of care and understand what local people need and want from their service provider) to current service users and carers in order to establish a strong profile and customer preference in readiness for the forthcoming more open market place (Section 4 and 6).

The Community Health Trust should strengthen, that is develop further, explicit and regular feedback to service user groups and practice patient participation groups to demonstrate how the recommendations of this HIA have been taken forward and their influence on future commissioning decisions about NHS and Adult social care service provision (Section 6 and 7).
1 Introduction

1.1 IMPACT, the International Health Impact Assessment Consortium at the University of Liverpool, was invited in March 2011 by Liverpool Community Health (LCH) Trust to undertake a Health Impact Assessment (HIA) of the Liverpool City Council (LCC) service changes on those Liverpool residents who use LCH services. Following further discussions and preliminary scoping work, the work was commissioned in August 2011 and began with an update training session for members of the Steering Group. The original scope was modified, from Liverpool resident service users of all divisions of the community health trust (that is all age groups) to Liverpool resident LCH service users aged 55 years and over, in the terms of reference of the HIA agreed by the Steering Group in October 2011. This was to assist LCH in their consideration of how best to accentuate any potential positive impacts and mitigate any potential negative impacts.

1.2 HIA is concerned with improving health and reducing health inequalities. It is a systematic process, which aims to identify what the health effects of a new policy, strategy or project proposal, such as the service changes in the City, might be on a particular group of people. HIA can be done at a national, regional, city or even ward level. It considers which key health determinants will be affected by the proposals and how these will in turn impact on the health and wellbeing of the population under consideration. By providing evidence to policy makers on the potential health effects of these proposals it helps to inform their decisions.

1.3 The Health Impact Assessment (HIA) is a rapid concurrent assessment and was conducted between October 2011 and January 2012. It aims to assess both the positive and negative potential health impacts of Liverpool City Council (LCC) service changes on older people who are resident in Liverpool and who use LCH services using a generic HIA methodology, at a time when health services nationally are seeking to make some £20 billion of efficiencies.

1.4 LCH view this HIA as a pilot to examine how HIA methodology can be applied to look at how service changes in the current financial climate can impact on health. This report will describe the scope of the assessment, including the methods and process, the data collected and the evidence defined from these data. The potential health impacts emerging from the analysis of this evidence will then be described in broad, qualitative terms. Finally, conclusions and recommendations for Liverpool Community Health Trust will be presented.

1.5 Policy analysis (section 4) involved the collection of policy documents to determine the context of the proposed service changes. Relevant secondary data were identified and retrieved from LCH and other sources to develop a profile of the population under consideration (section 5). Evidence from the literature was also gathered and distilled (section 6). Qualitative information and experiences were collected by discussions with community stakeholders at a participatory workshop and online, via the staff intranet (section 7). The evidence gathered from all sources was aggregated and analysed. From this, the key health impacts of the service changes were characterised in the impact analysis (section 8). Conclusions and recommendations are presented in section 9. Section 10 gives a discussion on evaluation in HIA, with a full bibliography and appendices in sections 11 and 12 respectively.
2 Summary of the Service Changes

Introduction

2.1 This section is populated with information presented to the HIA Steering Group in a presentation given on 12th October 2011 by a representative of Liverpool City Council. The presentation summarised information already in the public domain. The information also covers all divisions of LCH, beyond the revised scope of this HIA.

i. The first slide indicates that in the first year of budget reductions (2011/12) Liverpool City Council had a shortfall of £91 million pounds in its centrally allocated funding. In the second year (2012/13), this will be a further £50 million pounds, a total of £141 million pounds.

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget Gap (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>91</td>
</tr>
<tr>
<td>2012/13</td>
<td>50</td>
</tr>
</tbody>
</table>

ii. LCC is committed to maintaining a sustainable, balanced budget, shielding vulnerable services and protecting jobs, not merely implementing Government cuts. For example, services for children and young people are bearing a smaller proportion of “cuts” in order to support the life chances of children and young people for the future.

Savings Strategy

- Sustainable, balanced budget
- Shielding services for vulnerable people
- Protecting jobs
- Not just passporting cuts from Government
iii. This slide (below) indicates the apportionment of savings *in the first year* across council service areas.

### Savings by Service area in 2011/12

<table>
<thead>
<tr>
<th>Service Areas</th>
<th>Savings £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Health and Wellbeing</td>
<td>15.700</td>
</tr>
<tr>
<td>Childrens Services</td>
<td>13.587</td>
</tr>
<tr>
<td>Housing and Neighbourhoods</td>
<td>14.795</td>
</tr>
<tr>
<td>Operations</td>
<td>17.940</td>
</tr>
<tr>
<td>Regeneration</td>
<td>11.768</td>
</tr>
<tr>
<td>Corporate (incl. Chief Executives), Finance &amp; Resources</td>
<td>20.531</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>94.320</strong></td>
</tr>
</tbody>
</table>

iv. For example (below), despite the removal of the Area Based Grant (ABG), there remains some £25 million pounds in preventive services for Adults, with reductions made principally in “back office” functions following service reviews and reconfigurations.

### Impact overview - Adult and Health and Wellbeing

- ABG removal but still £25m in “preventative” services
- LA & Provider back office efficiencies – service reviews/service reconfiguration- in house transformation
- Specific efficiencies:
  - Potential removal Moderate eligibility for service (consultation just ended)
  - Freeze in contract price for external providers & Increase charges for non residential services
  - Housing related support provision reduced by 5-10% to LD/MH, Offenders, Substance Misuse
  - 20% reduction in Older people independent living service (shopping/help with bills/debt advice)
Similarly, within a 10% overall reduction in Children’s Services (below), services offered within Children’s Centres may be reduced and there was a period of public consultation on the future of four centres. For example, funding for short break support may be reduced.

**Impact overview – Childrens Services**

Removal ABG - reduction in LA provision & provision in vol sector orgs

Back office/support staff reductions

26 Childrens centres in City:

- Closure of day care in 3 of these from Nov 2011 and consulting on 4 more in most affluent areas
- Merged management of two children centres
- 10% reduction grants to all children centres but family information service still maintained
- Reduction in funding of short breaks (respite for carers)

Housing and Neighbourhoods (below) took the brunt of this round of cuts, where there is a substantial voluntary sector, presumed able to provide support. The ability to monitor this has however been somewhat reduced with loss of “back office” functionality. The Handy Person service has ceased.

**Impact overview – Housing and Neighbourhoods**

LA & Provider back office efficiencies – service reviews/service reconfiguration

- Removal of Area Based Grant (grants to the community)
- Reduction in support to city safe operations (community support wardens etc)
- Reduction in HMRI grant – capital programme – affecting most vulnerable neighbourhoods with reduced capacity to improve poor housings conditions
- Withdrawal of the Handy persons Service (assistance older persons with minor repairs, gardening and decorating)
- Withdrawal of Home Improvement Loans (assisted vulnerable homeowners undertake essential repairs to homes /decency standard eg Bldg fabric, failing wall ties, rotten windows etc)
- Cessation loft & cavity wall insulation programme (Older and vulnerable residents relieving fuel poverty) but still available from Central Govt.
vii. In Regeneration (below), a number of cultural events had been cancelled, parking fees will rise and highway repairs will take longer to get fixed. It is likely that there will be less collection of litter from the streets.

Impact overview – Regeneration

LA & Provider back office efficiencies – service reviews/service reconfiguration

- Increased parking fees & charges, planning fees
- Reduction in highway repairs
- Reduced staffing and consultancy for large capital projects
- Cultural events cuts, eg tall ships, new years eve celebrations

viii. In terms of community services (below), there is an assumption of transfer from local authority to voluntary/community sector provision. City Council staff are encouraged to adopt home working approaches (Authors note: although it should be noted that this transfers many of the costs from the employer to the employee) and policies such as transfer of local authority management to community management for facilities such as libraries are anticipated.

Impact overview – Community Operations

LA & Provider back office efficiencies – service reviews/service reconfiguration

Maintained capacity and achieved savings/efficiencies through initiatives;
Toxteth Sports Centre re-developed with local community/Fire Service to provide a local community centre/hub
- Woolton baths - in process of transferring to local community group.
- Reduction in accommodation and repairs (premises management)
- Libraries review (consultation until Nov 2011) some could be closed/transferred to community group
- Reduced capacity to deal with environmental enforcement, street cleansing, community skips
- Increase in charges, crematorium, bus lanes, parking fee
Subsequent Additional Changes

2.2 This presentation was given to the Steering Group in October, 2011. It is important to note that by the time of the stakeholder workshop held on 12th January, 2012, the decision not to provide support for those assessed as having moderate needs for adult care social services had been taken and implemented from the start of the year. Personal assessment will continue, in line with national policy, but only those assessed as having severe need shall receive support.

2.3 Humphries, R., writing in March 2011 described the current situation, noting that three quarters of councils had already implemented this change. That Liverpool City delayed making a decision and its’ implementation reflects the City Councils’ commitment to protect customer facing services for as long as possible in an area of high need. Humphries goes on to note that nationally, spending over the last five years for older people had increased by less than 3% and not kept pace with demographic change. In keeping with a policy promoting independence, there has been a fall of 7% nationally in the number of older people using publicly funded social care services and substantial drops of over 30% and over 18% receiving residential and nursing care, respectively. While awareness of the importance of preventive services is growing, this is at a time when such investments are losing priority as resources are squeezed. This has not been matched by expansion in community-based services such as home care, day care and adaptations, whose numbers have also fallen by 5%. Noting that such a decline in spending with fewer people receiving services defies demography is a worrying trend with implications for the NHS, he concludes that even fewer people will receive the care and support they need, with a consequent knock-on effect for people needing NHS care due to more emergency admissions to hospital, delayed discharges and longer waits for treatment.

2.4 At the stakeholder workshop, it was also explained that the time frame for further budget reductions had been extended from £91 million pounds savings in the first year and £50 million pounds in the second year, a total of £141 million pounds, to a total of £247 million pounds per over the five year period 2012-17, the detail of which was not presented.

2.5 Unless other forms of funding become available, it seems that savings of this magnitude will represent an increasingly substantial proportion of the total allocated budget for the City. This may challenge the stated savings strategy proposed by the City Council in the future. Health services are also required to make savings.

2.6 Despite announced spending increases in the 2010 Spending Review, intended to fund re-ablement services, personal social services and partnership working between the NHS and social care, this welcome funding is not ring-fenced. Even relatively modest reductions in social care spending by councils would lead to a sharp rise in older people going without support to remain at home and would place extra demands on informal carers (Forder & Fernandez, 2010). The complex interrelationship between social care and NHS funding suggests that productivity improvements and efficiency savings of an unprecedented order will be required up to 2014/15 in order to meet increased demands and improve quality of services.

Summary

2.7 The defined population considered in this HIA is Liverpool resident, LCH service users aged 55 years and over. The focus is those service changes described in the presentation most likely to impact upon the health and wellbeing of this group and how this may in turn impact upon service provision by LCH in years to come.
2.8 The pace of change in current national policy and legislative developments means that already, LCC has initiated some changes for which there is evidence that they assist the health and wellbeing of older people, for example a handy person service. Re-providing such a service using a different model and infrastructure, e.g. volunteers, or independent provision could be a way forward. Expansion of existing LCH ways of working and service provision, e.g. the Liveability service, or a similar model, is advocated in the literature (Section 6).

2.9 Future or scenario modelling to estimate the overall impact of service changes on older LCH service users is beyond the scope of a rapid HIA.

2.10 Considering the distributional effects of austerity measures (not the general financial downturn) across six European countries, Callan et al (2011) note that in the UK, the scale of spending cuts has been shown to be larger than that of changes in taxes and benefits, although this does not include either the impact of cuts in in-kind benefits and services on households or changes announced most recently for up to 2015.

2.11 Their research shows that in the UK, changes to benefits and/or pensions and benefits hit those on a low income hardest, with austerity measures falling more heavily on low income older people than the general population. A sharp rise in unemployment among primary earners also has serious implications for the tax base and demand for social support. They comment that other analysis of austerity measures announced for up to 2015 in the UK show a much more regressive picture, with the number of people at risk of poverty set to rise.
3 Methodology

Introduction

3.1 This section briefly describes the methods used to carry out this rapid concurrent Health Impact Assessment (HIA) and the limitations of the work.

Methods and Procedures

3.2 The assessment was conducted using a validated HIA methodology (Figure 1).

Figure 1. A Generic Model of Health Impact Assessment (HIA)

![Generic Model of Health Impact Assessment](image_url)


3.3 HIA is based upon a social model of health (Figure 2), showing how health is affected by a range of factors.

Figure 2. A Social Model of Health

![Social Model of Health](image_url)


3.4 The most common form of HIA is rapid prospective HIA, undertaken before any decisions are made. As a number of service changes had already taken place, with further changes to come in future, this is termed a rapid concurrent HIA.

3.5 Mapping of nation and local policy drivers was undertaken (Section 4). Policy searches were also undertaken by members of the LCH working group, with support from library services.
3.6 Routine data from secondary sources available in the public domain were examined which, with data provided by LCH, are presented in a profile (Section 5).

3.7 A scanning review of relevant evidence from published and grey literature was undertaken (Section 6). The strongest evidence is derived from ‘reviews of reviews’ followed by systematic reviews.

3.8 New quantitative data is not generally generated in a rapid HIA (Abrahams D et al 2004). New qualitative data gathered at a stakeholder workshop are shown in appendices A and B and discussed in Section 7.

3.9 Impact analysis (Section 8) was based on the evidence available at the time of writing. It identified evidence of impacts from the data collated and describes the potential health impacts from these in terms of health determinants affected and the potential effects on health outcomes and health services.

3.10 Conclusions and practical recommendations, where possible evidence based, are made founded on the information available at the time of writing and detailed in Section 9.

3.11 Section 10 discusses the importance of evaluation to HIA. A bibliography is given in Section 11, with appendices in Section 12.

3.12 With a strong strategic commitment to being a public health organisation, LCH identified 9 staff who had received HIA training through the North West HIA Capacity Building Programme 2008 – 2010. To support the LCH public health strategy, organisational HIA capacity building and develop new ways of working closely with service users, they were invited to participate in this HIA. The HIA commenced in August 2011, with revision of the terms of reference in October 2011, concluding in January 2012.

Limitations

3.13 The limitations of the assessment were its concurrent nature and the impact of service changes already made across all sectors and partner organisations, particularly how these affect communications, stakeholder engagement and professional capacity and workload.

3.14 There is always a necessary compromise between brevity and rigour in any study and examination of primary local data, a more comprehensive health profile and the opportunity to engage with other than an unanticipated, minimal number of stakeholders would have added rigour to the work. This brought an agreed emphasis on evidence from the literature.

3.15 The complex nature and scope of this rapid HIA made policy analysis and profiling challenging. Intelligence in the public domain is available, for example from the PCT and Council, but there are differences, for example in the definition of “older” and the denominator used by each organisation in their statistical analysis. It is recommended that in future a shared understanding be achieved. Commercial sensitivity may in future influence data availability in the public domain for independent service providers, such as the Community Health Trust. As a rapid HIA, the range of services provided for older people precluded a meaningful review of the evidence from the literature regarding specific interventions.

3.16 Establishing consistent, comparable data formats at a local level and from a number of sources will be important for monitoring purposes and in order to assess any changes in
the distribution of the impacts on health (see section 2). As a rapid HIA, the agreed scope of the HIA precluded consideration of the role and interface with secondary and tertiary care.

3.17 HIA methodology allows stakeholders the opportunity not just to raise issues and identify potential health impacts, but consider how best to enhance or mitigate the impacts these might have on the determinants of their health, prioritise those that are of greatest relevance to them and make appropriate recommendations to decision makers. Although cost efficient, use of electronic media may not be cost effective nor alone facilitate good coverage and market penetration in the defined population group. This puts a premium on direct and personal contacts in order to disseminate information to service users and staff (see section 6).
## 4 Policy Analysis

### Introduction

4.1 This section presents a brief mapping of the health policy context of the service changes, identifying policy drivers at national and local levels. The wide range of LCH services for older people and the scope of this HIA precluded a comprehensive mapping and consideration of policy regarding the wider determinants of health.

### Policy Map

<table>
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<th>Policy</th>
<th>Summary</th>
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<tbody>
<tr>
<td><strong>National</strong></td>
<td></td>
</tr>
<tr>
<td>Healthy Lives, Healthy People (2010) <a href="http://tinyurl.com/3j4yqam">http://tinyurl.com/3j4yqam</a></td>
<td>This White Paper sets out the Government’s long-term vision for the future of public health in England. The aim is to create a ‘wellness’ service (Public Health England) and to strengthen both national and local leadership.</td>
</tr>
<tr>
<td>Fair Society, Healthy Lives (the Marmot Review) (2010) <a href="http://tinyurl.com/7r3spwz">http://tinyurl.com/7r3spwz</a></td>
<td>The final report, ‘Fair Society Healthy Lives’, was published in February 2010, and concluded that reducing health inequalities would require action on six policy objectives: 1. Give every child the best start in life 2. Enable all children, young people and adults to maximise their capabilities and have control over their lives 3. Create fair employment and good work for all 4. Ensure healthy standard of living for all 5. Create and develop healthy and sustainable places and communities 6. Strengthen the role and impact of ill-health prevention</td>
</tr>
<tr>
<td>No Health Without Mental Health (2011) <a href="http://tinyurl.com/5r2ygrq">http://tinyurl.com/5r2ygrq</a> (MH Strategy)</td>
<td>This mental health outcomes strategy looks to communities, as well as the state, to promote independence and choice, reflecting the recent vision for adult social care. It sets out how the Government, working with all sectors of the community and taking a life course approach, will improve the mental health and wellbeing of the population and keep people well and improve outcomes for people with mental health problems through high-quality services that are equally accessible to all. This is a strategy for people of all ages using the word ‘people’ to encompass infants, children, young people, working-age adults and older people. The strategy is specific to England, but the challenges are common across the UK</td>
</tr>
<tr>
<td>Reference</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
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<tr>
<td>Liverpool PCT Strategic Plan 2009-2014 (2010) <a href="http://tinyurl.com/7wbc9pz">http://tinyurl.com/7wbc9pz</a></td>
<td>Identifies eight key goals for the next five years which reflect the health needs of the population, fit with what local people have identified matters to them, and make sense to local clinicians.:</td>
</tr>
<tr>
<td>• Delivery of the things that make a big difference</td>
<td>• A better understanding of self care and how health services can support it</td>
</tr>
<tr>
<td>• Gold standard primary care and community services</td>
<td>• Personalised care</td>
</tr>
<tr>
<td>• An end to waiting</td>
<td>• Joined up services</td>
</tr>
<tr>
<td>Putting People First (2008) <a href="http://tinyurl.com/7ebvferm">http://tinyurl.com/7ebvferm</a></td>
<td>Putting People First sets the direction for adult social care over the next 10 years and more. The document identifies four areas for health and local authority partners to focus on:</td>
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<tr>
<td>• Universal services (transport, leisure, housing, education, health, community safety and access to information and advice)</td>
<td>• Early intervention and prevention (manage long term conditions, help to maintain home and garden, support to start exercising)</td>
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<tr>
<td>• Self directed support (choice and control to choose and control the services they need)</td>
<td>• Social capital (communities participating in shaping decisions about their area and community life)</td>
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<tr>
<td>Supporting people with long term conditions (2007) <a href="http://tinyurl.com/yogjjg">http://tinyurl.com/yogjjg</a></td>
<td>The strategic aims of this guide are:</td>
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<tr>
<td>• To embed into local health and social care communities an effective, systematic approach to the care and management of patients with a long term condition.</td>
<td>• To reduce the reliance on secondary care services and increase the provision of care in a primary, community or home environment.</td>
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<td>• Patients with long term conditions need high-quality care personalised to meet their individual requirements.</td>
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</tr>
<tr>
<td>Document Title</td>
<td>Summary/Highlights</td>
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<tr>
<td>--------------------------------------------------------------------</td>
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<tr>
<td>Liverpool PCT Dementia Strategy 2009-2014. Summary (undated)</td>
<td>Summarises intentions for the first year of the strategy:</td>
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<tr>
<td><a href="http://tinyurl.com/6ixjm">link</a></td>
<td>- Develop a joined-up care for people with dementia</td>
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<td></td>
<td>- Assist GPs to become more confident about diagnosing dementia earlier by giving them better training and education opportunities around the condition, and clearer guidelines to follow.</td>
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<tr>
<td></td>
<td>- Help intermediate care staff become better at supporting people with dementia, by giving them easier access to advice and expertise when they need it, as well as training opportunities and clear guidelines.</td>
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<td></td>
<td>- Develop community services so they can offer people with dementia a wider range of ‘care at home’ options if people want them.</td>
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<td></td>
<td>- Strengthen the local mental health liaison service which we know is already very valuable in helping people in hospital get well and back home as quickly as possible.</td>
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<td></td>
<td>- Focus on improving quality of care for dementia sufferers who are coming to the end of their lives.</td>
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<tr>
<td>LPCT Carers Joint Action Plan</td>
<td>Reflecting the national carers strategy and yet to be updated (2011), this document includes a statement of intent to:</td>
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<tr>
<td><a href="http://tinyurl.com/7e5qaxk">link</a></td>
<td>- Identify and assess the needs of a much greater proportion of carers in the City of Liverpool.</td>
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<td></td>
<td>- Increase access to short breaks and carer’s support services, including the provision of training to support carers in their caring role.</td>
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<td>- Establish an accessible, responsive and reliable Carer’s Emergency Support Service.</td>
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<td>- Give more consideration to the different carer support needs of those from Black and Minority Ethnic communities.</td>
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<td></td>
<td>- Address the challenge of the large number of carers of working age who need support to access work, remain in work or return to work.</td>
</tr>
<tr>
<td>LPCT Joint Strategic Framework for mental health 2009-2012 (2009)</td>
<td>Building on earlier work and the experience of Healthy Cities and the Capital of Culture, this strategy sets out a framework for building on the developments already in place and strengthening the resolve of commissioners, their partners and peer networks to tackle the social determinants of mental ill-health.</td>
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<tr>
<td><a href="http://tinyurl.com/7hi8d99">link</a></td>
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<tr>
<td>Healthy Weight ,Healthy Liverpool 2008-2011</td>
<td>The aim of the Strategy is to halt the rise in obesity in both children and adults in Liverpool by 2010 and to reduce the levels of obesity from 2010 onwards</td>
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<tr>
<td><a href="http://tinyurl.com/7a995jg">link</a></td>
<td></td>
</tr>
<tr>
<td>LPCT Cancer Strategy 2009-14</td>
<td>Liverpool PCT Cancer strategy outlines the vision for cancer services in Liverpool:</td>
</tr>
<tr>
<td><a href="http://tinyurl.com/7g9vlxu">link</a></td>
<td>- Commission world class oncology services in Liverpool for our population so that there is more local access for radiotherapy and chemotherapy. The experience and health outcomes or our patients will be enhanced through closer alignment of radiotherapy and surgical oncology with the development of a cancer centre for Liverpool.</td>
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<td></td>
<td>- Ensure patients have timely results of their cervical screening and reduce variation in screening rates. Improve, increase uptake and extend breast and bowel screening services.</td>
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<td></td>
<td>- Improve waiting times for cancer treatments, ensure access to the latest surgical techniques, respond to new guidance for rare cancers, provide greater consistency across a range of treatments and ensure equity of access to cancer drugs.</td>
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<td></td>
<td>- Be responsive to patients living with and beyond cancer and ensure care as close to home as possible, access to appropriate psychological support throughout and beyond their cancer journey and support patients in making choices around their end of life care.</td>
</tr>
<tr>
<td>Taste for Health – Food and Health Strategy 2010-14</td>
<td>Reflecting national policy, this strategy seeks to contribute to the targets of reducing ill health, deaths from coronary heart disease and cancers and increasing life expectancy. It will also contribute to improvements in dental health.</td>
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<tr>
<td><a href="http://tinyurl.com/6wp8mot">link</a></td>
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<tr>
<td>Reducing Harm,Improving Care Liverpool Alcohol Strategy 2011-14</td>
<td>Liverpool’s third Alcohol Strategy, Reducing Harm, Improving Care, places increasing emphasis on the need to maximise the impact of resources and strengthen partnership working to deliver on a comprehensive set of actions to create a more positive culture and attitude toward alcohol and deliver better outcomes for people with alcohol-related problems.</td>
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<tr>
<td><a href="http://tinyurl.com/8798963">link</a></td>
<td>- Develop a programme of activity for alcohol improvement based on 3 key themes that cut across the alcohol improvement agenda and recognise that the key to improving alcohol outcomes is the strength of our partnership working in Liverpool and maximising the use of resources. These themes are Prevention, Treatment and Control.</td>
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<td>- Consolidate successful alcohol programmes and interventions that have had a positive impact on alcohol harm minimisation since our local alcohol strategy was first developed.</td>
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<td>- Build our plans going forward on the strong evidence base and guidance that has arisen from the National Alcohol Improvement Programme, including the High Impact Changes for alcohol harm reduction.</td>
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</table>
- Put in place an outcomes-centred performance management framework that will assist us in evaluating progress against our objectives and identify the current gaps in our alcohol improvement activity
- Ensure that the development of services serves to address health inequalities in the distribution of alcohol-related harm.

**LPCT Out of Hospital Strategy (2007)**

http://tinyurl.com/7hjx5qc

The Outside of Hospital Strategy “A New Health Service for Liverpool” was published in 2007 setting out Liverpool PCT’s commitment to:

- Provide more and better services in the community, so people only go to hospital when absolutely necessary
- Major investment to improve existing health facilities and to build new centres
- Improved access to healthcare, with extended opening hours and more patient-centred appointment systems
- Services in locations that are accessible by public transport and core services within a 15 minute walk for everyone in the city
- Investment in more community-based doctors, nurses and other health professionals
- Joined-up health services, bringing together more professionals in one location

Liverpool PCT is proposing that:

- Three significant new NHS Treatment Centres will be built in the city within the next 4 years providing a wide range of services during the day, in the evening and at weekends.
- Around 20 neighbourhood health centres will be upgraded or rebuilt by 2014, providing more capacity.
- The building programme identified will involve investment of £100m in premises.
- Patients who can walk will be able to walk to their nearest GP Practice within 15 minutes.
- Additional doctors, nurses and therapists will be working in the community providing primary care services as well as more specialised services.
- Patient clinical records will be available to the doctor, nurse or therapist seeing the patient at any location.
- NHS dental services will be located equitably across the city.
- Local pharmacies will be supported to remain in local communities.
- More detailed plans will be agreed with Liverpool City Council and others specifically for community developments with regard to
  - Older People
  - Children
  - Mental Health
  - Rehabilitation
  - Disabilities

**Summary**

4.2 It is clear that local health and social policy is strongly linked to the national policy agenda, although perhaps potentially having less synergy in future as the city seeks to build on improvements made to date in a context of national austerity measures. There are also clear and strong links between policies and strategies at a local level.

4.3 There is some evidence that legislative changes may result in a period of uncertainty. While Liverpool has a long and substantial history of innovative public health practice and strong partnership working, this uncertainty and its’ potential effects are alluded to by the joint Director of Public Health in her most recent Public Health Annual Report 2010-2011.

4.4 Health policy drivers such as out of hospital care continue to develop and may increase demand in future for community health services. This may become more likely with a planned reduction in hospital beds in the city if there is a future stagnation or reversal of the improvements made in life expectancy and morbidity to date.
5  Health Profile

Introduction

5.1 The purpose of the health profile is to give a picture of the health and socio-demographic context of this HIA in order to better understand its potential health impacts and the particular population subgroups that may be affected. Profiling involves collecting and analysing available secondary data (i.e. that readily available in the public domain) on a number of indicators that relate to the content and context of a proposal and its possible impacts on health or health determinants. Indicators are measurable variables that reflect the state of a community or of persons or groups in a community.

5.2 The structure of a HIA health profile is based upon the health determinant categories of the socio-environmental model of health (Dahlgren and Whitehead, 1991) that underpins HIA methodology, together with health outcomes. Figure 3 shows the structure of a health profile. Categories are not discrete, so some indicators may appear in more than one category.

Figure 3: Structure of a HIA Community Health Profile


5.3 Units of analysis are the areas/topics that are the focus of the analysis of the HIA. Examples of units of analysis include geographies, groups, individuals or social interactions. The geographic unit of analysis for this HIA is the resident population of Liverpool, further segmented by age (55 years and over) and attribute (are users of community health services provided by LCH).

5.4 The use of secondary data (information that has already been assembled, having been collected for some other purpose) has its advantages and disadvantages. The advantages of using secondary data are that the data is readily available in the public domain, wide ranging, often high quality and routinely collected and its assembly is far more resource efficient than the use of a range of primary data (new data collected for specific research purposes). The disadvantages are that the data is sometimes insufficiently detailed and does not always fit exactly to the HIA’s units of analysis; for example data may be available for the City, but not for LCH service users.

Sources of Profile Information - locally

5.5 Liverpool City Council and PCT have produced a statement of need (2011) to support the Joint Strategic Needs Assessment (JSNA). This is accessible at http://tinyurl.com/6qa8jw7. The definition of older people is those aged 65 years and over. Chapter 4 provides a more detailed statement of the health needs of older people aged 50 and over in the City.
5.6 There are 148,616 persons aged 50 years and over registered with a GP in Liverpool. There is likely to be a difference between the numbers registered with a GP and numbers resident in the City, with resident numbers greater. It is estimated that there are 85,375 people aged 60+ years resident in the City.

5.7 Overall, the resident population of the city is projected to increase from 444,800 in 2011 to 465,600 by 2033, an increase of 20,800 (4.7%) people. Due to increased life expectancy from birth, the proportion of those aged 80 and over will increase.

5.8 The largest proportion of 50-64 year olds (4.1%) live in Speke/Garston with the largest proportions of both 65-84 year olds (4.9%) and those aged 85 and over (5.8%) living in Woolton. In terms of household type, 'Families in low-rise social housing with high levels of benefit need' are most common in these age groups, with over a quarter of the population aged 50-64 years and the largest proportions of both 65-84 year olds and those aged 85 and over. Other features of this group are low income, unemployment, long term illness and dependency on the state. For those aged 85 and over, the second largest household group (almost 15%) are 'Elderly people reliant on state support'.

5.9 Key points concerning future population growth among the older population are:
- Population aged 65+ projected to increase by 33.4% over next 20 Years (21,000 more people).
- Population aged 85+ projected to increase by 70.8% over next 20 Years (5,100 more people).
- The older population growth is predicted to accelerate over time.

5.10 A disproportionate increase in the older population compared to that of the overall population of Liverpool indicates potentially a greater number of older people requiring health and social care services over the next 10 to 20 years, having a significant impact on resources. Given the projected increase in life expectancy, those requiring health and social care services will do so for longer.

5.11 Providing greater local detail in support of the JSNA, Area and Neighbourhood Profiles are also available at http://tinyurl.com/7778ntt. This web site also includes a 2009 directory of locally available contacts for services for support for all age groups, Liverpool 118, available at http://tinyurl.com/7rnr7t.

5.12 The Joint Director of Public Health Annual Report 2010-2011 http://tinyurl.com/6uf5lt2 and the supporting statistical appendix http://tinyurl.com/83ja2w2 provide a significant comprehensive profile of health in the City, with a section of the main report (pp28-35) succinctly summarising issues for the improvement of health in older people aged 65 years and over. This is summarised in Box 1.

Box 1

Considering demography, the report notes that there is likely to be a greater number of older people requiring health and social care services over the next 10 to 20 years, which will have a significant impact on resources. Given the projected increase in life expectancy (which in Liverpool is increasing, but remains some two years less than the national average), those requiring health and social care services will do so for longer periods of time.

Living older and longer can mean increased need for effective health and social care support services in order to enjoy better health and maintain their independence. The report notes that in 2009, Liverpool City Council identified that providing preventive health and social care services was a challenge.

Cancer, circulatory, and respiratory diseases, all of which are to a large degree preventable if lifestyle changes can be made earlier in life, are the major causes of death in Liverpool.

Only one fifth of those aged 65 and over in Liverpool consider their general health to be very good. Smoking and hazardous drinking are reported for fifteen and twenty per cent of the group respectively. Deprivation, fuel poverty, falls, dementia, social...
isolation, access to services and acting as a carer are identified as key factors adversely affecting the lives of older people in the city.

Based on 2007 indices of income deprivation affecting older people, a third of lower level super output areas (LLSOAs, of which Liverpool has 291) are in the most deprived 5% nationally, almost half are in the most deprived 10% nationally and almost nine out of ten are in the most deprived 50% nationally.

Older people are likely to form a significant proportion of those defined as being in fuel poverty that is living in a household where more than 10% of income is spent on fuel to adequately heat their home. Interventions to improve energy efficiency in dwellings alongside alleviation of fuel poverty and winter survival programmes have been in place in Liverpool for nearly a decade.

Falls and the fear of falling significantly impact on the health of older people, with the risk of serious falls injuries and premature mortality increased in winter due to adverse weather conditions, especially ice and snow. Falls leading to mortality constitute half of accidental deaths in Liverpool, mainly in those aged 65 and over. The mortality rate from falls in those aged 75 and over in Liverpool is over three times the national average, while the mortality rate for fracture of femur in the very old, 85 and older, is just over twice the national average. The likelihood of requiring hospital attendance for emergency treatment after a fall increases substantially with age. In 2009, some 1300 people aged 60 and over were referred after A&E attendance, to the local falls service provided by the Royal Liverpool University and Broadgreen Hospitals NHS Trust.

Dementia prevalence is set to increase in the coming years, from a current estimate of 4,300 to some 6,000 persons in the City by 2031. Advancing age is the main factor, with smoking, diabetes, high blood pressure and obesity associated with increased risk of some forms of the condition. Those with learning disabilities are at particular risk. Dementias develop over a period of time, affect all levels of society, complicate care provision and have devastating impacts on those affected and their carers, who are likely to be older themselves. The report notes that while assistance at diagnosis and intensive Intermediate Care Service support are improving the offer to affected families, community based alternatives to care need to be expanded and developed alongside awareness raising and education with universal access to care, if individuals are to remain healthy for as long as possible. The dementia care strategy has these elements factored in.

Low level support through access to a range of community support services is known to reduce social isolation and support active ageing. Social isolation can increase the risk of depression and may prevent some people from accessing the health and social care they need. It has been identified as a root cause of excessive drinking at home among older people. For those aged 50 and over, alcohol related hospital admissions in Liverpool are 58% higher than the national average, 40% higher among those aged 65 and over and 25% higher among those aged 85 and over.

Approximately 56% of those aged 65 and over have a limiting long term illness, placing demands on health and social care support. 12,962 people were referred to Adult Social Care in 2010, that is, just over 20% of the population in this age group, for services relating to dementia, learning disabilities, mental health, other vulnerable people and physical disability. 6756 had care packages implemented, with 17% entering a nursing or residential home. For over 95% of referrals, the most common need was as a result of some form of physical disability. The average age of client referral between services was just over 80 years.

Caring and poor health are clearly related. Carers giving high levels of care are twice as likely to have poor health compared to those without these responsibilities. Their responsibilities may lead them to neglect their own health, resulting in ill health that could be avoided or minimised. It is estimated that some 13% of 65-74 year olds, 9% of 75-84 year olds and 3.5% of 85s and older provide unpaid care to another person, partner or spouse.

The following recommendations are made in the report with regard to older people:
1. A whole systems service review should be commissioned through the JSNA process during 2011/12
2. An integrated falls prevention programme in the three re-ablement hubs across the city should be commissioned for 2012/13
3. Improve the early and accurate diagnosis of dementia March 2012
4. Key priorities for Older People should be identified through the JSNA process to inform the development of the Joint Health and Wellbeing Strategy
5. Joint Commissioners to develop evidence for how well carers are supported.

Information from City Council Equality Impact Assessments (EqIA)

5.13 Data presented in the EqIA in relation to changes in eligibility level for Fair Access to Care (Marr, P 2011) suggest that there are some 5892 persons receiving City Council funded care packages for community based services. Of these, 3677(62.4%) are aged 65 years and over, 1158 being assessed as having moderate needs. The EqIA notes that as a result of changes to eligibility (in place from 1st January 2012) there will be disproportionate negative impacts upon those aged over 80 years, those with a physical disability and women, both as service users and carers. Both the City Council and the Trust will wish to gather additional data to adequately capture information regarding some of the characteristic groups now defined in the Equalities legislation.
5.14 Data provided in the councils’ EqIA for routine re-tendering of personal care services (Markham, H 2011), also contributes to the profile. There are some 2253 people receiving [local authority] home care, 2006 (89%) of which are aged 65 years and over. This group is predicted to grow by 6% in the next five years. The main recipients are predominately female (60%) and disabled people, with those experiencing frailty, temporary illness and physical disability in the majority (72%). A further 16% have physical disability alone. Dementia, sensory disability, mental health, learning disability and substance misuse also account for other client categories. At the time of writing (August 2011) there were no anticipated negative impacts of routine retendering processes.

5.15 Undertaking an EqIA on changes to local housing allowance, housing benefit and council tax benefit, Rostron (2011) finds that there will be some negative impact for some people in the city claiming housing benefit and local housing allowance (LHA). Since older people are significantly more likely to be in receipt of housing benefit than LHA, they are more likely to be affected by changes in all types of housing benefit. There is limited data to show that people who consider themselves disabled will be disproportionately affected by changes to housing benefit. Since women are significantly more likely to make a housing benefit claim than men, it is possible that women will also be disproportionately affected by changes to housing benefit.

5.16 Local authorities are required to implement these national policy changes, but are able to take some mitigating action locally through communication with stakeholders (as part of a detailed communications plan), discretionary housing payments (but funding will be insufficient to assist the majority of customers affected by the changes) and effective implementation of the changes (including staff training and revised and updated process infrastructure). There will be a variable lead-in time for these impacts due to the phased nature of their introduction and transitional protection available to many customers. There is an expressed intention to monitor this closely, but since housing and Regeneration have borne the brunt of service changes to date, this may not be optimal over time.

5.17 The Community Health Trust provides information on its’ website summarising the general health of the population of the City and the range of interventions delivered by the organisation (Box 2):

Box 2.

Liverpool Community Health NHS Trust provides more than 60 different healthcare services and employs around 2,400 staff. Each year, on average, our staff work deliver care to:
- 52,000 people as outpatients within treatment rooms.
- 125,000 patients to our four Walk-in Centres.
- 51,000 sexual health service user visits.
- 250,000 visits to patients in their own home.
- 480,000 Immunisations and Vaccinations.
- 50,000 Community Equipment items delivered.
- 34,000 Wheelchair service items delivered.

Despite the fact that Liverpool has been one of the UK’s fastest growing cities, with a significant growth in the local economy of 72.9% between 1996-2006, Liverpool remains one of the most deprived cities in Europe, which has impacted directly on the health needs of the local population.

The health of the people of Liverpool is amongst the poorest in England. Despite progress, deaths from heart disease, stroke, cancer and alcohol related conditions in Liverpool are still significantly higher than the national average. As a consequence, Liverpool has the second worst life expectancy in England for males and the lowest life expectancy in England for females.

Liverpool has lower quality housing than the national average, with 7.5% of residents living in fuel poverty, which is the highest in the UK. However the implementation of local government initiatives such as the Warm Homes Strategy, which improves central heating implementation and delivers other home improvements aims to improve the quality of housing in the city.

This is why Liverpool Community Health wants to transform the provision of community health care in the city, so that we can really focus on delivering the quality care that the local population need, but also help prevent many instances of poor health in the first place.
5.18 It is interesting to note that “7.5% of residents are stated to be living in fuel poverty, the highest in the UK”. It is likely that this figure was published prior to the most recent increases in fuel prices. It should be noted that these data may not be timely and current. 2009 data from the Department of Energy and Climate Change suggest that 26.4% of Liverpool households are fuel poor.

Table 1. Liverpool patients over the age of 55 years registered with Liverpool Community Health Trust since 2005.
The table above (Table 1) presents information provided by the Community Trust. It shows that since the implementation of the Lorenzo system in 2005/6, the now community services trust has provided at least one service intervention for 99,102 persons aged 55 years and above, currently living, as identified by their NHS number. As might be expected, nearly 40% of these are aged 75 years and over, with a greater proportion of females. It should be noted that this represents the majority of patients in Liverpool, but as not all services use this system it does not represent a complete picture.

Following data mapping and a request to the trust, there was a limited response within the available timeframe, as above. The robustness of these data is therefore uncertain. Detailed breakdown of these data, for example per annum, geographically, by professional group, by source of referral, requires additional analysis beyond the scope of this HIA.

Also of note is the high proportion of service users for whom accurate ethnicity information is unavailable, despite this being a legislative requirement. The JSNA Statement of Need (2011) notes that while the proportion of ethnic minority population in the city is small (9%), migration from Poland, Czech Republic, India and other countries is set to continue to rise. Among the population aged over 60 years, 3.1% are thought to be members of BME communities. In common with other organisations, LCH will be keen to improve this data collection, not least since ethnicity is an important risk factor in some long term conditions and minority ethnic groups (especially women) are often underrepresented and experience barriers to utilising services (Section 6).

Although LCH is not a provider of mental health services, mental ill health is more prevalent in some minority ethnic groups, perhaps adding complexity for carers who are women. LCH may also wish to better understand the numbers and needs of carers (both child and adult) of their service users aged 55 years and over with regard to need or anticipated demand for health improvement support and interventions to safeguard their own health into the future.

As a major provider of community health services for older people in the city, LCH has an excellent opportunity, through a more detailed understanding of their service users and their carers, to both inform commissioning and develop patient focussed services likely to meet future requirements.

As a fast developing organisation, LCH is to be commended in its' timely action in strengthening its' understanding of the client profile. To this end, EMIS system is being rolled out across the Trust (although not to all services, it is understood), a Public Health Analyst has been appointed and patient-based service data is being gathered to form a more detailed user profile. Such activity can only have a positive impact for the Trust both as a public health organisation, but also to better position the Trust in the future market place.

Disease prevalence estimates are available at PCT, local authority and GP practice level, at http://tinyurl.com/7kndzn4

Updated health inequality indicators and IMD (Index of Multiple Deprivation) scores are now also available (16/12/11). These may be found at http://tinyurl.com/6vmawmh and http://tinyurl.com/7aj4cwo respectively.

Age UK produces a monthly update of publicly available “quotable statistics” referenced and from reputable sources, for people aged 65 and over. This includes sections
on demographics, health and wellbeing, home and care, money matters, travel and lifestyle (including digital inclusion, loneliness and isolation) and work and learning. [http://tinyurl.com/7grv8iu](http://tinyurl.com/7grv8iu) Box 3 presents some examples, from December 2011. Since they are taken from a range of published sources, some may appear contradictory.

**Box 3**

**Home Care**:
- There has been a decrease of 18% between 2000 and 2008 in the number of households in England receiving home care services.
- Of 2 million older people with care related needs, 800,000 currently do not receive any formal support.
- 1.5 million people in England have care and support needs that the state does not meet.
- It is estimated that around 6,000 older people with high support needs and 275,000 with less intensive needs receive no care at all, from state or informal sources.
- About 410,000 older people in the UK have an unmet need for help with practical household jobs.

**Older People as carers**:
- About 960,000 people aged 65+ years provide unpaid care for a partner, family, or others.
- Carers UK estimate that 58% of carers of all ages are women.
- There are estimated to be 600,000 people in the UK acting as main carers for people with dementia.
- Research by the Princess Royal Trust for carers found that almost 70% of carers aged 60 and over said that looking after someone else had damaged their own health.
- Nearly two thirds of those polled for the research said they had health problems or disability of their own; only half left confident lifting the person they cared for.
- 68% of those polled said being a carer damaged their psychological wellbeing, with 43% reporting their mental health had worsened in the past year.

**Elder Abuse**:
- It has been estimated that up to 5% of the elderly population are abused each year.

**Pensions**:
- 46% of pensioner couples and 73% of single pensioners receive over half their income from state pensions and benefits.
- 5% of pensioner couples and 16% of single pensioners have no source of income other than the state pension and benefits.

**Savings**
- 28% of pensioner couples have less than £1,500.00 in savings. For single pensioners, this figure rises to 40%.
- 1.8 million pensioners (16%) live below the poverty line, with 1 million (8%) in severe poverty.
- 9% of pensioners aged 65+ are materially deprived. 2% of pensioners are both materially deprived and on low income.
- Pensioners from BME groups are more likely to be in poverty than white pensioners, especially Pakistani and Bangladeshi pensioners, 46% of whom are in poverty.

**Spending**
- Average weekly expenditure for 1-person households mainly dependant on state pensions is £164.70, which is £20.00 more than the average disposable income for that group.
- On average, 17% of 75+ households spend more of their annual expenditure on housing and fuel than the all-age average of 12.5%.

**Fuel Poverty**
- 4.8 million people aged 60+ live in fuel poverty in the UK. In England, 1.2 million of these live alone.
- 36% of over 60’s in the UK sometimes stay in or live in just one heated room of their home to save money.
- Nearly one third of the oldest households in England (aged over 75 years) live in housing that has failed the official decent homes standard because of sub-standard heating and insulation. Those in private rented accommodation are at most risk of living in non-decent homes.
- Older people in the UK are more likely to turn heating off to save money, wear outdoor clothing indoors and go to bed early to save on heating costs than in other European countries.

**Transport and Accessibility**
- 18% of adults aged 60-69 and 38% of those aged 70+ have a mobility difficulty, compared to 12% of those aged 16 years and over.
- In England, 10% of those 75+ say they have very difficult access to a corner shop; 10% to a supermarket; 10% to a post office; 9% to a doctors surgery and 16% to a local hospital.
- 40% of people aged 60 or over use local bus services at least once a week.

**Community and Citizenship**
- 39% of people aged 65-74 and 24% of 75+ in England are participating in formal volunteering at least once a month.
- 87% of people aged 65+ feel they belong strongly to their neighbourhood, compared to 77% of all adults in England.
- 30% of people 65-74 and 29% of 75+ feel they can affect decisions in their local area, as opposed to 38% of adults in England.
- Although they visited public gardens and other green spaces less often than other age groups, 83% of over 65s said they go to these places.
Leisure and time use
- Over 65s are estimated to spend an average of 80% of their time in the home. 90% for people over 85
- People aged over 65 spend on average three and three quarter hours a day watching television/video/dvd.
- 48% of over 65s are active in social activities in their area, though this is less than other age groups
- 73% of over 65s report being involved in leisure activities or hobbies in the last two weeks

Digital Exclusion
- 17 million people of all ages are officially described as digitally excluded.
- Nearly 6 million older people (58% of those aged 65 and over) in the UK have never used the internet.
- There are marked social class differences in online uptake – among over 65s, social class DE are more than twice as likely to be offline than social classes AB.
- Men are more likely than women to be currently online
- Single people aged 65+ are less likely to be online than other households
- Less than two thirds of 65+ have a mobile phone; 98% rely on landline
- Older people are the most likely to have their mobile phone switched off unless they wish to use it
- Only 2% of over 65s use the internet on a mobile phone.
- 44% of over 65s have analogue-only TV and this age group are more likely to listen non-digital radio.
- More than 70% of older people say that if more services were provided on the internet, they would still visit or phone their local council to receive services
- A similar % disagree with the notion that if more council services were provide online, they would use the internet more
- To date, only 15% of older people had used a local council website to find information.

Loneliness
- Half of all people aged 75 and over live alone
- 10% of people aged 65 and over in the UK say they are always or often feel lonely
- 36% feel out of touch with the pace of modern life and 9% say they feel cut off from society
- Half of all older people consider television as their main form of company

Isolation
- 12% (over 1.1 million) of older people feel trapped in their own home
- 6% (nearly 600,000) leave their house once a week or less
- Nearly 200,0000 older people in the UK do not get the help they need to get out of their house or flat
- 17% of older people have less than weekly contact with family, friends and neighbours. 11% have less than monthly contact.

Crime
- 8% of people aged 60+ in England and Wales say they live in fear of crime; 90% of over 65s said they had not felt unsafe or threatened in the last two weeks
- Over 65s are most likely to think that crime is increasing “a lot” in the country, but are no more likely to perceive a similar increase in crime at a local level.

Employment
- 849,000 people aged 65 and over were in employment July-September 2011; a slight rise on the previous year and about 3% of the UK labour force
- The employment rate for State Pension age (SPA)+ is 8.8% (2.7% W/T, 6.1% P/T )
- 65% of older people believe age discrimination still exists in the workplace
- As reported in 2009, there is a trend to leave the workforce later, with the average age being 64.5 for men and 62 for women.

5.28 Forder and Fernandez (2010) considered the tightening fiscal situation on social care for older people and estimated impacts based upon projections, on three key aspects of the care system.

5.29 With regard to changes in the balance of funding responsibilities between state and private individuals, they found that reducing state expenditure leads to an overall fall in consumption of social care services and to a significant increase in the private - to - public social care funding ratio. Despite this, a reduction in state expenditure linked to the budget constraint still leads to a significant reduction overall in social care consumption.

5.30 Considering the impact on the number of recipients of social care in a reduced budget scenario and based upon these financial figures, the assumed reduction in state expenditure would lead to a very significant reduction in the number of people entitled to state support. This would be to a degree offset by an increase in the private users of social care, so an increase of around 300,000 self-payers, compared with 490,000 fall in state-supported recipients.
5.31 In terms of levels of unmet need, they find that there will be a significant increase in unmet need levels following the tightening in the needs eligibility criteria for state support. This is particularly significant if no account is taken of the support provided by informal carers. Proportionately, reduction in expenditure is associated with 56% and 90% increases in unmet need levels in 2011/12 and 2013 respectively. This suggests an increase of some 170,000 in the number of people with high needs who have some level of unmet needs.

5.32 In conclusion, they observe that the total numbers of older people that would be state-supported would fall by nearly half. The people no longer receiving state support would be those with lower needs, but there would be an increase in the volume of people with social care needs but no services. Unmet need would nearly double. Although some people would pay privately or seek informal care, those with needs cannot always afford the high costs of care. The equity consequences of this will mean that the rich would do better and the poor would be the biggest losers.

5.33 Public cost savings might be achieved through means other than raising eligibility thresholds, in particular by increasing capital thresholds in the means-test. This will also increase unmet need, but provide most protection to the poorest (rather than the neediest).

5.34 How quickly the costs of services will grow, how wealthy future cohorts of older people will be, how sensitive demand for care is and how sensitive people are to prices are all factors that would affect the scenarios presented. Price sensitivity (how much people are prepared to pay) for example could result in even greater falls in the number of people consuming services and in the overall volume of social services consumed.

5.35 Falkingham et al (2010) noted that planning health and social care for older people with high support needs requires accurate projections, based upon reliable estimates of the prevalence and incidence of cognitive and functional impairments. They found some estimates for these at national level, but very little at sub-national and local level, with these based on household surveys (so excluding institutional care) and not able to be disaggregated at for key characteristics, such as ethnicity. They identify forthcoming sources of more detailed information, such as the 2011 census, a new longitudinal household study (USoc), ELSA and the national birth cohort studies such as NSHD, but emphasise that continued investment in major data sources and their analysis is key to understanding the interaction of health, disability, economic and social wellbeing and independent living into old age.
Summary

5.36 Liverpool is a culturally diverse area (although numbers among the defined population are small) where resources have been targeted in order to reduce inequalities and improve the health and well-being of the population. This has brought demonstrable improvement in life expectancy, although a national increase in the inequalities gap has meant that in relative terms, the City continues to experience considerable levels of deprivation, exacerbated by the prevailing financial climate.

5.37 There is evidence in the literature (Taylor-Robinson, Gosling, R. 2011, Taylor Robinson 2011 and Barr,B. 2012) that reductions in government financial allocations have disproportionately impacted upon local authorities with the highest levels of deprivation and least affluent population subgroups, such as those in the north of England. Service changes made and to come at city level will then impact upon a population already disadvantaged, where a steady rate of improvement in health and wellbeing is slowing. The potential challenges this may present are alluded to in the annual report of the Joint Director of Public Health 2010/11 and have been acknowledged by partner organisations across the City.

5.38 Profiling has used ward level data (previously the lowest geographical level published in public health literature) to describe the characteristics of Liverpool. Lower geographical levels of analysis (output areas) are now in use which better describe discreet communities and so identify local “hotspots”, but as yet not all datasets can be manipulated at this level, making comparison and interpretation of change over time problematic. There are also challenges nationally to the systems and infrastructure of intelligence gathering for public health and health and wellbeing.

5.39 The Public Health Annual Report recommends that key priorities for older people should be identified through the JSNA process to inform the Health and Wellbeing Strategy. Most of the intelligence reported therein refers to statistical information regarding those aged 65 and over.

5.40 A more detailed understanding of the profile of their clientele would be beneficial for the Community Health Trust, not only in preparation for participation in a wider commercially competitive marketplace, but also to identify their contribution to reducing health inequalities as a public health organisation. It is understood that improved use of IT across the Trust is in progress, through roll out of the EMIS system, but this is originally GP practice performance based and may not be wholly appropriate for every service, or for monitoring health inequalities.
6    Evidence from the Literature

Introduction

6.1    This section presents the evidence from a scanning review of the secondary scientific literature and publications, e.g. literature reviews, guidelines, reports, concerning potential impacts of proposed service changes upon health and well-being. The search strategy was limited to literature published in English, following the methodology described by Mindell et al (2006). Priority was given to “reviews of reviews” and systematic reviews.

6.2    The rapid nature and limitations of the HIA and most particularly the timeliness of this concurrent HIA, compounded by the wide range of community health services utilised by the population of interest precluded a more detailed search of the literature.

Background

6.3    Considering the international evidence in relation to the situation in Ireland, Stuckler et al (2009) observe that health is at risk in times of rapid economic change, in both booms and busts. That is, it is the rapidity of economic change that is a key hazard to health. The impact on mortality is exacerbated where people have easy access to the means to harm themselves and is ameliorated by the presence of strong social cohesion and social protection systems.

6.4    The extent to which economic changes impact on health depends on the extent to which people are protected from harm. Three issues are relevant: exposure to risk factors; social cohesion (informal welfare) and social protection (formal welfare). Adverse health effects of rapid economic change are reduced substantially where many people are members of social organisations, that is, have someone who can be turned to to borrow money, food or shelter and get advice.

6.5    A combination of social support networks coupled with a well developed welfare state is likely to protect the population from the adverse consequences of rapid economic change (although individuals will fall through the gaps). It should be noted though that overall neutral population effects can mask a rise in inequalities.

6.6    Writing in 2008 for DCLG, Gordon, Travers and Whitehead noted the main challenges for local authorities were sustaining development processes and protecting the welfare of residents who are exposed to higher risks of housing repossession, homelessness and unemployment, with predictably negative social consequences. They note that for “some time to come” the workload associated with physical regeneration will be substantially reduced, while that in support of welfare functions of one kind or another is likely to be greatly increased. (This was of course, prior to the 2010 General Election, subsequent emergency budget measures and the service changes under consideration as a result). They made it clear that an assumption that “normal life” will be resumed in any future upswing, or that there will be scope to sustain any boost to local authority activity thereafter, is unfounded. They advise caution in guarding against local protectionism and advocate that rather than protecting places, local authorities should shield both vulnerable people and assets of continuing value (such as skills) from the worst consequences of the downturn. They made eight key points:

    • Local government can do very little without central government support (particularly in relation to finance) – and cannot substitute for it in raising general demand;
    • Need for rebalancing of local expenditure to meet shifting needs within constrained levels of overall activity;
• Local authorities’ most positive and appropriate roles would be in relation to mitigation of effects (on assets and vulnerable people) and relief of specific market/government failures.
• A priority is to identify immediate constraints on LAs capacity to respond, and examine how these might be overcome;
• During the downturn, the emphasis should be on reducing its impacts, with a focus on short term gains, rather than pursuing unrealistic development initiatives;
• Even so, nothing should be done in the name of relieving short-term pains that is not long term viable/desirable – there are plenty of positive opportunities;
• Concentrate on incentivising the private sector – even if it means more short term support - they will have to take the strain in the end;
• Avoid area discrimination – “shield” people and assets, rather than protecting places.

6.7 McLaren, Armstrong and Harris (2010) writing for the Scottish Parliament from a financial standpoint, note that there is little research that looks directly at how deep fiscal consolidations affect those who might be classed as vulnerable. They particularly note that while economic models can estimate the impact of tax and benefit changes on different sections of society, it is much more difficult to calculate the relative impact of cuts to public services. Not only may there be inconsistencies in data and its availability on such subsets of the population, but also uncertainty over what constitutes “vulnerable”, (such as those most vulnerable to economic poverty or those with existing physical or mental conditions that make them especially vulnerable to public service cuts.

6.8 McQuaid et al (2010) in their review of the evidence regarding the impact of reduced public services spending on vulnerable groups concluded that there is only limited concrete evidence on the impact of public spending cuts on equalities groups. They note that individuals can fall into multiple equalities groups, exacerbating their vulnerability to cuts in public services; variations within equalities groups necessitates consideration of subgroups, due to the differential impacts on some, such as users of specific services; that some individuals will be especially vulnerable both as public sector employees and public service users; the lack of official data regarding certain equalities groups may make the effects of spending cuts “less visible”; the effects of public spending cuts will be felt by those working in and using services delivered by third sector and some private organisations, with the effects of reduced public spending crossing sectoral boundaries.

6.9 Section 4 of the interim second report of the Marmot review team on the social determinants of health and the health divide in Europe (2011) considers the contexts of the review in light of the economic downturn, country differences and specific contexts and vulnerability. It notes that Europe was hit harder than any other region, so inequities in health are likely to widen considerably across the region, for example, mental health problems leading to alcohol misuse and relationship difficulties.

6.10 Some groups are more at risk of negative social and health outcomes as a consequence of the recession, including those with fewer years in education, families with higher rates of debt to income, people with disabilities and /or chronic conditions and older workers lacking transferable skills.

6.11 Negative and stigmatising attitudes towards minority groups have historically worsened in a recession, particularly among social groups most vulnerable to job loss and economic insecurity, as these groups come to be seen as a threat. The impact of recession also tends to vary according to pre-existing labour market position, such as the differences that are commonly seen between men and women.
6.12 There are likely to be long term impacts of the recession, with social problems also remaining long after the economy begins to recover and hitting the health of those hardest hit.

6.13 The more a group is marginalised, the more vulnerable it is to experiencing adverse events and the less capacity the group will have to respond to these events to minimise negative consequences. Nevertheless being a member of a vulnerable group does not make a person inherently more vulnerable or at increased risk. It is the interaction of several factors that creates increased vulnerability. These factors include poverty, inequality, discrimination, exposure to various threats (such as sexual abuse), the prevailing incidence or prevalence of disease (such as HIV) and the possibilities of epidemics (such as influenza).

6.14 The social exclusion network of the Commission on the Social Determinants of Health (CSDH), chaired by Popay,J (2010) defines social exclusion as comprising dynamic, multidimensional processes that are driven by unequal power relationships interacting across four main domains – economic, political, social and cultural. These processes operate at different levels – individual, household, group, community, country and global – and result in a continuum of inclusion and exclusion that is characterised by unequal access to resources, capabilities and rights and that lead to health inequalities.

6.15 It is noted that it is the intention of the review to examine how equitable access to resources, access to basic services, capabilities and rights, across sectoral domains, for disadvantaged groups can reduce inequity in health. This will also explore the role of health systems and cross-government inclusion efforts.

6.16 Robinson et al (2011) in their study to map priority-setting activity, noted that there is at present a focus on “tools and process” in disinvestment decision making in PCTs, with some important decisions made at executive level (but using a valid tool to do so), without adequate or sufficient stakeholder engagement. They make recommendations regarding engagement and involvement including allowing providers to maintain a percentage of the resource that they have realised by changing service delivery practices.

**Ethnicity and Health**

6.17 Despite the requirements of the Race Relations (Amendment) Act 2000, Fitzpatrick and Jacobson 2006) noted that only a limited number of routinely available ethnically coded health-related datasets were amenable to analysis, with few or no data from primary care or birth and death registration. Their analysis suggests that organisational factors are mainly responsible for the variation. This situation may have improved (and indeed Scotland is to be the first country to record ethnicity on death certificates), but information provided by the Community Health Trust in Section 2 suggests that there remains room for further improvement in this.

6.18 The main findings about ethnic inequalities in health are:
- People from most ethnic minority groups are generally more deprived in terms of socio-economic status.
- Health experience of different ethnic groups is not uniform. Pakistan and Bangladesh born people have the highest mortality rates from circulatory disease. Those from Ireland and Scotland have the highest mortality rates from all causes of death combined and cancer.
- Reflecting a higher prevalence of coronary heart disease, Pakistani, Bangladeshi, Indian and Mixed White & Asian groups have higher than average hospital admission rates.
• Higher prevalence of diabetes is also reflected by higher than average hospital admissions among the Asian groups, Black Caribbean and Black Other groups.
• Consistent with their higher prevalence of diabetes which is a known risk factor for cataracts, there is a reported higher prevalence of cataracts and thus above average proportion of cataract surgery among Indian and Pakistani groups.
• Among ethnic minority groups, Black Africans comprise the largest proportion of those seen for HIV care. Along with the Other ethnic group, Black Africans also have the highest rates of tuberculosis.
• Asian, Black and Mixed minority populations have lower rates of setting a smoking quit date. Females are more likely to set a quit date in every ethnic group.
• The highest treatment rates for drug misuse are in the Mixed group and lowest in the Asian group.

6.19 Published research (Clark and Drinkwater 2007; Palmer and Kenway 2007; Bagguley and Hussain 2007; Platt 2007; Salway et al 2007) shows that the poverty rate for minority ethnic groups is double that found among white people. An “ethnic penalty” may extend to access to social security benefits and other financial support. Bangladeshi and Pakistani groups have the highest rates of poverty in the UK.

6.20 For those suffering long term ill health coping skills are often lacking, with strong societal pressure to be “normal” leading to concealed ill health and delayed or refusal to seek help. Lack of social participation perhaps due to financial hardship, particularly affect carers of the chronically ill, resulting in social isolation or increased stress levels in social situations. A number of factors affect levels of lower income, including the number of people supported by that income.

Disability

6.21 Approximately 12% of parents in Britain are disabled, that is have a long term disability (including learning disabilities) or illness which adversely affects their ability to undertake normal daily activities. Moderate to severe mental health support needs have been estimated for between half and one and a half million parents. Others groups, such as parents with alcohol and/or substance misuse problems have support needs beyond those of the general population.

6.22 Disabled people are twice as likely to live in low income households and are four times more likely to be unemployed or be economically inactive than their non-disabled peers. Experience of discriminatory attitudes and fear of stigmatisation may prevent their timely access to health or social care. Disabled parents are more likely to experience socio-economic deprivation than non-disabled parents.

Transport

6.23 Douglas et al (2007) noted that over a twelve month period, nearly one and a half million people in the UK missed, turned down or chose not to seek medical help because they had transport problems.

6.24 Although access to a car has been linked to improved health irrespective of socioeconomic status, excluded groups have been shown to be heavily reliant on walking, public transport and lifts from family, friends and neighbours.

6.25 Public transport is not a feasible alternative to a private car for those with mobility problems, elderly people and people who are disabled, who find it difficult to use public transport, taxis, or to walk. Car access is a predictor for physically active leisure, regardless
of socioeconomic status. Lack of a car, or access to a car, may disproportionately worsen existing levels of individual deprivation and exclusion, particularly for less advantaged groups.

6.26 There is some evidence that using public transport may help otherwise inactive groups to become more physically active, but whether measurable health benefits would be realised from this potential increase in walking to and from stops is not known.

**Personalisation of budgets**

6.27 Standard economic theory implies that the label of a particular (cash) transfer should have no bearing on how that transfer is ultimately spent. That is, the recipient of a (cash) transfer with a suggestive label is expected to react in exactly the same way as s/he would have reacted had he been given a transfer of equivalent value with a neutral label. That is to say that an economist would not necessarily expect, for example Child Benefit to be spent on children, or personalised budgets on buying care, but that it could be spent on other things within a family. In light of doubts regarding “correct” utilisation of personal budgets and concerns around “buying the service it is intended for”, Beatty et al (2011) tested the hypothesis and found that with regard to the UK winter fuel payment, exploiting sharp eligibility criteria provided robust evidence of a behavioural effect of the labelling. That is, on average, households spend 41% of the payment on fuel, whereas if it was treated as cash, the expectation would be of only 3% spent on fuel. This suggests that together with appropriate eligibility criteria, labelling of cash transfers does lead people to spend most of the sum on the purpose for which it was intended.

**Finance and debt**

6.28 There is little doubt that the economic crisis is having a grave impact upon those in poverty; but it is the policy decisions on the austerity packages that could have a catastrophic long-term impact on poverty and social exclusion, irreversibly damaging welfare systems and universal services (Jones 2010). She observes that while there have been some short term positive austerity measures, there is a danger of a dwindling focus on those already excluded from the labour market, with a long-term erosion of the quality of work combined with a lack of proposals for investment in quality jobs. Over-indebtedness is a major issue for many European countries, including the UK, not just due to excessive housing costs, but also related to energy and fuel costs.

6.29 As also identified by Dreaves (2010), Jones goes on to say that lack of access to fair credit is making people in poverty easy prey to loan sharks who charge exorbitant interest rates, often combined with unscrupulous and aggressive recuperation methods.

6.30 In a HIA of the Speke Paylink Project, Dreaves proposed that financial exclusion is a significant determinant of health. The literature review showed that tenants, disabled people, those with mental health (MH) problems and their carers, people living in disadvantaged areas, minority ethnic groups, homeless, older people, women, those with Post Office accounts or basic bank accounts were all vulnerable groups for financial exclusion and less likely to be able to make good financial management decisions and access suitable financial products and services. Low income is an exacerbating factor for all the groups, but particularly for disabled and older people.

6.31 Some 50% of those entering custody may have problematic financial circumstances, so a significant portion of the work of the criminal justice system has been giving money advice, which has brought several benefits, not least in reducing workload, but also
benefitting offenders for example by maintaining family stability, avoiding homelessness and re-offending, reducing stress related health problems.

6.32 There is clear evidence from the third sector regarding the need for specialist debt advice, which was found in 2009 to be the primary issue in Citizen Advice Bureaux (CAB) nationally, with enquiries increasing exponentially. For example, over 50% of new referrals to CAB had four or more priority debts (mortgage or rent, fuel bills, council tax). 10% had ten or more credit debts. 45% of homeowners had mortgage or secured loan arrears, two thirds of which were in priority need for re-housing. A third of homeowners spent at least half their monthly income on housing costs. 43% of clients were defined as in fuel poverty (because they spent more than 10% of income on fuel), with half defined as in water poverty (because they spent more than 3% of their income on water). Nearly two thirds had no spare money to pay their credit debts.

6.33 There is evidence from Scotland of a burgeoning market for commercially provided for profit debt advice. Since low income exacerbates the debt experience of all vulnerable groups, seeking such advice (at premium rates) is likely to increase financial and social exclusion. Those on low incomes often have good budgeting skills out of necessity, but macro-economic factors often negatively impact upon on low incomes, those aged over 60 years, social tenants and single adults living alone, in effect “tipping them over the edge” of their ability to maintain repayments – there is a strong link between levels of financial stress and whether people think they would be able to manage to make ends meet with the loss of a main wage.

6.34 Low income groups, including those with learning disabilities or mental health problems can lead to a reliance on sources such as home credit and doorstep loans, mail order, sub-prime credit cards, pay day advances and cash converter lenders.

6.35 There is also evidence that it is not the size of the debt, but the level of anxiety about debt that is often the trigger to access support. Older people have been found to not usually consider contacting organisations such as CAB, but are more likely to pick up information in primary care settings. MIND also recommended that professional staff should be trained for brief advice and signposting to services; that debt advisory services should be accessible in health settings, with improved debt advice services in the community. Linked to this would also be optimal uptake of benefits, especially for the usually under claiming elderly, although it is noted that this may still not bring them up to an adequate minimum income standard for acceptable day to day living (unless they are in receipt of pension credit).

6.36 Taylor et al (2011) found that for both men and women, low financial capability has significant and substantial psychological costs over and above those associated with low income or deprivation. For men, the size of effect is similar to that associated with becoming unemployed and for women, with being divorced. Their work suggests that improving people’s financial management skills would have substantial effects on stress-related illnesses and the outcomes associated with such problems, bringing lasting benefit for individuals and the wider economy. Improving financial capability will also have wider impact through improving psychological health. The sizes of these improvements in psychological health dwarf those associated with raising household income, suggesting that the ability to manage income is more important than the level of income in determining psychological health.

6.37 Fondeville et al (2010) found that although older people over 65 are less likely to have high levels of debt than other age groups, it is a sudden drop in income that seems to be an important cause of a high level of indebtedness, especially for those with low incomes before the drop occurred.
Digital exclusion

6.38 Age UK/Fujitsu (2011) have published a report “Online government services and the offline older generation” that provides a detailed picture of the current status of the IT relationship between local authorities and older service users. While there is no doubt that older people agree that internet use is a way forward and many would be interested to utilise it, 60% of people aged over 65 do not currently use the internet. 55% of local authority members who responded believe that internet access is not difficult and 86% believe its’ use will save councils’ money. They seem unaware that over 60’s are not advocates of their online channels and would be unwilling to switch in future. 73% of older people would still visit or phone their council, even if more services were available online, especially to maintain face to face contact.

6.39 The report notes that the barriers to internet use among the elderly are not insurmountable, but in difficult financial times when older people are likely to be hardest hit by public sector cuts, with cost identified as a barrier, may be slower to progress. Other barriers include the confusing complexity of the material available and speed of communication, concern over lack of “digital” skills (no mention is made of literacy and numeracy issues, which will be of relevance in Liverpool, in the summary report), fear of the unknown and concerns about security. The wider social dimension is very important to older people who fear the loss of face to face interaction skills for themselves and indeed, younger family members.

6.40 Other findings are
- 74% of older people do not have internet access at home
- 18% of older people have ever used the Directgov website
- Only 8% of older people might consider using the internet to pay council tax
- 93% of older people are unlikely to apply for pension credits online

6.41 The report concludes that there is a large percentage of the population (older people), a potentially vulnerable group already recognised as a low internet user group, that could be alienated by a push towards online-only channels for government services, unless this is given careful consideration. They recommend the use of EU Procurement Directives to demand that inclusive design is included for goods and services, especially for those in later life. They call for strengthened consumer protection against computer fraud to allay fears about going online. Government is recommended to continue to provide alternative methods other than the internet for the delivery of public and essential services, at least until such time that the digital gap is narrowed and traditional or legacy service channels can be “switched off”.

Other HIAs

6.42 A search of the publications database on the HIA Gateway and informal discussions with HIA expert colleagues elsewhere in the UK reveals that as yet, few HIAs have been published related to the topic, other than a review from WHIASU (Elliott et al, 2010).

6.43 Looking back to the still current effects of recession in Wales in the 1980’s, Elliott et al note that the social and associated health impacts can lag long after (some thirty years) even a short period of economic recession and these can be uneven, affecting particular groups and places more than others. They make ten broad recommendations based upon their review to support future decision making, rather than detailing what should be protected, cut or merged. These include:
• Strengthen the consideration of public health outcomes in all policy areas within Welsh Assembly Government, with resources focussed on those determinants that support good health and prevent avoidable illness
• Implement flexible active labour market programmes to support people entering, re-entering or staying in satisfactory employment in parallel to maintaining and generating good health.
• Encourage employers to develop strategies and approaches that address uncertainty, anxiety and job stress
• Protect and develop services to support vulnerable children and young people
• Address personal debt through the regulation of doorstep lenders, promoting other sources of credit and protecting advice services (see also Dreaves, 2010)
• Identify models of effective mental health support at primary care and community levels
• Identify mechanisms for pooling resources across localities for maximum health benefit
• Adopt HIA approaches as part of the public spending review process
• Evaluate active labour market programmes in terms of their impact upon health
• Monitor the impacts of social and economic change.

6.44 Kentikelenis, Stuckler and McKee (2011) in a report in The Lancet draw attention to the emerging health impacts of the financial crisis in Greece, with data and conclusions used to highlight their plight at EU level, in a press release circulated by EuroHealthNet. This notes that there has been a marked reduction in accessing medical care that is reflected in supply-side problems such as cuts in hospital budgets of 40%, understaffing, occasional shortages of medical supplies and bribery used to queue jump in overstretched hospitals. Despite this, hospital admissions rose by 24% in the year 2009-10 and by 8% in the first half of 2011, compared to 2010. 14% of citizens report that their health is now “bad” or “very bad”. Suicides have officially risen by 17% (and unofficially by 25%), with a 40% increase in the first half of 2011, compared to 2010.

6.45 Observing the usual reductions in alcohol consumption and reported drink driving associated with recession, there are other alarming data quoted, such as almost two fold rises in violence, homicide and theft rates; 40% reduction in obtaining sickness benefits due to budget cuts, significant increases in HIV infections, a large proportion of which are among IV drug users. Heroin use has risen sharply, with cuts of a third in street programmes.

6.46 Plainly, with resources scarce, there may be fewer commissioned HIAs, but there is evidence in the literature (Hawe, 1997) that when resources are scare that is the optimal time to build HIA capacity, as demonstrated by the commitment of the LCH HIA working group.

6.47 There is also anecdotal evidence that Mental Wellbeing Impact Assessment (MWIA) using the MWIA Toolkit for Wellbeing http://tinyurl.com/6nfywfm is being utilised in many areas of the UK to capture stakeholder evidence and present recommendations to decision makers.

How the future might look

6.48 Humphries (2011) observes that the interdependency of social care and NHS resources makes difficult evaluation of their differential impacts, however investment in services likely to reduce the need for NHS care and its duration (such as intermediate care) and prevention and early intervention services that reduce the need for healthcare could improve effectiveness. Single or shared assessment frameworks (for which Miller and Cameron 2011 have found positive evidence), integrated local teams and integrated care pathways could also contribute to this, as would organisational arrangements (pooled budgets, integrated commissioning, joint appointments and shared back office functions
(ultimately in newly established care trusts). Local culture and leadership is key, with personal chemistry between key local players, quality of relationships between people and organisations and the time needed to build up trust crucial.

6.49 Evidence from the literature is cited showing that emergency response/integrated care services, of which there are numerous models, can reduce hospital admissions and unplanned entry into long term care. The positive effects of rehabilitation and reablement services, when coupled with telecare, aids, community equipment and physiotherapy or occupational therapy have been identified up to two years after an intervention, but it is not clear whether increased investments beyond a certain point will necessarily produce further benefits.

6.50 Although evidence about what works in prevention is weaker than in more established policy areas, Humphries cites a systematic review of a range of early intervention services (such as POPP – Partnership for Older People Projects, Supporting People and LinkAge Plus) showing that resource savings up to £2.65 for every £1 spent can be achieved and commends these models to NHS commissioners and councils for future utilisation of the funding allocated within NHS settlement to support social care.

6.51 There is emerging evidence that investment in good primary care health services (dentistry, podiatry, incontinence, dehydration monitoring, falls prevention, stroke recovery) may reduce demand for both social care and secondary health care, but a clearer understanding of the reciprocal impact of NHS and social care investment and activity is needed.

6.52 Financial allocation arrangements currently produce competing pressures between national NHS priorities and localist approaches in local government. A unified view of funding is needed to achieve local alignment of these resources around people’s needs.

6.53 A better shared understanding of an analysis of local needs, drawing upon the experience of people who use health and care services will be essential in order to understand how best to utilise current financial allocations, through transfer to the local authority.

6.54 Based upon an improved understanding of local needs, it is thought likely that local resources could be much more closely aligned and focussed on outcomes through care pathways at a whole system level.

6.55 Health and Wellbeing Boards have an opportunity to take an overall view of how resources are used across all parts of the local health and care system and to what effect.

6.56 Councils and their NHS partners should:
- protect existing achievements, such as jointly funded services and other Section 75 agreements and see how these could migrate to GP consortia with options for further alignment of resources using place-based budgeting and other approaches
- identify local pressure points, for example, continuing care, emergency admissions of older people and special placements, and see how these will be monitored and managed with jointly agreed contingency plans for winter pressures
- develop a better understanding of how resources are being used across the health and care interface and how local performance, costs and outcomes look against national comparators with a set of shared metrics to manage and measure performance to inform the joint strategic needs assessment
• agree how the local allocation of the £1 billion assigned to the NHS to support social care can best be used to enhance health and social care outcomes by indentifying those areas of NHS investment in social care that will have the greatest impact
• ensure that these actions are driven by open dialogue and conversations between local leaders including key players in GP consortia so that system leadership is not lost in the transition to the new structures.

6.57 Humphries and Curry (2011) state that integration of health and social care services has been a policy aspiration for 40 years, but patchy progress and a now transformed policy and financial climate demand new ways of achieving them. Significant opportunities exist now to improve how these services work together to achieve better outcomes, but some aspects of reform could undermine existing achievements and make integration harder in future. There is uncertainty about the impact and a number of scenarios are possible (integration, a fragmented system, stasis, or combinations of these).

6.58 Future integration will be driven clinically and locally, with less reliance on national policy drivers, although it is unclear if it will be possible to avoid local variations in service and local management of poor performance. New commissioning arrangements, including “any willing provider” may make integration harder. They report that although there is presently optimism and energy to address the revolutionary scale of change, there are risks as well as opportunities. The success of service integration at local level will depend upon a number of factors:
• the scale and pace of change in the transition to the new arrangements, which in some places could undermine local achievements in bringing services closer together
• the extent to which GP consortia are committed to partnership working and how they can be supported to embrace their new roles
• the ability of health and wellbeing boards to promote integration through exerting local influence and leadership and whether they will have sufficient powers to do this
• how far financial pressures will promote the shared planning and use of resources or conflict, for example cost-shunting
• the unknown impact of market mechanisms of choice and competition and whether this will result in disintegration rather than collaboration between providers and commissioners
• whether three separate outcomes frameworks for the NHS, adult social care and public health will offer sufficient incentives for aligning services around the needs of people rather than organisations.

6.59 Box 4 (over) shows the results of a survey of PCTs and local authorities, identifying the factors thought likely to promote or hinder local integration. With the exception of changing leadership, Humphries and Curry observe that the top hindering (disabling) factors are national, while the top helpful (enabling) factors are local.
### Box 4

#### Factors helpful to and hindering local integration

<table>
<thead>
<tr>
<th>Helpful factors</th>
<th>Hindering factors</th>
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<tbody>
<tr>
<td>Friendly relationships (35)</td>
<td>Performance regimes (40)</td>
</tr>
<tr>
<td>Leadership (31)</td>
<td>Financial pressures (34)</td>
</tr>
<tr>
<td>Commitment from the top (26)</td>
<td>Organisational complexity (30)</td>
</tr>
<tr>
<td>Joint strategy (24)</td>
<td>Changing leadership (26)</td>
</tr>
<tr>
<td>Joint vision (24)</td>
<td>Financial complexity (22)</td>
</tr>
<tr>
<td>Co-terminosity (20)</td>
<td>Culture (19)</td>
</tr>
<tr>
<td>Additional funding (16)</td>
<td>Commissioning (15)</td>
</tr>
<tr>
<td>Patient and user focus (14)</td>
<td>National policies (14)</td>
</tr>
<tr>
<td>Frontline staff commitment (13)</td>
<td>Local history (14)</td>
</tr>
<tr>
<td>Joint commissioning (13)</td>
<td>Data and information technology (14)</td>
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<tr>
<td>Central guidance (13)</td>
<td>Planning (12)</td>
</tr>
<tr>
<td>Joint appointments (11)</td>
<td>Workforce (11)</td>
</tr>
<tr>
<td>History of success (11)</td>
<td>Other (3)</td>
</tr>
<tr>
<td>Other (5)</td>
<td>Numbers in brackets show the number of reports of this factor in the survey. (NHS Confederation 2010)</td>
</tr>
</tbody>
</table>

#### 6.60 Ruane (2010) reiterates some of the points made by Humphries and Humphries and Curry, identifying that the key to any efficient and sustainable system is coherence, so that actions do not conflict and mixed signals are avoided. She cites resource allocation mechanisms as a way of ensuring that access by users to services align with stated policy objectives. Examining the current situation in Ireland, her expert group found that the present system lacks coherence, is not fit for purpose and is not sustainable. Like England, Ireland needs a system that covers national policy setting and local delivery, standards of care and clinical pathways, capital and current spending and integrated care delivery, both public and private.

#### 6.61 Expressing optimism that now is the opportune time to reform resource allocation and financing systems to achieve, she notes that crude cuts made now may generate disproportionate losses in healthcare and a growth in hidden costs elsewhere and so should be viewed in a whole system context.

#### 6.62 Among a comprehensive list of recommendations from her expert group are:

- a common framework incorporating all dimensions of health and social care expenditure, populated by the best available data so that decision makers can openly and transparently confront the impacts and costs of their actions
- Population health needs allocation model with top-slicing for public health campaigns, high level education and training, research and national specialities (where there is only one)
- Greater use of individualised solutions to meeting care needs in the community and continuing care sector
- Agreements with trade unions with regard to workforce flexibility to allow for transfer of resources within and across local areas to meet health-care needs in a cost-effective manner
- Coherent structure of entitlements to primary and community care services and drugs, with user fees and drug co-payments to encourage appropriate patterns of service use. Primary care providers receive appropriate capitation payments to co-fund entitlements to services registered with them. Public subsidies supporting those with high levels of need for services and related more closely to incomes
- User fees reduced where they are likely to deter service use or place a heavy burden on sick people, where they make it difficult to put in place integrated care models, or where they incentivise inappropriate use of secondary care when primary care would be
appropriate – achieved by re-categorising groups into higher categories in a coherent funding framework

- Ensure full costs in relation to health care are fully counted and understood, with data on health accounts placed in the public domain
- Staff contracts in the health and social care sector simplified and standardised, configured to ensure the delivery of accessible and integrated services across all sectors.
- Ensure that governance systems are in place, with no gaps that could leave the system exposed
- Evolve performance management with a limited number of indicators to focus on what is considered priority, the key cost and service drivers

6.63  Humphries (2010) writing for the Dartington Hall Trust generated four possible scenarios for social care by 2020. These are described as a “residual service” with publicly funded services for poor people being poor services, with which the public are dissatisfied, alongside a resurgence of interest in the third and private sectors; “incremental betterment” with political stability, expansion of individual budgets and market diversification, telecare developments, continuing public spending restraints and rising pressures on NHS and recession-generated demand; “care crunch” with some of the features of incremental benefit, but demographic and other pressures bringing the system to point of collapse; “transformed wellbeing” whole system superceded by universal offer and a new model based on partnership (a la Wanless) or social insurance principles.

6.64  It is interesting to note that both scenarios three and four require political stability post 2010 General Election. In a postscript (pre-election) Humphries notes that adult social care is not protected from budget reductions, with access to publicly-funded care likely to become increasingly restricted, citing the evidence and benefits of a whole systems approach to the use of health and social care resources in an integrated way.

6.65  Harvey et al (2011) reporting a simulation exercise based upon the health and social care needs of older people and those with mental health problems reiterate that there needs to be a complete rethink of how entire health and social care systems use their combined resources, identify legacy issues (Table 2) in such transformation and tensions that exist in doing this.

<table>
<thead>
<tr>
<th>Issues</th>
<th>Opportunities for improvement</th>
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<tbody>
<tr>
<td>Joint Strategic Needs Assessments provide insufficiently granular information to really inform decisions about future investment of health and social care resources</td>
<td>Information needs to be available for different levels of aggregation – from whole council areas to neighbourhoods and GP commissioning consortia areas. Information also needs to be shared across organisations more freely. There should be greater use of predictive modelling of trends in needs and demand linked to resourcing and capacity requirements.</td>
</tr>
<tr>
<td>Too much public money is tied up in buildings</td>
<td>There is scope to realise savings by reducing duplication in assets, both within the health sector and between health, social care and other public services. These assets can be redeployed to provide a new source of revenue income. NHS trusts can consider renegotiating the terms of private finance initiative (PFI) contracts to give greater flexibility in planning how they use space.</td>
</tr>
<tr>
<td>Voluntary sector organisations have had their funding cut and feel they are being forced to choose between their roles as advocates and service providers</td>
<td>In many places, the voluntary sector is quite fragmented. While cuts to voluntary organisations may be a somewhat short-term response to achieving the necessary budget reductions, councils and health and wellbeing boards can consider how they can help voluntary organisations to reduce their operating costs and overheads by sharing infrastructure and back office support and improving management systems.</td>
</tr>
<tr>
<td>The drive to improve procurement processes and contracting can inhibit collaboration between suppliers</td>
<td>Competition can be a lever for service improvement, but the procurement process and contract incentives can also be designed to encourage providers to collaborate with each other so that they can combine to offer a more integrated approach to meet client and carer needs.</td>
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</table>
Approaches that engage local citizens in decisions about budget reductions reach a limited section of the community and have not always been transparent about the case for change.

The new focus on the Big Society is an opportunity for more mature, deliberative dialogue with citizens and communities. Devolving some resources and responsibilities to neighbourhoods can also provide the basis for greater engagement.

Health and social care regulators focus on organisational performance rather than on impacts and outcomes for service users. The standards used to assess community foundation trust applicants are proving a barrier to service integration.

The performance regime will shift when Monitor’s role is focused on economic regulation. With both regulators covering health and social care, there are opportunities to align the outcomes and operating frameworks with regulatory levers and incentives. There is a case for a single outcomes framework covering health care, social care and public health.

6.66 In their advice to health and social care and support systems, providers of health and social care are advised to recognise that the combination of competition, personalisation and choice will require them to be more flexible in the way they design their services so that they can deliver both quality and productivity improvements. They should:
- Build better skills to gain a deeper understanding of customer needs and the impact of services on their experiences and outcomes
- Begin to market services directly to customers so that they can understand what is available and how it can address their needs
- Make links with other providers as supply chain partners who together can offer an integrated approach to meeting people’s care and support needs.

Asset-based approaches

6.67 Foot and Hopkins (2010) produced a report describing for local authorities the asset-based approach to tackling health inequalities, containing a forward describing the priority being given to this in the North West. There is evidence that such approaches can improve a community’s efficacy in addressing its’ own needs and its’ capacity to lever in external support, succinctly described below.

Table 3 Moving from a deficit approach to an asset approach

<table>
<thead>
<tr>
<th>Moving from a deficit approach to an asset approach</th>
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<tbody>
<tr>
<td><strong>Where we are now – the deficit approach</strong></td>
</tr>
<tr>
<td>Start with deficiencies and needs in the community</td>
</tr>
<tr>
<td>Respond to problems</td>
</tr>
<tr>
<td>Provide services to users</td>
</tr>
<tr>
<td>Emphasise the role of agencies</td>
</tr>
<tr>
<td>Focus on individuals</td>
</tr>
<tr>
<td>See people as clients and consumers receiving services</td>
</tr>
<tr>
<td>Treat people as passive and done-to</td>
</tr>
<tr>
<td>‘Fix people’</td>
</tr>
<tr>
<td>Implement programmes as the answer</td>
</tr>
</tbody>
</table>

6.68 Techniques that could help develop asset-based approaches to improving community health and wellbeing include asset mapping (i.e. an inventory of resources, skills and talents of individuals, associations and organisations, collating links between the community and agencies); asset based community development (i.e. community building based upon asset mapping to build social capital and civil society); appreciative enquiry (i.e. a process to value and draw out the strengths and successes in the history of a group, community or organisation to create a realiseable vision for the future and a commitment to take sustainable action); participatory appraisal (i.e training community members to research the views, knowledge and experience of their neighbourhood to inform needs assessment.
and set priorities for future plans); open space technology (i.e. "whole system" open-ended discussion events, with a market place of conversations that each make recommendations and say how and who will implement them).

6.69 An assets alliance was launched in Scotland by the Scottish Government in 2010, with a base of some 23 demonstrator projects. Its outcomes were identified as:
- Policies and strategies should demonstrate an assets based approach.
- Workforces deliver to communities in an equalities sensitive, person centred manner
- Disadvantaged communities are fully and meaningfully involved and feel as difference to their quality of life.
- Measures and targets are in place that reflect that disadvantaged communities are supported to reach their potential in ways that are appropriate to them.

6.70 More recently, Nelson et al (2011) have produced guidance on the development of a method for asset-based working, citing examples from four pilot sites, of which Liverpool is one, together with Central and West Lancs, Cumbria and Stockport. Examples of other good practice cited by Nelson are in Knowsley, Blackburn with Darwen, Manchester, Halton and St Helens, Wakefield, Salford and Gateshead.

6.71 This guide makes it clear that an asset is both acceptable and available, going well beyond merely a directory, map, or register of what is out there. These may include assets, but many do not have usefulness to users as a criterion for inclusion, which is key. Nor do they usually include the strengths and skills of individuals and informal community networks. Such service directories often have an assumption of being “free”, at no cost to users. This could be an issue for potential users and the agency providing the asset should be referenced and this made clear. Timeliness is crucial. Connectivity, “hearts and minds” and organic growth (i.e. the “how” will be more important than traditional models of change.

6.72 Liverpool is a leader in this, with a member of the Steering Group for this HIA being a contributor to the guidance and a member of the North West asset based working steering group, the latter having produced a short paper (Stansfield et al, 2011) on how asset-based approaches will be intrinsic to new ways of working with crucially, the centrality of communities in public sector planning and provision. Appreciative enquiry and community participation approaches to improve heart health in Liverpool are cited.

6.73 Writing for the NHS Confederation, Stansfield et al (2011) have identified how wellness services might achieve efficiencies and improve outcomes. Wellness services are those focussing on health and wellbeing improvement, encompassing and integrating mental and physical health with wellbeing issues. They seek to empower individuals to maintain and improve their own health and have been shown to make savings in care costs, improve quality of life and enable independent living, underpinning behavioural change.

6.74 Segmentation models (a commercial marketing technique, often used to identify individuals or addresses for direct mailing and other targeted advertising) have been used to identify who uses local services and whether or not those who need services most are actually using them. This form of activity brings substantial savings in the commercial, e.g. insurance, sector by being able to cost efficiently and cost effectively target marketing interventions and bring significant returns for investment. These approaches are not new to health, but could be helpful at a local level. The briefing paper notes that wellness services are more cost effective as they align services and avoid duplication of service support structures.
Mental health and Long-term conditions

6.75 Naylor et al (2012) report a review of the research evidence relating mental health to long-term conditions and identify how integrated working, particularly strengthening the interface between mental and physical health care (at primary/social care and community level) can potentially improve clinical outcomes for conditions such as CVD, COPD and diabetes.

6.76 They found that the interaction between co-morbidities and deprivation makes a significant contribution to generating and maintaining inequalities, suggesting that better integrating mental health support with primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals, through collaborative care arrangements, can improve outcomes with no or limited additional net costs.

6.77 In terms of delivering effective care and support, they found evidence that
- debt advice and befriending initiatives for the elderly can be effective and deliver a return on investment in reducing mental health needs;
- that although both patients and practitioners tend to focus on physical symptoms in consultations, active case-finding (for example, of depression) could detect mental health needs among those with long-term conditions and as a consequence improve their self-management and demand for other services and support;
- integrating (not overlaying) programmes of mental health interventions into rehabilitation or chronic disease management programmes, with collaborative working between mental health and other professionals offer the best chance of improving outcomes and also offer opportunities for savings, with the costs of doing this outweighed by improved health and decreased service use;
- targeted referral of those with co-morbid mental health problems to self-management programmes will require additional support, for example from peers, but there is evidence that this can bring large benefits;
- enhanced forms of primary care provision, such as the collaborative care model advocated by NIHCE and implemented in Sandwell and Kensington and Chelsea, provide an evidence-based framework for sharing responsibilities between GPs and specialists.
- an enhanced role for liaison psychiatry could facilitate hospital discharge to independent living rather than institutional settings, reducing demand for social care and costs to the NHS (although there are practical barriers that need to be overcome around contractual matters, IT systems and confidence in information sharing)
- social support, public health, the voluntary sector and others working more closely together could help alleviate problems such as unmanageable debt by providing advice and support

6.78 The model of collaborative care implemented in Sandwell, cited as innovative good practice by Naylor, has several points consistent with the strategic intent of LCH and way of working in Liverpool. These include, for example
- “bottom-up” service redesign based on extensive community engagement
- systematic mapping of community and public service assets including the third sector leading to a more federated entity to provide a range of services
- building a culture of independence and self management, teaching problem solving and self-management skills, with the use of peer support and social prescribing
- transforming libraries into community hubs
- care management for people with complex needs.
Although there are presently significant policy and infrastructure barriers, the authors propose that redesigned payment mechanisms and incentives to providers in the short term could do much to encourage change, with future commissioners better placed to make standard the consideration of emotional, behavioural and mental health aspects of physical illness, based on a detailed understanding of the data, perhaps through disease registers.

The report recommends that service providers, should
- strengthen disease management and rehabilitation programmes through inclusion of psychological or mental health input
- consider the business case for investing in liaison psychiatry in acute hospital settings
- build mental health skills in primary care and other settings, using training programmes developed specifically for physical healthcare professionals
- make use of clinical tools and consultation techniques that normalise the discussion of the mental and emotional aspects of physical illness
- target people with long-term conditions and co-morbid mental health problems for referral to self-management support programmes
- provide people with long-term conditions with advice and interventions to prevent the onset of mental health problems.

They conclude that there is evidence clearly indicating that the current shift towards self-management and reduced demand for formal care is at risk of failing unless the challenges presented by co-morbid emotional or mental health problems (exacerbated by underlying deprivation) for those with long-term conditions are addressed. Developing more integrated support could improve outcomes and help the NHS meet the QIPP challenge. With a large and growing number of people with multiple health problems, the interface between mental and physical health care needs to be strengthened, with health professionals of all kinds equipped with basic mental health knowledge and skills. This needs a more enabling policy framework that values and rewards improved outcomes for those with combined mental and physical health problems.

**Disability**

Wood, Cheetham and Gregory (2011) writing for DEMOS collated freedom of information request responses from local authorities (LAs) to map and summarise how cuts to social care budgets affected disabled people. They found a shocking lack of local information on disabled people, but derived a ranking system for how well LAs are coping with cuts. This ranked Liverpool at 23rd out of 152 councils in England, with a level of medium cuts (prior to January 2012) and a good coping level. Interestingly, they note that across England and Wales, there is no clear urban/rural demarcation, nor does social deprivation (IMD) predict how well a council copes with cuts. They postulate that far from being a “postcode lottery”, the wide local variations suggest that it is a “minefield”, with life changing differences in levels of support between neighbouring areas posing a challenge to the localism agenda.

In terms of “solutions”, the clearest message is that among those authorities who cope best, protecting frontline services is an art rather than a science, with no one particular strategy predominant, or as yet proven. Features however do include common sense and practical approaches to involving service users in decision making and prioritising services that promote independent living. The authors identify strong “capabilities”, i.e. asset-based, approaches that create opportunities for co-production, i.e. a participating role in designing, planning and delivering the services used; integration of health and social care services (but there may be natural limits in how far this can go); progression and “just enough” support, that is towards independence and building social capital; personalisation and individual budgets seen not as a means of achieving cuts, but as an important driver in enabling users
to draw on their own resources and be creative in extending their package of support; and outsourcing to independent organisations, either “arms length” or becoming commissioning authorities.

6.84 Established integrated health and social care services, with pooled budgets and joint teams, including leisure and cultural services (Knowsley and Herefordshire); integrated services, a separate community services organisation delivering social care, adoption of personalisation and individual service user contracts for an independent living support service (Peterborough); integrated “whole person” support services with local community navigators assessing individual need, tailoring packages for individuals from combined services, coupled with low level and preventive support provided through a community interest company (handyman and gardening, befriending, benefits advice, mobile outreach), personalisation and direct payments (Hartlepool) are all exemplars of local authorities departing from traditional approaches, with a clear degree of protection for their disabled populations.

6.85 Darlington has built upon its strong partnerships with community organisations, shifting power to individuals and phasing change to assist the third sector in developing financial and non-financial means of offering support. Essex focuses on personalisation, progression and outcomes, combined with a commercial strategy for a more preventive, less crisis-driven social care provision, improving quality through personalisation and coproduction.

6.86 Sutton continues with its strategy to move most vulnerable residents out of residential care into supported living (purpose built flats in popular parts of the borough with good amenities and telecare wiring). It is interesting to note that they do however retain residential care for dementia sufferers.

6.87 London tri-boroughs have focussed on joint management, collaboration on procurement and service redesign. This includes a single commissioning organisation for adult social care and an integrated single provider organisation for social and community health services. The model is contested as to its sustainability.

6.88 Blaenau Gwent and Caerphilly adopt as similar approach to the tri-boroughs, but do not go as far, merging only social care commissioning and provision and workforce development. It is thought that they have greater co-terminosity and shared demographic characteristics than the tri-boroughs.

6.89 DEMOS has initiated a tracking study following disabled families through this Parliament. The first report by Wood and Grant, reveals the experiences of families living on the edge of uncertainty, financial stress and disability poverty, with financial debt already having increased between autumn 2010 and April 2011, prior to any further changes in benefits. Financial shocks (e.g. high utility bills, heating boiler breakdown, wheelchair battery replacement) were already being experienced by people with no savings to fall back on, leading to a shortfall in daily living costs and a “hand to mouth” existence. Mortgage arrears and warnings from lenders have already occurred. They anticipate this period as the calm before a storm, that is, only initial hardship, with the effects of unexpected impacts and further “cuts” only just beginning to be seen and too complex to model at this point in time. It is the uncertainty and vulnerability coupled with a lack of financial resilience that is the strongest message emerging to date.

Financial Strategies and cost effectiveness

6.90 The Audit Commission (2010) suggests that councils that work to a longer time horizon will be in a stronger position to test different income scenarios, find alternative
models for sharing local resources more effectively and increase the impact of their spending and influence. Strategic financial management over a longer period, based upon robust and easily understood information allows all staff to work efficiently towards shared objectives and can help overcome the constraints of short-term cyclical, process-driven approaches that are too inflexible during a period of rapid external change. Financial risk management could be improved. Self assessment tools and a checklist are provided for use by councils in their progress towards strategic financial management.

6.91 In a further report, the Audit Commission (2010) states (pre-election) that to tackle the financial implications of an ageing population, councils will need to better understand both the costs of their ageing population and of the savings from preventive and collaborative action. For example, small investments in housing and leisure can reduce or delay care costs and improve wellbeing. Demographics, data about older people’s preferences and information on the impact of preventive work should inform longer term financial planning. Engaging with older people can reveal information on what works and the value of support to independent living. Cheaper alternatives are often the services most valued by older people, their families and communities. The Commission recommends that councils:

- update their sustainable community strategy, financial and service strategies
- build older people’s views and experiences into plans for service delivery
- update commissioning strategies to reflect a future role in preventing, reducing or delaying health and social care costs
- work with partners to integrate prevention, early intervention and care services
- use delivery chain analysis to overcome obstacles to joint working to reduce need for hospital admission and high-level residential support.

6.92 In 2011, the Audit Commission went on to say that while large scale transformational change, to prevention, personalisation, building community capacity and independent community living is difficult, the pace of change has been slow.

6.93 They particularly note that savings from such strategies are uncertain and unlikely to be cash releasing, but will require good (and timely) data, leadership, and strong partnerships with housing, transport, leisure and NHS services. Initiatives such as more efficient and collaborative procurement processes, revised contracts, citizen assessor schemes, outsourcing services and refocusing on re-ablement have produced some efficiency savings, as has electronic monitoring of home care actually delivered.

6.94 Prevention initiatives, for example home repairs and befriending and early interventions such as reablement, telecare and intermediate care services are reported by councils as bringing efficiencies, but evidence of financial savings is as yet scarce. Despite some variation, there is evidence that people needed less or no care following reablement, although research findings show no statistically significant difference between those receiving reablement and those not. Back office and staff efficiencies have been commonly reported, but need careful consideration in order to appropriately monitor and provide intelligence as change progresses. Changing the balance of care to community services offers value for money to councils, as does personalisation, mainly not as a result of savings, but as a result of improved outcomes.

6.95 Partnership working, largely through co-location rather than joint commissioning (as yet) has brought some efficiencies, but this may be a benefit to a council at the expense of transferring costs elsewhere, for example to the NHS. Whole system integrated approaches will be required for the taxpayer to benefit. Assessment and care management, benefit maximisation and debt advice have also brought efficiencies.
6.96 All these interventions may be regarded as either transactional (largely traditional, often cash releasing, opportunistic and short term) or transformational (redesign, innovative, longer term, not always cash releasing, provide better quality of service to users). Transactional efficiencies need to be implemented well, transformational change and integrated approaches take time but can work well across organisational boundaries.

6.97 Owen et al (2011) have for the first time in England published a list of cost-effectiveness estimates for public health (preventive) interventions. They found that of two hundred base-case cost-effectiveness estimates analysed, 15% were cost saving, 85% cost effective at a threshold of £20,000 per QALY, 89% cost effective at a threshold of £30,000.00 per QALY. They conclude that the vast majority of interventions considered thus far by NIHCE are highly cost effective. They note that not all interventions are included in this first study, nor are those included prioritised in any way.

What older people want

6.98 Clarke, A (2011) identified that older people want and value “that bit of help”, ie low level support that promotes health, wellbeing and quality of life in the communities where they live. The benefits of this are realised over many years, making it harder to prove their impact and protect funding of often small scale initiatives in the face of immediate clinical need. She finds that cutting prevention will have long-term negative impacts, particularly for health services and that due to cuts in the community and voluntary sector, those groups who provide “that bit of help” may struggle to survive. It may become harder to find resources to involve older people in designing, delivering and evaluating services.

6.99 To support better outcomes for older people she proposes that involvement of older people can improve outcomes and effectiveness, using different and more affordable approaches; collective solutions to stimulate “that bit of help” in the community can provide the assistance needed to sustain the health, activities and relationships that are important to them; these solutions should be based upon what older people need, choose and have experienced and delivered through greater local connectivity in placed-based approaches that reflect the whole of people’s lives.

6.100 Bowers et al (2011) researched older people’s experience of support based on mutuality and reciprocity. In their interim report, the findings of which are informing current policy debates, they found that there is at present a prevailing perception (often from professionals) of older people with high support needs as being “passive recipients”, with some scepticism expressed about the degree of success likely to be achieved by their active participation in both giving, as well as receiving, support. However, there is interest and enthusiasm from older people and their families, who wish to understand what is involved and participate. A very wide variety of models have been examined, with key characteristics for success being flexibility and informality. The models focus on:

Mutually supportive relationships. This refers to personal, often informal arrangements developed between 2 or more individuals (often friends, neighbours or relatives). Whilst these are typically informal in nature, such arrangements may evolve and become more formal or organised over time, for example if one of the participants develops greater need for support than the other(s).

Mutually supportive communities / neighbourhoods. Mutually supportive communities are those ‘where people of all abilities live and work together, contributing whatever they can to the well-being of their fellow community members’. They are most often designed to help people develop social relationships and foster integration with the wider community, implying that these are often communities which are set apart from local neighbourhoods.
Co-housing developments. These are collective housing arrangements set up and run by their members for mutual benefit. Members are consciously committed to living as a community; developments are designed to encourage social contact and a sense of neighbourhood; common spaces facilitate shared activities like community meals; and other amenities like laundry, heating, transport, etc may also be shared. They are very much about the living arrangements and the mutuality of shared living experiences which may or may not include support.

Co-operative and mutual housing. An independent commission emphasised the characteristics of developments that are democratically owned, including managed housing, where those living in them ‘take more responsibility and feel a greater sense of belonging, identity and ownership’. Importantly, whilst some co-operatives include co-housing arrangements, not all co-housing arrangements are co-operatives. Shared costs and responsibilities for accommodation and contributions to the immediate neighbourhood / community are other key features. As above, these developments do not always involve aspects of care and support.

Homeshare. Homeshare schemes involve the offer of housing in return for help in the home which is arranged on an individual basis. Most Homeshare schemes in the UK are not for or about people with high support needs, although there is one example of a scheme in Bristol that involves people living with dementia (apparently this is a very informal arrangement). It is more common overseas than in the UK – especially in the USA, Spain, Portugal and Australia. It is currently unregulated and cannot involve personal care as part of the arrangement.

Shared Lives. The emphasis here is on the care arrangements and the carer, rather than the housing / community living arrangement. They are also mainly set up as individual rather than collective arrangements. Participants use the carer’s home as a resource, and the relationship between the person needing support and the person providing the accommodation and support is key. It is the largest form of support for people with a learning disability in Belgium. There are increasing numbers of Shared Lives carers in the UK, where it is regulated.

Timebanking. Time banking is a pattern of reciprocal service exchange that uses units of time as currency. A ‘time bank’, also known as a service exchange, is a community that practices time banking. The unit of currency (an hour’s worth of any person’s labour) used by these groups has various names, but is generally known as a time dollar in the USA and a time credit in the UK.

Circles of Support. A Circle of Support is a small group of people (often family and friends) who come together to help someone identify what they need or would like to do in their life, and then work out how to make it happen. Mutuality and reciprocity lie at the heart of successful circles, which can be formal or informal. Co-ordination and planning are also central to success, regardless of the formality involved.

Volunteering. Examples of volunteering included in this research are those where support is provided and received on a volunteer (unpaid) basis, typically through an organised scheme where the volunteer support is reciprocal in nature.

Peer support / mentoring. This refers to a range of approaches, groups and networks where members support each other on the basis of having shared experiences. This can include arrangements where people with more experience coach or mentor those with less experience.
Wistow et al (2011) undertook a case study to examine older people’s wishes and experiences of commissioning health and social care services. They conclude that stakeholders need to be empowered through the development of both individual and collective capacities and capabilities if they are to exercise genuine influence on commissioning. Hard to reach groups are targeted on an ad hoc rather than a systematic basis and issues tend to be approached individually rather than with a concern to identify and address the underlying causes. They recognise that there needs to be an agreement on the desired “destination”, with citizenship, as well as service user paradigms developed as part of the transfer of power to older people, suggesting that this can strengthen both commissioners and providers of services. There is as yet little evidence that involvement has resulted in participation in commissioning that has improved outcomes. They propose that older people’s groups may find that strategies other than straightforward “traditional” participation are more fruitful. For example, effective commissioning may be a condition of their participation in the process and using their resources in scrutiny and campaigning activity (rather than participating in commissioning) may be options.

Older people with high support needs

Considering those older people with high support needs, Blood (2010) found that low expectations and a service-centred approach, together with an ageist culture, communication difficulties and lack of opportunity to meet together are barriers to hearing the views of this group.

Factors identified about what makes life better for this group include “fresh air and roast potatoes” (ie low cost) actions. For example,

- continuity, personal identity and self esteem;
- meaningful relationships;
- personalised and respectful support;
- autonomy, control and involvement in decision making;
- a positive living environment: security, access, privacy and choice;
- meaningful daily and community life: making a contribution, enjoying simple pleasures;
- good accessible information to optimise health and quality of life.

Manthorp (2010) goes on to consider international good practice for innovation and better lives for this group. He found evidence of current good practice in advice services, such as

- First Stop telephone advice line that meshes organisations, Employee Assistance Programmes (e.g. BUPA, Westminster and Hampshire councils), usually for working carers, but by demand also supporting relatives of and older people directly. He notes that a “gold standard” book of advice for those in crisis would be helpful.
- Shared information for reablement and hospital teams to reduce assessment beaurocracy (e.g. Kent county Council, Cumbria, Rochdale and Lewisham), including budgetary information and a gateway to direct and individual budgets
- Befriending, peer support and counselling schemes, for example Counsel and Care, Contact the Elderly, Scottish Dementia Working Group, Lewy Body Society and the work of those such as Danuta Lipinska and Tom Kitwood are cited.
- Barriers remain with regard to these types of initiatives for BME groups, such as language (such as literacy in the first language, not just English), religious and cultural beliefs (such as the absence of a word for dementia in the main sub-continental languages), issues centred on attitudes to gender and simple preference to share memories with those whose memories, pastimes and assumptions are familiar. Monocultural support with a settings approach and language radio are featured, with more integrated projects where there are higher proportions of varied cultural backgrounds, such as Leicester and London.
• Attitudes to sexuality can be problematic, especially for older people with dementia who grew up in times of intolerance and legal restraint. Both the Alzheimer's Society and Age UK local groups are cited as exemplars.
• Advocacy projects, particularly provided by the Alzheimer's Society, are expanding, with high profile examples in Bradford and Croyden, being based upon good memory clinics and creative practice by enabled staff.
• Dementia management presents ethical challenges that require a well-focussed debate, but Nuffield Council for BioEthics take a robust approach to risk management and health and safety issues in order not to close down lives and reduce the quality of life.

6.105 LinkAge; extra care; retirement villages; residential care as part of a community; specialised housing for older people; floating (housing) support, similar to that provided by sheltered housing wardens, but for all older members of the community; equity release (while still maintaining benefit support); cohousing and co-operative housing; use of assisted technologies; are all cited as means of providing practical support.

6.106 Place shaping, that is shaping services (Hertfordshire and Manchester, London and Scotland) the street (Newcastle and Stirling University), transport and disability friendly travel (London and Hertfordshire) are cited as ways forward for those older people with high needs, the latter being considered essential for those who have adapted housing but can’t easily socialise outside it.

6.107 The Liverpool Care Pathway is cited as having had a noticeable positive impact on practice, which coupled with work around the hospice movement is bringing together best practice in end of life and palliative care.

Housing and Fuel Poverty

6.108 A global problem, Braubach et al (2010) produced for the World Health Organisation (Europe) methodological guidance for the quantification of health effects of selected housing risks. This work found that (per 100,000 population in Europe) low indoor temperatures can cause 13 deaths, exposure to second hand smoke 7 deaths and exposure to radon 2-3 deaths per year. Traffic noise exposure and lack of home safety features cause an annual loss of 31 and 22 Disability Adjusted Life Years (DALYs) respectively.

6.109 The evidence regarding the health impacts of Cold Homes and Fuel Poverty were summarised by the Marmot Review Team in 2011. With regard to older people, the main direct health impacts are:
• Countries which have more energy efficient housing have lower Excess Winter Deaths(EWDs).
• There is a relationship between EWDs, low thermal efficiency of housing and low indoor temperature.
• EWDs are almost three times higher in the coldest quarter of housing than in the warmest quarter (21.5% of all EWDs are attributable to the coldest quarter of housing, because of it being colder than other housing).
• Around 40% of EWDs are attributable to cardiovascular diseases.
• Around 33% of EWDs are attributable to respiratory diseases.
• There is a strong relationship between cold temperatures and cardio-vascular and respiratory diseases.
• Mental health is negatively affected by fuel poverty and cold housing for any age group.
• Cold housing increases the level of minor illnesses such as colds and flu and exacerbates existing conditions such as arthritis and rheumatism.
6.110 The main findings on the indirect health impacts of cold housing and fuel poverty and on other social benefits deriving from improved housing are:

- Fuel poverty negatively affects dietary opportunities and choices.
- Cold housing negatively affects dexterity and increases the risk of accidents and injuries in the home.
- Investing in the energy efficiency of housing can help stimulate the labour market and economy, as well as creating opportunities for skilling up the construction workforce.

6.111 The Marmot Review team went on to consider several population subgroups affected by fuel poverty and cold housing. They noted that there are measurable effects of cold housing on adults’ physical health, well-being and self-assessed general health, in particular for vulnerable adults and those adults with existing health conditions. For older people, the effects of cold housing were evident in terms of higher mortality risk, physical health and mental health.

6.112 Improving the energy efficiency of the existing stock is a long-term, sustainable way of ensuring multiple gains, including environmental, health and social gains. Government policy documents and reports recognise the tangible impact of cold housing and fuel poverty on people’s health and well-being.

6.113 Cold housing has a dramatic impact on cardiovascular and respiratory morbidity and on the elderly in terms of excess winter deaths. Fuel poverty has a stark effect on mental health across many different groups. Achieving minimum standards of thermal efficiency would have the strongest impact on the poorest households. Fuel poverty has already reached levels predicted for 2016 because of the underestimate in the rise in fuel costs; the current energy efficiency of existing housing stock is unable to mitigate such high increases. Major energy efficiency retro-fit programmes have been estimated to reduce fuel bills of the fuel poor by half, removing over 80% of fuel poor households from fuel poverty, as well as reducing domestic CO₂ emissions by over 50% and are the only long-term sustainable way of ensuring a number of multiple gains. This also represents a good lever to stimulate the economy and the labour market in relation to the green economy.

6.114 There is however, a clear contradiction between government recognition of the link between health and cold housing, its support for reduction of fuel poverty and CO₂ emissions and its lack of commitment to support this agenda. The impact of the funding cuts to local authorities on investment in fuel poverty and energy efficiency programmes is likely to be highly detrimental, especially in conjunction with other repeal of the Home Energy Conservation Act and other measures.

6.115 There is evidence that elderly home owners have made a trade off between energy use and thermal comfort, who found new controls difficult to use or were fearful of increased bills. This is also the case for some households who received help through the Warm Front programme, where preference was based on long-term adaption to low temperatures and lay beliefs of what constitutes a healthy temperature. Support and training is required for these households.

6.116 Where income is particularly low, or improvements are hard to implement, upgrading would still leave a number of households in fuel poverty. Financial support may be needed for these at-risk households, or indeed the standard for upgrading could be raised to high efficiency. It has been shown that once the trade-off issues for at-risk households are addressed, energy efficiency interventions always bring multiple health and environmental gains.

6.117 The messages of the Marmot review team are further reinforced by Goodman et al (2011) who undertook an analysis of EU-SILC data in Northern Ireland that showed that
there has been a consistent rise between 2007 and 2009 in the proportion of all older people who have gone without heating “at some stage in the last year”. It is believed that these data may under-represent the scale of fuel poverty experienced by older people. There is a cohort of people who are not managing on low incomes even with economies of scale. All the factors associated with fuel poverty, e.g. older property, less insulation and fewer efficiency measures, owner occupying and living alone, worsen through the age cohorts. Older people (and perhaps therefore, the defined population) may be more likely to be housebound to some extent and vulnerable to the effects of cold temperatures through aggravation of existing conditions.

6.118 They also note that as well as extending life expectancy alone, ensuring the quality of that life is essential to allow people to “age in place”. Stress due to anticipation of fuel bills for debt-averse elderly can lead to anxiety with diversion of income leading to loneliness and social exclusion, resulting in mental health problems. Recommendations include indoor exercise for the mobile elderly as a means of maintaining circulation, improving mental health and reducing falls.

6.119 A literature review of evidence undertaken for the North Mersey PCTs by the Public Health Observatory, Liverpool University (Winters et al, 2011) also includes an analysis of potential health impacts of the economic downturn, both positive and negative, shown in tables 2 and 3, with recommendations made for the joint commissioners.

6.120 With representation in the Steering Group for that piece of work, LCH demonstrates a clear commitment to evidence based and innovative activity, together with the laudable objective of minimising duplication and ensuring best use of scarce resources.

Table 4: Priority positive health impacts from the economic downturn

<table>
<thead>
<tr>
<th>Category of Influence</th>
<th>Predicted health impacts (Quantifiability of impacts (Q) qualitative; (E) estimable; (C) calculable)</th>
<th>Certainty of Impact</th>
<th>Definite (D); Probable (P); Speculative (S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leisure</td>
<td>Increase in leisure time as working hours reduced (Q)</td>
<td></td>
<td>P</td>
</tr>
<tr>
<td>Income</td>
<td>As income reduces a decrease in hazardous health behaviours such as alcohol and smoking these if these substances are not cheaply available (E)</td>
<td></td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Decrease in hazardous health behaviours (E)</td>
<td></td>
<td>P</td>
</tr>
<tr>
<td>Social Support</td>
<td>Decrease in traffic accidents and fatalities as less miles travelled due to cost of fuel (C)</td>
<td></td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>Members of social organisations are protected from adverse health effects of economic crisis (E)</td>
<td></td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Informal social welfare provides opportunities to borrow money, provides food, shelter, advice on sources of food (Q)</td>
<td></td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Crisis may offer possibilities to strengthen social capital, is protective of health (Q)</td>
<td></td>
<td>(S)</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>More people reported to be growing own fruit &amp; vegetables. (E)</td>
<td></td>
<td>(S)</td>
</tr>
</tbody>
</table>

Table 5: Priority negative health impacts from the economic downturn

<table>
<thead>
<tr>
<th>Category of Influence</th>
<th>Predicted health impacts (Quantifiability of impacts (Q) qualitative; (E) estimable; (C) calculable)</th>
<th>Certainty of Impact</th>
<th>Definite (D); Probable (P); Speculative (S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of income</td>
<td>Unemployed are almost twice as likely as population average to experience persistent poverty over a four-year period. (E)</td>
<td></td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Long-term unemployment can lead to poor mental health (C)</td>
<td></td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Job loss associated with increase in acute CVD (E)</td>
<td></td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>Alcohol abuse (E)</td>
<td></td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Rise in alcohol-related deaths (C)</td>
<td></td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Rise in suicides (C)</td>
<td></td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>Rise in fuel poverty (E)</td>
<td></td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>Rise in poor diets/food poverty (E)</td>
<td></td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Rise in households living in poverty (E), Child poverty increase (E)</td>
<td></td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Rising health inequality between rich and poor (E)</td>
<td></td>
<td>P</td>
</tr>
</tbody>
</table>
Young
Unemployment:
Can have a scarring effect on future employment prospects and wages. (E)
Parasuicidal episodes are up to 25 times more likely for unemployed young men.(C)
They are at a higher risk of getting mental health problems (C)  P

NEETs
Those with low skills more likely to be unemployed (E) and unemployment (from survey data) :
Can cause arguments with family (Q)
Drove some to drugs & alcohol (Q)  P

Vulnerable groups
Disabled, ethnic minorities, those living below the poverty line, some women and single mothers (and their children), older people – normally at a disadvantage, their health can be further compromised & suffer an unequal recovery. (E)
P

Ethnic minorities
Rise in unemployment or working in precarious insecure, low paid employment. (E)  P

Education
Efficiency savings in schools could impact on classroom behaviour and exam results. (Q)
Changes in funding may reduce women’s access to further/higher education (Q)  S

Social support
This is tested in economic downturns with different groups fighting for scarce resources (Q)
Economic downturn is probably increasing the social exclusion of vulnerable groups if they have to sacrifice social activities (Q)  S

Public policy
Austerity measures will impact most on poor and other vulnerable groups (E)  D

Public services
Increase in anti-depressant prescribing (C)  D
Reductions in LA funding to adult social care could increase isolation of vulnerable adults (E) and
increase hospital admissions and bed-blocking (C)  P
Increased use of specialist mental health services (E)  D
Increases in alcohol related hospital admissions particularly among young (E)  D

6.121 With specific regard to the defined population of this HIA and based upon an assumption that a substantial proportion are “older” elderly people, many living with limiting long-term conditions with some mental health co-morbidity, positive potential impacts are perhaps less likely than stated by Winters et al and would be regarded as possible and speculative rather than definite and probable.

6.122 Among the negative impacts, several are particularly pertinent to the defined population and based on the same assumptions, may be more likely to occur, being regarded as definite or probable. For example, loss of income for those coming out of work as “young” older people due to their own condition, or as a result of becoming a carer, or both; isolation and lack of social support, scarcity of resources for social support and sacrifice of social activity (e.g. costs of petrol/public transport/participation) leading to mental health problems, with perhaps rises in alcohol abuse and suicide; increases in fuel, food (and water) poverty due to reduced or loss of income or benefits; increased stress within families also coping with younger members seeking financial and other support; increased financial pressures leading to anxiety about debt and debt management, with those with mental health problems less likely to be able to manage their affairs; further compromise of the health of vulnerable groups, who are most likely to suffer unequal recovery; unequal burden of caring placed upon women; general impact of austerity measures and demographic trends will bring more older people into those who fall into high and complex needs categories; increases in hospital admissions, bed-blocking, use of specialist mental health services and alcohol related admissions are very likely to impact on the secondary and tertiary sectors (outside the scope of this HIA), at a time when hospital bed numbers are decreasing, putting a higher premium on the success of out of hospital initiatives.
7 Evidence from Stakeholders

Introduction

7.1 This section presents the evidence gathered from stakeholders, including evidence gathered from staff using online methods and key informants. Stakeholder evidence can be particularly valuable in identifying specific local issues that may result in or affect health impacts. Professional key informants (“experts” or “specialists” in the field) bring a wider view and a degree of validation.

Background

7.2 Liverpool City Council has undertaken a number of consultation events, particularly with regard to potential changes in eligibility for adult care services, but these have had a very specific focus and utilised scenarios for discussion. As such they are of crucial importance, but are concerned only with a part of the range of services included in the scope of this HIA. Statutory consultation processes rarely capture stakeholder evidence intended to accentuate positive potential impacts and mitigate potential negative impacts, with recommendations made by stakeholders.

Stakeholder Workshop Format

7.3 The aim of the workshop was to offer community stakeholders the opportunity to consider and share views on the potential impacts of the service changes proposed by Liverpool City Council on their health and well-being.

7.4 This was achieved by the following objectives

- Providing information about the main elements of the service changes and the HIA project
- Facilitating focus group discussions considering
  - The potential effects of the service changes on health and well-being
  - How those effects could be managed to ensure that opportunities to improve health and well-being are maximised and how any potential risks to health and well-being could be minimised.

7.5 The commissioners of this HIA recognised that it was important to invite a wide range of groups to attend the workshop in order to gather as many views and experiences about potential health impacts from various perspectives as possible.

7.6 The original scope of this assessment included three stakeholder workshops for community participants and representatives of Liverpool organisations. A sample frame is defined from information sources available in the public domain, such as databases of community group contacts found on voluntary sector websites (Dreaves, H., Pennington, A., Abrahams, D., 2007; Abrahams, D., Dreaves, H., Pennington, A., 2007). In this instance, such a single source database with contact details was not accessible in the public domain. In discussion with Liverpool Council for Voluntary Services (LCVS), a sample frame of 510 community groups was defined, from three network streams, senior citizens (117 groups), disability (215 groups) and health and social care (178 groups). LCVS was unable to provide a database base for direct despatch of invitation letters by IMPACT, but circulated a flyer to each of the 510 groups, thus creating an indirect means of seeking community engagement.

7.7 Usual good practice in HIA is to send an invitation letter, giving some three weeks’ notice, for a nominated representative from each group identified to attend a participatory workshop.
A total of 510 organisations and groups were circulated with an invitation to nominate a representative to attend one of three "geographical" workshops to be held for stakeholders at the end of November into December. Responses are accepted on a first come, first served basis, with as a contingency, numbers constrained only by the Health & Safety capacity of the workshop venue. Given the high degree of public concern and turn out during a separate, but related, public consultation earlier in the year, it was thought prudent to make best use of resources by postponing the planned three half day workshops when responses were unexpectedly minimal.

The LCH HIA working group considered the possible reasons for this level of response, the principal being the now indirect nature of the invitation. The group proposed circulation of a revised flyer through intermediaries known to the Trust and other organisations, such as housing associations, for a single workshop to be held at a central city venue early in 2012. Evidence regarding the extent of digital exclusion, both among older people and in deprived areas is discussed in section 6.

Using contact details available in the public domain on Liverpool City Council website, twenty one local housing associations were circulated with a revised invitation flyer, giving a months' notice, to residents to attend the workshop. The ten PCMS GP practices associated with LCH were also circulated and the three PCT Neighbourhood Managers were also asked to appropriately circulate the flyer and information.

Relative to this circulation, it was noted that despite the apparent ease (and minimal cost) of electronic communications and the potential for wider unknown dissemination of them, all organisations are now seeking to minimise printing on economic grounds (not just for reasons of sustainability) and it was unlikely that there would be sufficient "market penetration", i.e. reaching of the intended target group, by displaying for example a single flyer on a practice waiting room noticeboard.

Ten enquiries were received in response to this second circulation, demonstrating that there has been wider dissemination of the information. A total of eight attended the stakeholder workshop held on 12th January, 2012.

The programme for the workshop was modelled on tried and tested HIA best practice. Following an introduction and presentation from IMPACT describing Health Impact Assessment, a presentation about the proposed service changes was given by a council representative.
Evidence from the Stakeholder Workshop Group

Issues that affect health

7.14 Health Impact Assessment uses a broad social model of health based upon the model shown in Section 3 that shows the main determinants of health as layers of influence and demonstrates that health is affected by a range of factors (Dahlgren and Whitehead, 1991).

7.15 Following brief presentations on HIA and the proposed service changes to be considered by the City council, participants were invited to note down on Post-Its as many issues, concerns or factors about the changes that they thought were of relevance to their health and well-being.

7.16 They were invited to put these under five headings:
- Age, genetics and biology
- Lifestyles
- Social and Community Networks
- Living and working conditions (including services)
- General socio-economic conditions, legislation and environment

Full details are presented in Appendix A.

7.17 Participants were then invited to identify emerging themes by clustering together the issues within each of the headings and give each cluster a name. From this they identified eleven themes, listed below, for further discussion in a focus group to be facilitated by members of the HIA working group.

7.18 The focus group identified eleven themes of interest to them. These were:
- Mobility x2
- Information/Advertising Services x2
- Crime/Antisocial behaviour x2
- Transport
- Waste and efficiency
- Social networks
- Non-English/Adult education
- Mental health/Learning disability
- Residential care/Sheltered housing
- Service uncertainty
- Risk or opportunity? (This was clarified as a reflection that the need for service changes in the city need not be only negative, but offer an opportunity for positives, such as innovative service delivery - for example, the use of new technologies and closer partnership working)

Potential health impacts

7.19 Stakeholders recognised that this was a substantial list for discussion within the time available in the workshop, but agreed to proceed “from the top”. An appraisal framework was made available to the group should they wish to use one, to record the discussions which were facilitated by members of IMPACT using the following questions:
- How might the health determinant change as a result of the service changes?
- Which population sub group(s) are most likely to be affected?
- How might the expected changes affect the health and well-being of those people?
- What do you think should be recommended as a result of what has been identified?
Appendix B details the tables presenting the discussions arising from the focus group. Proposed recommendations included:

- LCH should remind service users about their entitlements to screening, such as for breast and bowel, even though recall systems cease at age 70 years. This could be done in a similar way to the Flu Programme each year, through PCMS GP practices.
- It would be useful to provide clear information on which organisation provides what service, what is currently provided and for whom and who will provide what in future. This could usefully inform future commissioning groups who are not familiar or expert in providing information.
- LCH may not as yet be a widely recognised organisation and should seek to raise its profile in the community – a branding exercise is in progress.
- LCH managers should engage more closely with staff and service users to better understand the nature and challenges to volunteering and networking locally – staff should formally participate in this process.

**Evidence from the Staff**

Although the defined population for this HIA is Liverpool resident LCH service users aged 55 years and over, both the Steering and Working groups recognised the potential impacts of proposed service changes on LCH staff, particularly those working in client facing roles, who might wish to provide evidence on behalf of their clients with whom they have developed relationships, as well as in their own right.

As a rapid HIA, there was insufficient resource to equitably release staff to participate in workshop(s), although this would have been methodologically desirable. A number of methods were considered for their suitability to pose the same questions to staff as would be put to stakeholders and adequately capture their responses in a similar format. None was ideal, but the use of a freely available proprietary survey tool offered both a systematic approach that could be disseminated electronically to all staff and straightforward analysis.

Freely available Survey Monkey software allows up to 100 responses to be gathered. An online questionnaire was designed asking staff the same questions as those to be posed at the stakeholder workshop focus group, but firstly on behalf of “their” clients and secondly as staff members. This was distributed to all LCH staff through the staff intranet and internal newsletter in December 2011.

The Community Health Trust has some three thousand three hundred staff, many of whom would not be providing services to the defined population and therefore unlikely to wish to participate. All NHS staff should have computer access. There was a national day of action shortly before members of staff were invited to participate and it was approaching Christmas, which may or may not have had some bearing on the level of response. Six staff responded, making it impossible to reliably draw on the information provided.

While clearly it would be desirable to seek the participation of a greater number of members of these and other population sub-groups, this was beyond the scope of this HIA.
8 Impact Analysis

Introduction

8.1 This section brings together the evidence from all the data collected from the different sources and by using different methods; the report section that evidence is drawn from will be identified in the text. It identifies and characterises the potential impacts of the proposed service changes on the defined population describing:

- **Health impacts** – the health determinants affected and the subsequent effect on health outcomes;
- **Direction of change** – health gain (+) or health loss (-);
- **Scale** – the severity (mortality, morbidity and well-being) and magnitude, where possible (size/proportion of the population affected);
- **Likelihood of impact** – definite, probable, possible or speculative based on the strength of the evidence and the number of sources;
- **Latency** – when the impact may occur

8.2 For the purpose of impact analysis, a hierarchy of evidence from level I to V has been defined describing the relative strength of evidence for a relationship between health determinants and health outcomes; this includes evidence from the literature, key informants and stakeholders.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>Reviews of (systematic) reviews or meta analyses</td>
</tr>
<tr>
<td>Level II</td>
<td>Systematic reviews; reviews of several HIAs</td>
</tr>
<tr>
<td>Level III</td>
<td>Single studies or HIAs</td>
</tr>
<tr>
<td>Level IV</td>
<td>Expert witnesses (key informants)</td>
</tr>
<tr>
<td>Level V</td>
<td>Stakeholders</td>
</tr>
</tbody>
</table>

8.3 Where evidence collected from multiple research methods converges, this adds extra strength to the evidence and the likelihood of impact. Definition of the likelihood of the impacts is described the following qualitative terms. The likelihood of the impact is based on the assessed strength of evidence. For clarity throughout the impact analysis section, the potential impacts are in **bold** and the likelihood of an impact is **underlined**.

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definite</td>
<td>Will happen.</td>
</tr>
<tr>
<td></td>
<td>Overwhelming strong evidence from a range of data sources collected using different methods (level I)</td>
</tr>
<tr>
<td>Probable</td>
<td>Very likely to happen.</td>
</tr>
<tr>
<td></td>
<td>Direct strong evidence from a range of data sources collected using different methods (levels II/III)</td>
</tr>
<tr>
<td>Possible</td>
<td>More likely to happen than not.</td>
</tr>
<tr>
<td></td>
<td>Direct evidence but from limited sources (level IV)</td>
</tr>
<tr>
<td>Speculative</td>
<td>May or may not happen.</td>
</tr>
<tr>
<td></td>
<td>No direct evidence to support (level V)</td>
</tr>
</tbody>
</table>

8.4 The level of analysis is focussed on the defined population. Where possible, it will describe the potential impacts on different population sub-groups, although service changes already made and yet to come, coupled with the pace of change in the central policy agenda have made it difficult to assess the distributional effects, size of population affected and latency of these impacts.
Assumptions

8.5 In the absence of a comprehensive review of the literature on specific service interventions, it is assumed that every provider of services to the NHS (in this case, Liverpool Community Health Trust) will strive to provide modern, high quality, evidence-based preventive, primary or secondary care in line with their respective national strategy or appropriate national guidelines and clinical good practice.

8.6 There is a clear and strong local commitment to delivering the national policy agenda. National policy drivers likely to substantially reconfigure and reform health and social care provision, particularly in an increasingly dynamic and politicised, but financially pressured field, build uncertainty into predicting impacts.

8.7 This is particularly so given the potential for change in the legislative framework, future NHS commissioning arrangements and projected demographic change in the population structure that is of continued overall growth, with an increasing proportion of minority ethnic groups due to natural population growth and migratory factors.

8.8 The scope and methodology agreed by the Steering Group are based upon robust and proven HIA methodologies. Based both upon HIA good practice and demonstrable substantial participation in previous separate, but related, public consultation processes in the City, it was assumed that levels of stakeholder engagement might in this instance and in HIA terms, perhaps be markedly greater than usual and indeed be greater than that which occurred, which was minimal. Potential reasons for this were discussed, but cannot be certain.

8.9 Many types of evidence are appropriate for use in HIA. Rapid HIAs, by definition, do not have the scope or resource to examine primary peer reviewed research literature. It was assumed that the very timely and concurrent nature of this HIA would in fact, be “early” in terms of published studies and summaries of research findings. In general terms, a sensitivity surrounding all budget efficiencies and service changes across the public sector became evident during the literature search, necessitating a broad set of search terms. Many of the burgeoning number of reports found in the grey literature reflected this sensitivity in their careful use of language and euphemisms.

Impacts identified from Section 2 – Summary of the service changes

8.10 A number of these service changes may increase financial pressures, not just for service users themselves in terms of maintaining their level of service, but within their families (acting as carers of young children, or financially supporting young adults), increasing anxiety, limiting social engagement and leisure activity, resulting in more time spent in accommodation that may be falling into disrepair, or be inappropriate for elderly living, with associated increased risk of falls and characterising a reduction in quality of life likely to add to the burden of falls and dementia, already identified as challenges for the City due to demographic trends, regardless of financial austerity.

8.11 Further, there may be increased numbers of “newly vulnerable” older people, such as those who will for the first time have to bear the cost of non-residential services, either themselves, or within the family, possibly having to realise assets to do so. Bearing new or increased costs of services, utilities and commodities, for already vulnerable people who may have limited skills or resilience, may prompt a further increase in numbers getting into debt and fuel poverty.
8.12 Digital exclusion, common among older age groups, may reduce access to information and contact with the outside world. Those with sensory impairments and for whom English is not their first language may be particularly vulnerable, increasing social isolation, affecting quality of life and increasing their risk of ill-health. There is evidence that older people will continue to prefer telephone and face to face contacts for social reasons (Section 5, Box 3).

8.13 The impact of such recent changes may not immediately be manifest (although there is evidence elsewhere in the country that suicide rates [a proxy indicator of mental wellbeing] are already rising), with older people “soldiering on”, perhaps withdrawing from utilising services and becoming “invisible” until such time that they are referred to community health services, perhaps through A&E attendance, hospital discharge, or their GP.

8.14 The City has a long history of partnership and community action, with assets such as skills and capacity mapped at both City and local levels. Current initiatives, such as asset-based approaches and the Liveability service, build on this positive “face to face” approach and will be important if the City is to be able to maintain its level of progress in increased life expectancy and reducing mortality rates, quality of life and wellbeing to date.

Impacts identified from Section 5 – Health Profile

8.15 A patient based intelligence system, shared definitions and resolution of the “denominator issue” (ie registered and resident) would greatly facilitate the development of patient focussed services for older people across the city. It is speculated that moving towards market-driven arrangements may not optimally facilitate such intelligence sharing.

8.16 It is clear from the profile that Liverpool experiences high levels of deprivation, with a population profile that suggests its older residents who use the services of the Community Health Trust are among those experiencing some of the worst health in the country, despite marked improvements. It is probable that an increasing number and proportion of older people will in time become community service users, either in their own right, or as carers.

8.17 The impacts of national legislative changes and local and national policy both in train and to come, together with local service changes, are probably likely to negatively impact on the health of the defined population. It is probable that there will be increased need in the population and demand for services, both at earlier ages and in greater numbers, on community services, although there will be some degree of lead-in, as yet unknown, but anticipated to become more evident in an area such as Liverpool in the shorter term. LCH should put robust systems in place and develop their capacity to analyse and closely monitor in detail referrals, demand for and utilisation of their services against projected need in the City.

8.18 With clarity lacking with regard to future patterns of commissioning and data as yet either unavailable or not comparable, estimation of the direct impact for LCH is problematic. It is probable that LCH health improvement and healthcare initiatives will contribute to reducing the impact of the service changes, but that these may well not be sufficient to counter, in the medium and longer term, the impacts of national legislation and policy changes and further austerity measures beyond the control of both the city council and LCH.
Impacts Identified - Overall

8.19 Potential impacts identified by Winters et al (2011) are broadly applicable to the defined population group. There is evidence (sections 5, 6, & 7) suggesting that there is likely to be a more differential impact on those likely to be current or future service users, that is those with existing health care needs may be among those most likely to be impacted upon by service changes, for some of which there is evidence that they are local mitigating measures.

8.20 Organisationally, it is probable that there will be increased need and potentially demand for community health services. While this may be a positive impact for the Trust in a business sense, it may be negative for staff who may bear potentially increased workloads. Since there is as yet a lack of robust client-centred comparable data available, it is speculated that this may negatively impact upon the health and wellbeing of the defined population.

8.21 The most significant possible positive impact will potentially result from working closely with service users and increasingly their carers, maintaining a focus on health improvement and public health initiatives likely to continue the reduction in premature deaths and gradual increase in life expectancy seen in the city to date.

8.22 The main negative impact that while there will be a probable overall reduction in state-provided social care and an increase in private provision in the market place, there is likely to be an overall reduction in volume of social care service and an increase in unmet service need.

8.23 It is probable that there will be increased demand on NHS services, most likely to be managed through gatekeeping arrangements between the Clinical Commissioning Groups and Health and Wellbeing Board.

8.24 It is speculated that the history of close partnership working in the city, the reluctance of the city council to impose service reductions and their commitment to protecting frontline services where possible, may mitigate some of the negative impacts.

8.25 It is possible, however, that LCH, (or in future other NHS willing providers) may face increased demand in the short to medium term, particularly from those with financial difficulties, lack of informal carer support and those who would require low levels of service support to maintain their independence and wellbeing. It is speculated that in the longer term, overall reduced take up might lead to reduced volume of service.

8.26 It is probable that there will be both increased demand for and increased importance for health improvement services, although it is probable that this may not be directly beneficial solely to the community trust, but to the future health and wellbeing of Liverpool residents and LCH service users.

8.27 There is some local evidence (Campbell, 2011) that frontline staff members are especially well placed to both inform and indeed influence understanding of service changes in their client group and in fact, do so. It is probable that staff will be well placed to explain service changes to clients and provide appropriate advice and signposting when they have a clear understanding of the legislative and policy environment and future structure of service provision. It is possible that prevailing uncertainty and the current roles and requirements of professional posts may not optimise this. There is evidence from the literature (section 6) that there is a timely opportunity to address this
through contractual means, as part of a substantial and innovative re-development of integrated service provision.

8.28 It is possible that through full integration of services to build upon successful client facing models of assessment and support in the community, it will be possible to make better use of scarce (joint) resources, reducing potential negative impacts of service reductions. This would be construed as a positive impact, if this way forward was able to maintain relatively “healthier, younger” older people in independent living for longer.

8.29 However, as Winters (20011) notes, Liverpool performs very poorly in terms of community resilience, with the highest concentration of deprived localities in England, extremely high levels of benefit claimants and low levels of social cohesion. It is therefore possible that despite the stated strategic aim of the Trust, its’ clinical and health improvement professional activity and high degree of commitment from staff, it may not be possible for the Trust to solely counter entirely the negative impacts of policy and legislative changes that have necessitated service reductions by the City Council. It is speculated that gains in health and wellbeing may not continue and may worsen over time, with a wider gap emerging between “healthy, able” older people and those who are unable to utilise independent services.
9 Conclusion and Recommendations

Conclusion

1. Rapid assessments involve collecting and analysing mainly existing, accessible data and some new data with the impacts described in broad, qualitative terms: the limitations of these assessments reflect the necessary trade off between brevity and rigour. The timeliness of a concurrent HIA adds a further degree of complexity.

2. Key impacts have been defined, but the complexity and degree of uncertainty of the council service changes necessary to achieve a balanced budget over the longer timeframe, pace of change in the central policy agenda and varying data availability for a real understanding across local organisations, have made it difficult to assess the distributional effects, size of population affected and latency of these impacts.

3. It is clear that the city council has held off as long as possible from making service changes in order to protect the health and wellbeing of the population, compared to other areas of the country. Liverpool has a strong history of partnership working, leadership and other factors deemed to be helpful in the integration of services, demonstrated by the hard won gains in health and life expectancy. There is anecdotal evidence of very different situations in some parts of the country.

4. It is clear that the proposed service changes will have both positive and negative health impacts upon Liverpool residents aged 55 years and over who are users of community health services provided by Liverpool Community Health Trust.

5. The main positive impact will be for those community service users who are older people who have sufficient resilience and are in a position to exercise choice and utilise their own and public resources to maintain their health and manage their own service provision in a future market scenario, living an independent and participatory, healthy lifestyle into their older years.

6. The main negative impact is that by virtue of being community service users and set against the demographic profile and projected increases, for example in dementia, there will be both increased need and demand for vulnerable population groups without the skills (for example, financial management), resilience (for example, mental wellbeing) and support (for example carers) to safeguard their own health and manage their own care. Precarious and fragile existences may become the norm for a larger proportion of the defined population for longer until some event (perhaps a fall or indebtedness) precipitates a change in circumstances, making them high need and eligible for reduced provision of state-provided safety net services.

7. The net impact on future population health of the defined population, particularly in reducing health inequalities and providing equitable access to services for population subgroups, will need to be carefully monitored, especially in light of NHS commissioning and Adult Social Care reorganisations and a possible reduction in intelligence capacity and capability, not least especially through the transition period and into the medium and long term.
Recommendations

- The relationship between mental health services, self management programmes and primary care should be strengthened (Sections 5 and 6).
- Trust staff should be trained in order to develop basic mental health skills, possibly by expert staff from MH Trusts (Section 6).
- Trust staff should all have a greater awareness and training in providing basic debt advice. It may be appropriate to train some staff to a more specialised degree, as has been the case in the voluntary sector, in order to expand the support available elsewhere in the community (Section 6).
- The Trust may wish to strengthen links to other not for profit debt advisory agents, such as those provided in association with the courts, to improve their capability for “signposting” to services (Section 6).
- LCH should put robust systems in place and develop their capacity to analyse and closely monitor in detail referrals, demand for and utilisation of their services against projected need in the City (Section 5 and 6).
- Information systems and audit trails should be established by the Community Health Trust, where possible shared with partner service providers, to monitor patient flows from and between services, particularly Acute and Care Trust services, to properly monitor population need, user demand and utilisation of services at an individual level. This might involve the use of segmentation techniques. Comprehensive analysis of work load and practice, for example by professional group and source of referral should enable the Trust to better target prevention and health care services to members of the defined population (Sections 5 and 6).
- The Trust should seek to better understand, through data collection and stakeholder participation, the numbers, needs and preferences of the carers of service users, both child and adult, to inform new ways of working (Sections 4, 5 and 6).
- The Trust should seek to develop programmes such as the Liveability scheme, linking closely with similar initiatives that may be ongoing in the City, in order to better capitalise on “single gateway” contacts with particularly hard to reach groups of older people (Section 6).
- The Trust should engage in and develop asset-based approaches to living well, linking with activity in the city and elsewhere in the North West. This should include moving towards community asset mapping (not merely the development of directories), with a high degree of stakeholder input, in conjunction with partner organisations (Section 6).
- The Trust, as part of the branding initiative currently in train, should more actively market it’s activity and unique selling point (high quality local services to local people by local people who provide continuity of care and understand what local people need and want from their service provider) to current service users and carers in order to establish a strong profile and customer preference in readiness for the forthcoming more open market place (Section 4 and 6).
- The Community Health Trust should strengthen, that is develop further, explicit and regular feedback to service user groups and practice patient participation groups to demonstrate how the recommendations of this HIA have been taken forward and their influence on future commissioning decisions about NHS and Adult social care service provision (Section 6 and 7).
10 Evaluation

10.1. Evaluation is an important part of Health Impact Assessment, both of the assessment process and the report recommendations. Timely process evaluation for those undertaking the assessment and engaged in it, is important for lessons to be learned that can improve efficiency and also contribute to the robustness of the methodology.

10.2. For commissioners, it is essential that a clear pathway for the evaluation of the Health Impact Assessment report be developed. This is important in mapping out which recommendations have been taken up and monitored (by when and by whom), not just in the immediate future but regularly throughout the period of transition, worsening financial situation and return to growth.
11 Bibliography


Audit Commission(2011) Going the distance – achieving better value for money in road maintenance http://tinyurl.com/3mjneby


Demos (2011) Mapping cuts to disability services, how your council is coping. A web-based coping with the cuts index. http://tinyurl.com/8xt6g7x


European Public Health Association (2011) EUPHA Statement on Health Impact Assessment (HIA) http://tinyurl.com/6qufggl accessed 02/12/11

Faculty of Public Health (2011) Public health experts fear "nightmare" future for public health, according to Faculty of Public Health Survey. Press Release UK Faculty of Public Health 30/11/11 http://tinyurl.com/7k7kgph


Fujitsu UK (2011) Online government services and the offline older generation. Executive summary. Published by Age UK. http://tinyurl.com/6psopac


Hill,A. (2011) Key Facts from additional topics included in the Health Survey for England 2010. Circulated by email to PUBLIC-HEALTH-INTELLIGENCE@JISCMAIL.AC.UK


Marmot,M et al (2011) Interim second report on social determinants of health and the health divide in the WHO European Region. WHO Regional Office for Europe, Denmark. http://tinyurl.com/6pg7g6m


Ryan, P. (2011) Transforming primary care in Ireland: information, incentives and provider capabilities. Circulated by email via AAHPN mail group 07/12/11 [http://tinyurl.com/7vxoaqw](http://tinyurl.com/7vxoaqw)


Selvarajah, P (2011) Budget cuts disaster for most vulnerable women. The Vibe
http://tinyurl.com/7zomzh accessed 15/08/11

Shah, K et al (2011) NICE’s social value judgements about equity in health and healthcare.
CHE Research paper 70. Centre for Health Economics, University of York.
http://tinyurl.com/c9yhzof


Taylor-Robinson, D (2011) Bigger cuts to local authority budgets in the most deprived areas are likely to widen health inequalities. British Politics and Policy at LSE. http://tinyurl.com/7chdq9e


APPENDIX A  Stakeholder Workshop “Graffiti Wall”
Health and well-being issues as identified by stakeholder workshop participants on the “Graffiti Wall”. The views and experiences reflected here are those of the participants.

<table>
<thead>
<tr>
<th>Category of health determinant</th>
<th>Issues</th>
</tr>
</thead>
</table>
| **Age, genetics and Biological factors** | • Need to advertise screening services for older people (breat and bowel) more widely  
• I only discovered I had breast cancer by remembering to have a 3 yearly mammogram – recall doesn’t happen after 70 years of age.  
• Age is not a barrier  
• I can walk miles because of my specially made shoes for my bunions. It would be terrible if there was a cutback on that. |
| **Lifestyles** | • Cuts to care packages will affect quality of life and health of service user. This will impact upon the service user and their family, carers will be stressed and cause illness.  
• Service users with MH and learning disability problems will be at risk of losing lifestyle choices. People will be more vulnerable due to lack of funding and support.  
• Health messages need to be aimed at “grass roots” to people in their own environment  
• Cutbacks in adult education will affect quality of life for all, particularly for immigrant older people learning English |
| **Living & Working Conditions including services** | • Risk or opportunity? |
| **Social and community networks** | • Why do hospitals send letter after letter and phone calls when you’ve told them that you are coping without another operation? One hand doesn’t know what the other is doing and the enormous waste of using appointment cards only once!  
• Cutback on supported home living will make life more difficult (or impossible) for people who will need more residential care.  
• Cutbacks in Children and young people services could lead to more crime and anti-social behaviour leading to more fear amongst older people  
• Greater levels of social inclusion for older/at risk members of population through more effective use of GPS telemetry and household/domestic mobility appliances  
• Transport for senior citizens enables activity, wellbeing and socialisation  
• Some cuts cause loneliness & can lead to forgetfulness and so maybe dementia.  
• Need to develop mutual networks of support  
• Community cuts can infringe on people’s ability to form own social networks – major concern |
| **General Socio-Economic Conditions, Legislation, Environment** | • Some organisations risk averse  
• Sheltered housing is very reassuring. It’s a pity more people don’t avail themselves of these facilities instead of struggling on on their own.  
• Not clear if the Council will make cuts in public health services it takes over next year.  
• Cutbacks on recreational centres (sports centres, etc) will reduce mobility and independence  
• After knee surgery I joined the gym in Woolton which closed, so I have to go to Speke, which I love and has helped my mobility. I also walk a lot every day and would be very upset if they closed the gym, socially & physically  
• Cutbacks in road & pavement repairs could lead to more people tripping and ending up in hospital |
# APPENDIX B

## 12 January Focus Group Discussion on Identified Determinants of Health

<table>
<thead>
<tr>
<th>Description of impact</th>
<th>+ve or – ve?</th>
<th>Determinant(s) affected</th>
<th>Population(s) affected</th>
<th>Enhancement / Mitigation measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td>-ve</td>
<td>Environmental</td>
<td>Greenbank area Pram pushers Mobility scooter users &gt;55’s</td>
<td>Find out who owns them and approach to repair Selling a mobility scooter as they can’t use it due to potholes.</td>
</tr>
<tr>
<td>Libraries</td>
<td>+ve</td>
<td>Social &amp; Community</td>
<td>All age groups Croxteth</td>
<td>Example of new ways of working – good model Promoted social cohesion. A lot of people pulled together Shared tasks (multi-tasking) Reduce waste and beaurocracies “Good neighbour scheme” Time banking Adopt a granny Grandparents babysit</td>
</tr>
<tr>
<td>Blocked Paths in park</td>
<td>-ve</td>
<td>Social &amp; Community</td>
<td>All age groups</td>
<td>Blocked paths in the park caused the cessation of walking groups because no one knew who owned them</td>
</tr>
<tr>
<td>War on Welfare State</td>
<td>+ve -ve</td>
<td></td>
<td></td>
<td>People pull together in wartime, but also there are people on the make Social cohesion only comes when it’s “back to the wall” time Library example a good one, but Big Society is not an excuse to cut for cuts sake</td>
</tr>
<tr>
<td>Organisations/waste/inefficiency</td>
<td>+ve</td>
<td></td>
<td></td>
<td>Not just cuts, but impacts elsewhere – is it a good thing that will encourage closer shared working across organisations eg nurses making cups of tea Increased self reliance in families (eg women) to be encouraged, not always looking to the government</td>
</tr>
<tr>
<td></td>
<td>-ve</td>
<td></td>
<td></td>
<td>Hard to build in areas with split families geographically Formalising neighbourliness through</td>
</tr>
<tr>
<td>+ve</td>
<td>-ve</td>
<td>+ve</td>
<td></td>
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<tr>
<td>Council support – eg the postman &amp; milkman, are now done by charities</td>
<td></td>
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<td></td>
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<tr>
<td>• Liverpool has had its’ own Big Society for years doing just this.</td>
<td></td>
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<tr>
<td>• Do people stay “closer” when they are less affluent – less lonely- the more affluent may be more lonely eg “I pay someone to do my washing/get shopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Every organisation should prevent “duplications”</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Bring back participatory government like in 1976</td>
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<tr>
<td>• Breast cancer call back ceases after 70 years, because recall isn’t cost effective</td>
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<tr>
<td>• REC Community Trust should remind users about their entitlement and invite people over 70 for breast screening</td>
<td></td>
<td></td>
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<tr>
<td>• Bowel screening, too needs reminders about your entitlement REC A scheme (like for flu each October) as a reminder – REC LCH could do this through PCMS GP practices</td>
<td></td>
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<tr>
<td>• Since routine screening has gone to LCC Scrutiny Committee in the past, all partners could help improve understanding what’s available REC Simple clear information on which organisation provides what, what is currently provided, who receives what and what future provision will be. This will be important as CCG’s aren’t expert at info giving, so more is needed from those who are</td>
<td></td>
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<tr>
<td>• As well as information about entitlements and provision, inform people that PALS exist</td>
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<tr>
<td>• REC LCH need to have a higher profile in the community – a branding exercise is in process</td>
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<tr>
<td>Topic</td>
<td>Description</td>
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<td>-----------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>There should be a national standard for treating older people</td>
<td>Community health should mitigate inequalities in health services eg screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community health should mitigate inequalities in health services eg screening</td>
<td>Time banks (Annette James LPCT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability groups</td>
<td>CRB checks goes against participation in voluntary groups. Retired people easier to get to volunteer – kids have lost that. It’s easier to get kids into one off projects, not longer term.</td>
<td></td>
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<tr>
<td>Grandparents</td>
<td>Youth Parliament participation encouraged</td>
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</tr>
<tr>
<td>Central services still needed, though for the most vulnerable.</td>
<td>Most vulnerable will be protected,. But so far, this is all “like to do”, but there’s “got to do” to be done.</td>
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<tr>
<td>Community service people eg offenders, could mend the potholes</td>
<td>Get rid of the government!</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ask the staff not outsiders, with managers talking to users and staff. REC formally get the staff to participate</td>
<td>Charity shop donations wasted by being left out in the weather.</td>
<td></td>
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<tr>
<td>Changes or loss of infrastructure could seriously impact upon the ability of service users to reach both service and social events, leading to increased isolation.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Local networking lost, eg police</th>
<th>-ve Disability groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>-ve</td>
<td>Time banks (Annette James LPCT)</td>
</tr>
<tr>
<td>+ve</td>
<td>CRB checks goes against participation in voluntary groups. Retired people easier to get to volunteer – kids have lost that. It’s easier to get kids into one off projects, not longer term.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transport systems</th>
<th>-ve Learning disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>-ve</td>
<td>Changes or loss of infrastructure could seriously impact upon the ability of service users to reach both service and social events, leading to increased isolation.</td>
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</table>