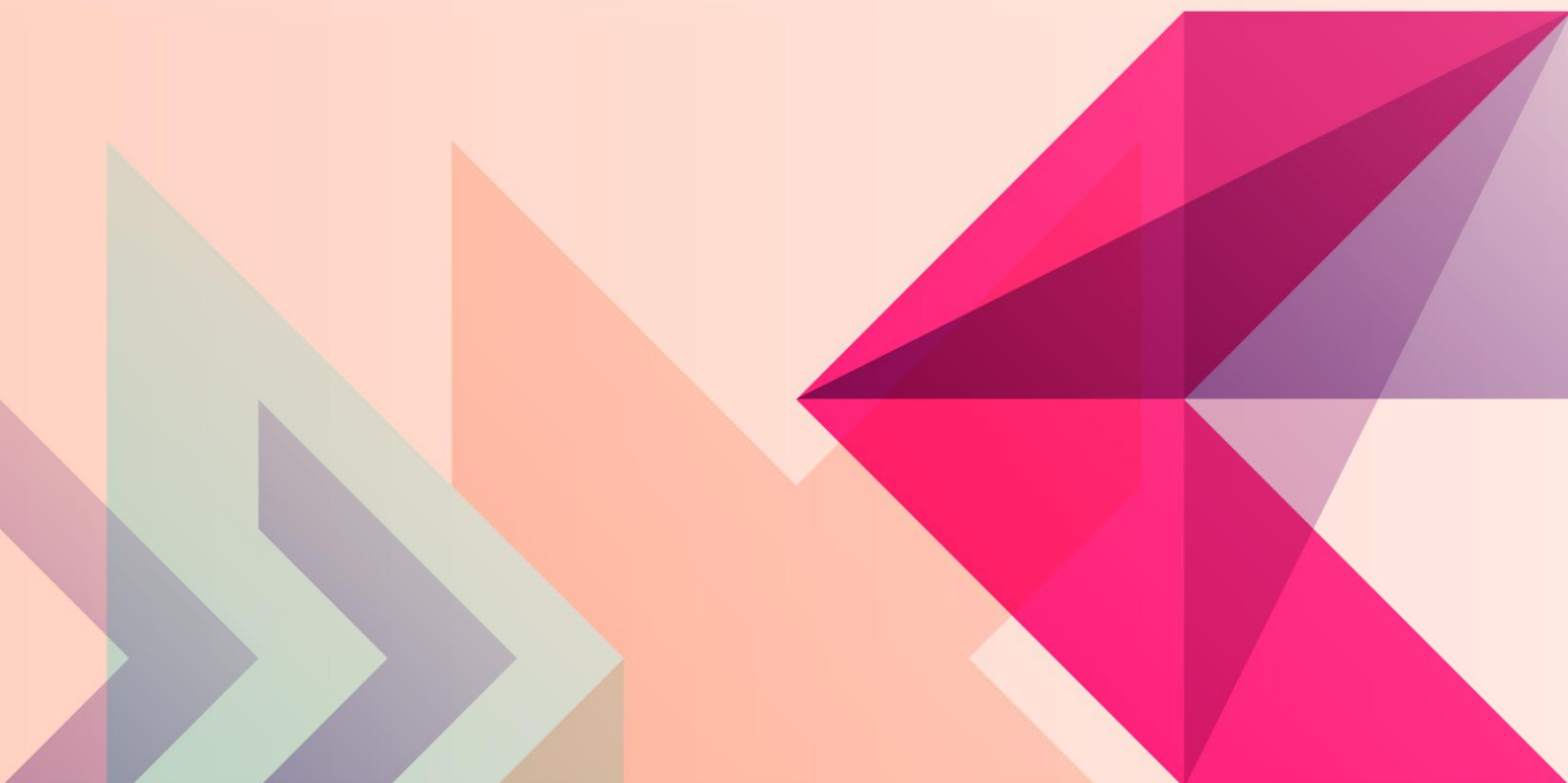


Public Health Improvement Programme (PHIP)

Public Health Peer Review Report

Cheshire West and Chester Council

Date: 1st October 2026



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1. Executive Summary

The Peer Review Team is satisfied that Cheshire West and Chester Council is fulfilling its public health responsibilities well, with examples that demonstrate a consistent Health in All Policies approach.

The Council has proactively adopted the Marmot principles for reducing inequalities and improving health outcomes for its population in 2022 and its progress can be strongly evidenced in its strategies and policies.

There is strong evidence across the Council of political and senior officer commitment and engagement in reducing inequality and improving the public's health in its communities. However, converting aspirations into improved outcomes is proving to be a challenge in some areas, such as persistent inequalities in school attendance, self-harm in those aged 10-24, falls related hospital admissions for older people and the percentage of adults who are overweight and who smoke.

Changes taking place across the wider health system, particularly in the Integrated Care Board (ICB) and place-based arrangements, will require the Council to build new relationships and partnership arrangements that embrace opportunities to influence the development of local services and the neighbourhood health agenda.

The Council is clearly committed to improving and protecting the health of its local population; however, it has a huge number of priorities, not all of which it will be able to direct sufficient resources to. Further work is encouraged to focus on those areas that are most important and where the evidence demonstrates to the Council and its partners that they can have the biggest impact. The Public Health Team, with its well-developed data and intelligence function, is well placed to do this.

2. Key recommendations

The following are the Peer Review Team's key recommendations to the Council:

1. Be bold in maintaining your progress on the implementation of a Marmot Council.
2. Review the public health priorities for the whole Council to enable greater focus and to match the resources available to deliver them.
3. Consider the capacity and capability of the public health resource needed, including the composition and focus of the Public Health Team and implement a staff succession and development plan to enable this.
4. Build a shared understanding of the ways in which the Council can continue to influence partners within the emerging wider health system to drive improvement and achieve priorities at place/ neighbourhood level.
5. The Council should take the initiative in influencing and shaping the

neighbourhood health model with health and other partners to enable improved outcomes for communities.

6. Development of a broader range of qualitative data linked to lived experience and improved outcomes for individuals, communities and families will help the Council to understand and build on its current position and where it can make a difference.
7. Increase awareness of the core public health priorities at a strategic level, to increase impact across the breadth of the Council's reach and to drive improvement in health outcomes across the community.

The Peer Review Team is impressed by the Council's commitment to being a public health-led local authority, and the implementation of a Marmot Council has been key to this. However, the Council has many priorities. Focussing on a smaller number will help target resources in areas that will help reduce inequalities and tackle the wider determinants of health that impact most on the public's health.

The Director of Public Health and Public Health Team are key to delivering on these aspirations, and consideration should be given to ensuring the capacity and capability is in place to provide the required leadership, level of influence and support as the Council's journey progresses.

The Council's relationship with NHS organisations in Cheshire West and Chester is key to the success of its public health agenda, Whilst the ICB is currently undergoing reorganisation, ensuring that it remains fully engaged at place level to jointly deliver population health priorities and neighbourhood health will be crucial to achieving local public health priorities and outcomes.

The Council has well established means of engaging with its residents through elected members, Community Partnerships and the voluntary, community, faith and social enterprise (VCFSE) sector, which will help to ensure it understands their needs, views and experiences. The Council works well with partners to help shape its planning and commissioning activities, as evidenced in the Joint Health and Wellbeing Strategy and by evidence-based programmes such as the Healthy Child Programme.

3. Public Health Peer Review approach

Public Health Peer Reviews are part of the Public Health Improvement Programme (PHIP), delivered by the LGA and funded by the Department for Health & Social Care (DHSC).

The Peer Team

Public Health Peer Reviews are delivered by experienced elected member and officer peers. The peers who delivered the Public Health Peer Review at Cheshire West and Chester Council were:

David Williams	Lead Peer, Chief Executive, Eastleigh Borough Council
Amanda Healy	Director of Public Health, Durham County Council
Cllr Kelly Middleton	Member Peer, Cabinet Member, Telford and Wrekin District Council
Claire Robson	Public Health Consultant, Trafford Council
Marcus Warnes	NHS Peer, former CEO
Cliff James	LGA Peer Review Manager
Steve Penfold	Shadow LGA Peer Review Manager
Hannah Folb	LGA Advisor, Public Health Improvement Programme

Scope and focus

The peer team considered the following six themes, which form the core components looked at in all Public Health Peer Reviews that have been developed with the public health sector as critical in answering the question: “to what extent is the Council fulfilling its public health responsibilities?”

1. Leadership and Governance
2. Vision and Priorities
3. Partnership Working
4. Data, Intelligence and Outcomes
5. Resources, Quality and Commissioning
6. Statutory Responsibilities

In addition, the Council asked the Peer Review Team to feedback on five questions as part of its consideration of the six key themes:

- Whether the current Public Health Team has the required capacity to deliver its priorities, while maintaining staff wellbeing and professional development?
- Whether the current areas and levels of Public Health Grant investment are

appropriate to deliver the Council's key public health mandated and statutory duties and achieve the greatest health and equality impact for residents?

- How the Public Health Team can strengthen its visibility, influence and involvement across the Council and wider system, including engagement with Directorate Management Teams (DMTs), scrutiny processes and strategic decision making?
- Are wider Council directorates and services sufficiently contributing to the delivery of public health duties and what are the opportunities to strengthen this?
- Is there learning from other areas regarding preparations the Public Health Team can take to sustain delivery of its statutory responsibilities in different future political environments?

The peer review process

Cheshire West and Chester Council was the first Council to have a Public Health Peer Review as part of the Public Health Improvement Programme. It is important to stress that this was not an inspection. Public Health Peer Reviews are improvement focussed and tailored to meet individual councils' needs. They are designed to complement and add value to a council's own improvement priorities. The process is not designed to provide an in-depth or technical assessment of plans and proposals. The Peer Review Team uses its experience and knowledge of public health, especially in a local authority setting, to reflect on the information presented to them by people they met, things they saw and materials they read.

The Peer Review Team prepared by reviewing a range of documents and information to ensure they were familiar with the Council and the challenges it is facing. The team then spent three days onsite at Cheshire West and Chester Council during which it:

- Spoke to more than 60 people including a range of Council staff together with councillors and external partners and stakeholders.
- Gathered information and views from more than 40 meetings along with additional research and reading.
- Collectively spent more than 240 hours to determine its findings – the equivalent of one person spending more than seven weeks onsite.

This report provides a summary of the Peer Review Team's findings. It builds on the feedback presentation provided by the Peer Review Team at the end of its on-site visit from 8th to 10th September 2026. In presenting feedback to Cheshire West and

Chester Council the peers have done so as fellow local government officers, elected members and partners, not professional consultants or inspectors. By its nature, the Public Health Peer Review is a snapshot in time. We appreciate that some of the feedback may be about things the Council is already addressing and progressing.

4. Feedback

This section sets out the feedback from the Peer Review Team to the Council against the six themes that are the core components of all Public Health Peer Reviews. The feedback is presented as strengths and areas for development. The feedback includes judgements and observations from the Team, the evidence and examples that helped it to form its conclusions, the implications and impact for the Council, and what the Council and its partners may wish to do next.

4.1 Leadership and Governance

Strengths

1. Strong evidence of political and senior leadership involvement in the delivery of the Council's priorities for public health.
2. The Director of Public Health has strong visibility, is part of the senior management team, and uses her position and influence to bring focus and energy to key public health issues facing communities.
3. There is good evidence of shared leadership of public health across directorates, such as children's services, adult social care, transport and highways, and place and growth.
4. There is good evidence of effective community engagement and co-production in helping the Council address its Marmot principles, and in the development of public health policies and strategies.
5. There are good governance arrangements in place across the public health function, including processes for commissioned services and the Public Health Grant.
6. Public Health Team members feel well supported in their roles, with individual contributions valued and respected.
7. Active engagement of Council and Public Health leadership in the Combined Authority.

The Peer Review Team is impressed by the level and extent of the Council's leadership and ownership of the wider public health agenda. The phrase, 'this is a Public Health-led Council' was repeated with conviction in many of the interviews and focus groups the team attended, by Council elected members and officers and external partners. For example, the Leader of the Council is a passionate advocate for public health within Cheshire West and Chester and her position as the Chair of the Combined Authority offers opportunities for the Council to take an increasing public health leadership role across the wider region.

The Director of Public Health is visible and influential within the Council and with partners. This is helped by her membership of the Council's senior management team and reporting directly to the Chief Executive. Evidence from other councils that members of the Peer Review Team have worked with would suggest that these leadership and reporting arrangements are not universal and will help to ensure that this Council is well placed to continue to strengthen its public health leadership role.

Whilst recognising the key leadership role of the Director of Public Health and her team in shaping and implementing the Council's approach to prevention, inequalities and the wider determinants of health, public health is clearly seen as the responsibility of all Council directorates. For instance, the Peer Review Team heard examples from Children's Services about the value of the Healthy Child Programme, from Transport and Highways regarding active transport and from Place and Growth regarding apprenticeship work with developers.

It is clear to the Peer Review Team that Public Health Team members feel valued for their individual strengths, contributions and backgrounds, and are respected. Management is supportive of their wellbeing and is very open to different ideas and creativity. Also, that they operate within robust governance arrangements that facilitate their roles and enable effective public health commissioning and use of the Public Health Grant.

Areas for improvement

1. The opportunity given by the stability of the current leadership and administration to progress the public health agenda needs to be grasped at pace, as these alignments can change.
2. The opportunities created by having the new Combined Authority need to be grasped to further the public health agenda.
3. Building new relationships with the emerging NHS system needs to be a priority. The work on neighbourhoods could be used to facilitate this, including the use of shared data and intelligence across organisations.
4. Consideration to be given to the Portfolio Lead for Public Health being a voting member of the Health and Wellbeing Board to influence and give greater visibility to public health.

5. Reviewing prioritisation, skill mix, and strategic influence may address concerns we heard about capacity and a sense of overload within the Public Health Team.
6. Increase the profile and work of the Public Health Team, its programmes and forthcoming campaigns across the Council and with partners, which we think would be helpful in increasing awareness and influence.
7. There is an opportunity to take Health in All Policies further, and we heard a willingness for innovation across other directorates, e.g. Transport.

The Council has been fortunate that the relative stability of its political administration and executive leadership has enabled it to embed and progress its policy framework and longer-term strategic approach to inequalities, prevention and the wider determinants of health. However, the Peer Review Team feels there are opportunities to go further and faster, such as by leveraging opportunities presented by the Combined Authority, the shared use of data and intelligence across partners to shape and refine priorities, and by building on the well-established Community Partnerships to further develop neighbourhood working.

Concerns were expressed in many focus groups and interviews about the impact the restructuring and downsizing of the Integrated Care Board has had on leadership relationships, capacity and place-based governance arrangements. The need to build new relationships with health partners and ensure partnership arrangements are robust and fit for purpose should be a priority as the restructuring draws to a close over the remainder of the year.

Further opportunities exist to strengthen public health leadership within the Council, such as reviewing the role of the Portfolio Lead for Public Health on the Health and Wellbeing Board, the expansion of Health in All Policies across directorates, and the prioritization of the work of the Public Health Team, which may help to address some of the capacity issues the Peer Review Team heard from several quarters. Transport provides an excellent example of how the priorities of two directorates can align, where the desire to increase the number of children walking to school would also improve the public health objective of children becoming more active. Synergies such as these present clear opportunities to embed public health across the Council.

4.2 Vision and Priorities

Strengths

1. There is a clear and shared Council ambition for the health of its residents, demonstrated through the Marmot principles and the involvement of residents through community inspirers and the Poverty Truth Commission.
2. The Public Health Team helps shape the Council's priorities and has worked well

with other directorates to influence their policies and strategies. There are evident benefits from joint work across all directorates, e.g. funding change resistant drinkers work with Adult Social Care and a joint bid between the Public Health Team and Transport and Highways for an active travel and social prescribing project.

3. Public Health Team influence in local authority planning and place making is working well with a clear focus on dealing with inequalities in the Borough Plan.
4. Good evidence of working at community partnership level to identify areas of inequality and high levels of need where targeted support is needed, e.g. joint working with children's services to use data and intelligence to prioritise certain neighbourhoods for focused support.
5. The Council's vision and priorities are shaped by engagement with local communities and informed by evidence, to which the Public Health Team makes a significant contribution.

The Council's commitment to being a Public Health-led Council is clear from the various documents the Peer Review Team reviewed along with much of what the Team heard in the focus groups and interviews.

The Council's three public health priorities - to reduce health inequalities and give children and young people the best start in life; prevention and improving healthy life expectancy; and addressing the wider determinants, whilst broad and ambitious, are evidently influencing the Council's strategy. For instance, the Healthy Child Programme, work around drugs and alcohol, and green transport and active travel plans are evident in the Borough Plan.

The Peer Review Team was impressed by the community inspirers and the way the Council draws on their experiences to shape and co-produce its vision and priorities, policies, strategies and plans.

The Poverty Truth Commission in 2016, declaration of a poverty emergency in 2016 and work on Fairer Futures are also examples of a long-term vision and commitment to tackling inequalities and the Council's ongoing efforts to involve its citizens and communities in this work.

Areas for improvement

1. The Council has a lot of priorities; there is a need to focus on those areas where it is likely to achieve the greatest impact, based on local political choice and evidence from the Joint Strategic Needs Assessment, community engagement and evaluation.
2. Council and public health leadership should collectively play a proactive role as

system convenors in determining what the neighbourhood health agenda means for Cheshire West and Chester, alongside the Integrated Care Board and other partners.

3. The Council could improve the way in which it understands, articulates, tracks and demonstrates impact over time, for instance in breastfeeding rates.

Having reviewed key documentation and spoken with a wide range of colleagues during its visit, the Peer Review Team notes the broad range of priorities being addressed, e.g. three public health priorities, six missions in the Borough Plan and the eight priorities in the Joint Health and Wellbeing Strategy. Indeed, we heard in one interview that, “everything is a priority and it’s hard to know where to start.”

Whilst recognising that the Council has a wide range of responsibilities to deliver, it would nonetheless benefit from focussing on a smaller number of sharper priorities, based on the data and intelligence contained in the Joint Strategic Needs Assessment, insight from communities and wider stakeholders, and evidence about what actions will drive impact and outcomes.

Further work is suggested on how the Council understands the impact of its various strategic and operational initiatives on longer-term outcomes. We saw evidence of monitoring and reporting the activity and outputs from its commissioned services, but more effectively determining their relative success or otherwise on outcomes may help the Council to prioritise its resources to best effect.

The Peer Review Team found it difficult to discern a shared understanding of neighbourhoods and neighbourhood health within Cheshire West and Chester and across the wider Cheshire and Merseyside system. As a democratically elected body with statutory duties and undoubted expertise, there is an immediate opportunity for the Council to play a convening role with the Integrated Care Board and other partners to set out a clear vision for neighbouring working in Cheshire West and Chester.

4.3 Partnership working

Strengths

1. Strong evidence of joint work and engagement with partner agencies and the voluntary sector throughout the Public Health Team, Council directorates, Health and Wellbeing Board and other partnerships.
2. The Community Partnerships are well established and provide a strong basis for neighbourhood working.
3. A strong relationship with the UK Health Security Agency that enables effective

delivery of the Council's Health Protection responsibilities.

4. Good learning gained from reviewing cases, e.g. alcohol and drug related deaths, suicide audit, and Joint Excess Deaths Contingency Plan to help improve service response and prevention.
5. Public Health Team influence over the Council's activities is increasing, including partner companies and regulatory and planning services, e.g. the Healthier Advertising Policy, targeting seldom heard populations, smoking cessation, influencing the siting of fast-food outlets, and reviewing the content of vending machines.
6. Partner agencies and the voluntary sector are very supportive of the work produced by the Public Health Team and feel the data, intelligence and strategies they produce help shape their services and priorities.
7. There are examples of good partnership working between the Public Health Team and the University of Chester, e.g. the Annual Haygarth Public Health Lecture and application to NIHR for grants to support evaluation of a healthier vending programme.

The Peer Review Team is impressed by the scope and breadth of partnership working and arrangements across Cheshire West and Chester. Place based arrangements such as the Health and Wellbeing Board and Community Partnerships enable partners, stakeholders and communities to engage with each other and the Council, and to share public health data and intelligence that helps shape priorities and services and supports their bid-making to bring funding into the area. The recent streamlining of partnership arrangements, such as the Health and Wellbeing Board taking on the responsibilities of the Health and Care Partnership have helped reduce duplication.

The influence of the Public Health Team over the activity of the Council is clear, such as the Healthier Advertising Policy and its impact on the siting of fast-food advertising. Also, the relationship with the UK Health Security Agency (UKHSA) is strong, which is evident in the delivery of the Council's health protection responsibilities

Areas for improvement

1. There are further opportunities for collaboration between partners to align strategies and maximise the impact of messaging and campaigns, e.g. there is an appetite for further collaboration around physical activity and the role it can play in tackling inequalities and improving health and wellbeing.
2. The Council and partner agencies would benefit from developing a more joined up approach to public health campaigns, particularly regarding drug and alcohol

issues, and public safety.

3. The ICB Place Teams supported place shaping, the development of neighbourhood working and integrated partnership arrangements, such as the Health and Wellbeing Board and Integrated Neighbourhood Partnership Board. Clarity is needed as to how the ICB will engage at place once its reorganisation has concluded.

Whilst partnership arrangements appear generally strong, despite some recent streamlining, the partnership landscape is still quite complicated. There are a lot of partnership organisations with strategies, plans and campaigns, each with their own priorities. Many of these were shared with the Peer Review Team in advance of its visit.

During the focus groups and interviews, opportunities for further alignment and collaboration in areas such as mental health, primary care, early years, housing, economic growth and physical activity were discussed.

A recurring theme from the focus groups and interviews was the impact of the ongoing changes in the NHS, notably the restructuring and downsizing of the Integrated Care Board (ICB) on partnership arrangements. The Peer Review Team was told that there will no longer be an ICB Place Director role or Place Team, and that this may have detrimental consequences for joint working in Cheshire West and Chester as one of nine places in the Cheshire and Merseyside ICB. The Council needs to work with the ICB to influence how this might be addressed.

4.4 Data, Intelligence and Outcomes

Strengths

1. The investment of Public Health Grant and integration of public health analysts within the wider corporate data and intelligence team is helping to realise synergies.
2. There is a good breadth and depth of data and intelligence available to inform priorities and strategies, with consistent messages of data-driven approaches and strong working with data and intelligence colleagues. For example, the Council uses Acorn and PayCheck to expose hidden inequalities.
3. The Public Health Team goes above and beyond the nine protected characteristics on Equality, Diversity, and Inclusion (EDI). They include factors such as rural disadvantage, those who have been involved in the care system, and carers in its impact analysis of services.
4. The Public Health Team has worked with partners, residents and subject matter

experts to carry out needs assessments. We heard examples of the difference they have made, e.g. sexual health commissioning.

5. Data and intelligence are owned by other parts of the Council and by partners, with a shared strategic function across the Council and in the Cheshire West and Chester Joint Intelligence Board.
6. Commitment by the Data and Intelligence Team to publish outputs has meant that other partners have been able to bid for funding, e.g. Age UK used the Social Isolation Dashboard to inform a grant funding bid.
7. Strong examples in the Director of Public Health's Annual Report of children and young people's voices being heard, e.g. a strong youth service, and young people's voices in schools' forums.
8. Some evidence of measuring impact and outcomes, both qualitative and quantitative, e.g. change-resistant drinkers work with Adult Social Care demonstrating positive, life-changing outcomes.
9. The data and intelligence team has carried out training with other parts of the Council, including elected members, which has been well-received and is developing skills and awareness.
10. There is data-sharing with the ICB, which is something the Council can build on, e.g. cardiovascular disease (CVD), respiratory, and cancer data to inform targeted commissioning. NHSE cancer mortality data within secure local public health dashboards have been discussed at Overview and Scrutiny Committee.
11. The Council is creating a business intelligence (BI) dashboard that will allow Brio Leisure to assess and address equity of access to services.

There is a good depth and breadth of data and intelligence available to the Council to inform its priorities, policies and strategies and to help focus on inequalities. The use of Acorn, which provides Council-wide data, and PayCheck at ward level have helped identify hidden inequalities, such as the impact of a high cost of living on students.

The public health data and intelligence analysts are embedded within the Corporate Team, which the Peer Review Team heard is a shared strategic function that is valued across the Council and by partners. The Cheshire West and Chester Joint Intelligence Board is frequently cited as an example of this approach in action.

There is some evidence of data sharing with partners for conditions such as CVD and cancer within public health dashboards, with an impressive commitment to publish as much data and intelligence as possible. An example of the value of this approach to partners was the use of the Social Isolation Dashboard by Age UK to develop a funding bid.

The Public Health Team's data and intelligence function despite its limited capacity,

is providing or involved in an impressive array of work. Examples include needs assessments to inform the commissioning of services in areas such as sexual health and early years, outcome measurement in adult social care, training for elected members, and informing work with at risk groups, e.g. veterans at risk of suicide and self-harm.

Areas for improvement

1. There are opportunities to integrate qualitative feedback from residents alongside statistical data to enhance communication of the impact that services are having on population health outcomes.
2. The Joint Excess Death Contingency Plan could benefit from data on heatwave-related excess deaths and indirect deaths during pandemics.
3. More use could be made of data to inform long-term decision-making, e.g. use of the Joint Health and Wellbeing Strategy Dashboard.
4. There are some challenges in providers capturing data in ways that mean they can report on impact, e.g. the Healthy Child Programme.
5. Health Equity Audit could be further used to inform fair access to services and interventions, e.g. vaccination uptake.

The Peer Review Team is impressed by the wealth of quantitative data routinely gathered and utilised by the Public Health Team and Council directorates. However, the development of a range of qualitative data would add to the richness of data and intelligence both for assessing need and measuring the impact of commissioned services on the experience of service users and residents. This may also help develop powerful narratives and storytelling to convey public health messages and influence. In addition, ensuring data is captured in a way that can be used to assess impact, such as evaluating delivery of the Healthy Child Programme would be helpful.

Given the large number of priorities the Council and its partners have, using data and intelligence to drill down into those priorities to understand where partners can have the greatest impact and to inform long-term investments and decision making would be beneficial. For instance, the Peer Review Team heard examples of pockets of deprivation in geographic communities that could benefit most from access to training and employment opportunities, and population segments such as younger men at greatest risk from mental health crisis and suicide where stigma may prevent them from seeking support.

The use of health equity audits and involving service users in equality impact assessments when commissioning services could help to reinforce existing efforts to ensure fair access to services.

4.5 Resources, Quality and Commissioning

Strengths

1. We met a talented, professional, enthusiastic, and committed public health workforce.
2. Good evidence of close working between the Public Health Team and other Council directorates across the commissioning cycle, e.g. 0-19 (25 with SEND), emotional wellbeing of children in care, domestic abuse services, family nurse partnership, and transport.
3. Commissioning teams make good use of data, hold providers to account, understand service priorities, and listen and respond to the voices of service users and wider community.
4. There is evidence of a collaborative approach to the use of the Public Health Grant, which appears to align to the public health objectives of the Council, with evidence of the impact of those resources on outcomes and priorities.
5. There is evidence that social value is incorporated into the commissioning process, e.g. apprenticeship work with developers, work with partner providers on supporting care leavers into employment.
6. Good evidence of the use of performance dashboards to inform contract management and priorities for investment in services.
7. Sustained investment of resource around the Poverty Truth Commission is improving quality, reach and impact, e.g. training for customer-facing teams around relational practice, digital literacy through device-lending libraries, wording of housing rent arrears letters, influencing Crisis Resilience support to be accessible via a freephone number.

The Peer Review Team was impressed by the members of the Public Health Team and staff from the other directorates it met during the interviews and focus groups. They had a good grasp of the Marmot approach and their contribution to it. They are clearly committed to the Council and progressing its public health agenda. Their talent, enthusiasm and motivation shone through.

The Public Health Team works closely with and across the Council's directorates with members embedded in commissioning teams and the corporate data and intelligence function. This approach supports the Council's ambition to be public health led, with public health expertise woven throughout the organisation rather than confined to a single public health directorate. Examples of the Public Health Team working closely with other teams are plentiful, including children's services, adult social care,

transport, and place and growth. There is evidence of a collaborative approach and senior oversight across the Council in how the Public Health Grant is invested.

A public health-led approach to commissioning is evident in the Council's strategic commissioning function and commissioning teams. There is good use of evidence and data to shape commissioning intentions across directorates and examples of social value built into the design process. This is particularly evident in the Council's partner companies, such as Brio Leisure and Cheshire West Recycling, with examples including apprenticeships and job opportunities for local people, and supporting care leavers into training and employment.

Engagement with communities and service users when assessing need, designing service specifications and reviewing service delivery is evidenced throughout the commissioning cycle, e.g. in the Healthy Child Programme and sexual health services. Contract management across a range of services appears robust, with performance dashboards and evidence of holding providers to account for delivering activity and outcomes, e.g. falls prevention, smoking cessation and NHS Health Checks.

Areas for improvement

1. Ensure that the future commissioning of inclusive leisure services is shaped by public health outcomes.
2. When introducing new strategies, consideration needs to be given to resourcing.
3. Succession planning and staff development within the Public Health Team requires ongoing attention as part of a recruitment and retention strategy.
4. Ensure shared understanding of what strategic commissioning means at place, across Health, VCFSE, and the Council.
5. Whilst implementation of strategies is hindered by funding constraints, this is an ongoing reality which needs to be addressed by sharper prioritisation and managing expectations of partners and communities.
6. Joint commissioning with the ICB has been negatively impacted by the reorganisation of the ICB and requires attention once concluded.

The Council is understandably ambitious in its efforts to reduce inequalities and improve the health and wellbeing of its population. This is to be commended but clearly needs to be seen within the context of finite funding and resources. It was evident to the Peer Review Team that significant Public Health Grant funding is being invested in leisure services. Whilst the service is delivering against wider wellbeing priorities, the Council must continue to provide assurance that Public Health Grant funding is being invested in ways that deliver against the breadth of core and wider public health responsibilities.

Having strategic ambitions without the resource to necessarily carry through was voiced by some partners as a frustration. Stepping into a role as strategic convenor of whole systems ways of working may enable the Council to identify new ways of pooling resources with partners, e.g. addressing population mental health outcomes across the life course.

The Public Health Team is a valuable and valued resource within the Council. Development opportunities within the team, succession planning and recruitment and retention would all benefit from attention. The capacity of the Team is finite, so consideration should be given to the demands the Council and partners place on the Team, the impact on staff wellbeing and motivation, and how its work can be prioritised to best effect. For example, as the Council continues its Marmot journey, having put in place strong data and intelligence capabilities and systems, its needs may shift slightly more towards softer influencing and communications skills to secure traction and outcomes. This aligns with recommendations about effective communications and engagement and giving greater attention to qualitative data.

4.6 Statutory Responsibilities

Strengths

1. The Council demonstrates that it is fulfilling its statutory responsibilities and mandated functions for public health.
2. Strong whole systems approach to influencing the wider determinants of health, with examples of partnership working with strategic planning, regulatory services and transport to influence at scale
3. Very strong leadership and governance in relation to Health Protection.
4. There is a good relationship with the UK Health Security Agency, e.g. outbreak management.
5. The Public Health Team's engagement in emergency planning is effective, with good evidence of learning from incidents and scenario planning, with Emergency Plans updated.
6. Evidence of a wide range of health improvement programmes, including across mandated functions and use of commissioning processes to preserve and enhance the value of investment in services such as the Healthy Child Programme.
7. Ability of the Public Health Team to work in an agile way to deliver against new funding opportunities in tight timeframes
8. Good examples of targeted work to focus on populations in greatest need, e.g.

smoking cessation.

9. Good examples of integrated and joint work to implement health improvement priorities between Public Health and other directorates, e.g. embedding public health posts in adult social care with public health outcomes attached to work programmes.

Leadership of the Public Health Team and public health responsibilities across the Council is strong, as exemplified in Health Protection. There are good governance arrangements, strong whole system approaches to tackling inequalities and the wider determinants of health across Council directorates and with partners. Public health influence is strong, as evidenced in areas such as strategic planning, regulatory services and transport.

The Public Health Team is agile, proactive and responsive. It engages effectively across statutory responsibilities including mandated functions and successfully influences partnership working both across Council directorates and with wider system partners. It responds efficiently in making pragmatic decisions to invest new funding streams, such as oral health improvement.

As such, the Peer Review Team is confident that the Council has demonstrated it is fulfilling its statutory and mandatory public health responsibilities well.

Areas for improvement

1. The Council could consider taking Health Protection assurance to an overview and scrutiny committee or management board.
2. Mental health remains a key area for further development. The Public Health Team could go further in taking a lead role in acting as system convenor for mental health promotion and prevention.
3. There could be increased visibility and reporting within the Council at a strategic level of outcomes from public health commissioned services, including equality and equity outcomes to ensure corporate oversight of quality and performance.
4. Ageing Well should be considered during the prioritisation process given the estimated 22% population growth in residents aged 65 years and over by 2030.
5. There is a recognition that Healthcare Public Health needs increased focus, and the team is working on this.
6. Review the approach to commissioning NHS Health Checks aligned to the evidence in relation to cardiovascular disease prevention.
7. Strengthen partnership working with the ICB, primary care and VCFSE sector to enable assurance of uptake of screening and immunisations.

Whilst leadership of Health Protection and the relationship with the UK Health Security Agency is strong, a role for overview and scrutiny in providing further assurance might be prudent and increase the visibility of public health among backbench members.

Reporting the outcomes of commissioned public health services and activity could be strengthened and more visible, as well as their impact on equity and inequality. For instance, the commissioning of NHS Health Checks from GP practices has 100% uptake across practices, and whilst the number of patients taking up the offer of a health check is reported, their impact on outcomes and variation between disadvantaged and more affluent communities is less clear. The level of investment allocated to the commissioning of Health Checks could be reviewed aligned to the evidence for return on investment enabling early intervention to prevent cardiovascular disease.

Further assurance could be provided to the Council from the ICB and NHSE in relation to screening and vaccination and specifically to provide assurance that inequalities in uptake are being addressed across Cheshire West and Chester.

The Peer Review Team was told in some focus groups and interviews that, whilst there is a significant focus on physical health, there are opportunities for the Council and Public Health Team to take a leading or convening role for mental health promotion and prevention. For instance, whilst recognising the impact of the current ICB restructuring, mental health could be an overarching strategic priority, with Council and ICB commissioners working with providers to ensure early interventions and prevention to secure the lowest level of intervention to meet need, e.g. reversing costly out of area mental health placements and building more community-based support into neighbourhood health plans. This would build on existing work aiming to prevent suicides.

5. Next steps

- Report published within three weeks of the peer review
- Support for improvement planning provided by the LGA's Public Health Improvement Programme
- Improvement plan developed within three months and oversight by the DHSC Regional Director for Public Health
- Potential of support for improvement plan priorities
- Evaluation
- Shared learning

The LGA appreciates that Cheshire West and Chester Council will want to reflect on the report findings and suggestions to determine how the organisation wishes to take things forward. Following the Public Health Peer Review, an improvement plan is to be developed by the Council with support from the Public Health Improvement Programme (PHIP). The improvement plan will be produced within three months of the on-site dates.

There is potential for further support for implementation of improvement plans and discussions are underway to determine how best to facilitate this.

In the meantime, the LGA is keen to continue the relationship we have formed with the Council throughout the Public Health Peer Review process and enable shared learning opportunities.

The LGA would like to thank Cheshire West and Chester Council for being the first in the mandated public health peer reviews of which 90 will be delivered over the next three years. Also, the positive and open way in which everyone contributed to the peer review, for the successful planning and for the time given by everyone who participated. We wish the Council well in all its future endeavours.