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Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday, 27th June, 2023**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the top of each report.

It should be noted that Part 1 items of Cheshire East Council decision making meetings are audio recorded and the recordings will be uploaded to the Council's website

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Appointment of Chair**

2. **Appointment of Vice Chair**

3. **Apologies for Absence**

4. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

5. **Minutes of Previous meeting** (Pages 5 - 14)

   To approve the minutes of the meeting held on 21 March 2023.

6. **Public Speaking Time/Open Session**

For requests for further information
Contact: Karen Shuker
Tel: 01270 686459
E-Mail: karen.shuker@cheshireeast.gov.uk with any apologies

In accordance with paragraph 2.24 of the Council's Committee Procedure Rules and Appendix on Public Speaking, set out in the Constitution, a total period of 15 minutes is allocated for members of the public to put questions to the committee on any matter relating to this agenda. Each member of the public will be allowed up to two minutes each to speak, and the Chair will have discretion to vary this where they consider it appropriate.

Members of the public wishing to speak are required to provide notice of this at least three clear working days' in advance of the meeting.

7. **Associate Member Nominations 2023-2024** (Pages 15 - 18)

   To agree the Associate members of the Cheshire East Health and Wellbeing Board for 2023-2024.

8. **Cheshire Youth Justice Services Health Needs Assessment** (Pages 19 - 42)

   To receive the Cheshire Youth Justice Services Health Needs Assessment.

9. **Cheshire and Merseyside Integrated Care Board Draft Joint Forward Plan** (Pages 43 - 88)

   To consider the draft Cheshire and Merseyside Joint Forward Plan.

10. **Outcomes Framework first quarter monitoring report** (Pages 89 - 140)

    To receive an update of the development of the Joint Outcomes Framework and plans for next steps.

11. **Joint Strategic Needs Assessment update: the 2023/24 work programme** (Pages 141 - 146)

    To consider the Joint Strategic Needs Assessment 2023/24 work programme.

12. **Better Care Fund end of year report 2022-2023** (Pages 147 - 174)

    To receive the Better Care Fund End of Year report 2022-2023.

13. **Better Care Fund 2023-2024** (Pages 175 - 234)

    To receive a report on the Better Care Fund Plan 2023/24.

14. **Cheshire East Health and Wellbeing Board draft revised Terms of Reference** (Pages 235 - 256)

    To consider a report on the draft revised Terms of Reference for the Cheshire East Health and Wellbeing Board.

15. **Cheshire East Health and Care Partnership update** (Pages 257 - 262)

    To receive an update on development of an Integrated Care System across Cheshire and Merseyside and in Cheshire East.

Membership: L Barry, Councillor C Bulman, H Charlesworth-May, Councillor S Corcoran (Chair), D Frodsham, Dr P Kearns, T Knight, Dr L O'Donnell, Councillor J Rhodes, Dr M Tyrer, M Wilkinson, Dr A Wilson (Vice-Chair), Councillor J Clowes (Associate Non Voting Member), V Elliott (Associate Non Voting Member), C Hart (Associate Non Voting Member), C Jesson (Associate Non Voting Member), K Sullivan (Associate Non Voting Member), J Traverse (Associate Non Voting Member) C Williamson (Associate Non Voting Member), I Wilson and D Woodcock

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CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 21st March, 2023 in the Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Voting Members
Councillor Sam Corcoran (Chair), Cheshire East Council
Councillor Carol Bulman, Cheshire East Council
Councillor Jill Rhodes, Cheshire East Council
Mark Groves, Healthwatch Cheshire
Helen Charlesworth-May, Cheshire East Council
Mark Wilkinson, Cheshire East Place Director

Non Voting Members
Deborah Woodcock, Executive Director of Children and Families, Cheshire East Council

Associate Non-Voting Members
Councillor Janet Clowes, Cheshire East Council
Kathryn Sullivan, CVS Cheshire East

Cheshire East Officers and Others
Paul Brightwell, Green Spaces Manager
Alison Davies, Project Officer, Green Spaces for Wellbeing
Guy Kilminster, Corporate Manager Health Improvement
Dr Susie Roberts, Public Health Consultant
Karen Shuker, Democratic Services Officer
Sarah Trelfa, Trainee Manager, Workforce Development Team

46 APOLOGIES FOR ABSENCE

Apologies for absence were received from Denise Frodsham, Dr Lorraine O'Donnell, Dr Matt Tyrer, Claire Williamson, Dr Andrew Wilson and Isla Wilson.

Mark Groves attended as a substitute for Louise Barry.

47 DECLARATIONS OF INTEREST

There were no declarations of interest.

48 **MINUTES OF PREVIOUS MEETING**

RESOLVED:

That the minutes of the meeting held on 21 January 2023 be confirmed as a correct record.

49 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no public speakers.

50 **THE JOINT LOCAL HEALTH AND WELLBEING STRATEGY AND FIVE-YEAR PLAN 2023-2028**

The Board considered the refreshed Joint Local Health and Wellbeing Strategy and Five-Year Plan 2023-2028 which would underpin the work to reduce inequalities and improve health and care service provision over the next five years.

The Strategy took into account the NHS Cheshire and Merseyside Integrated Care Board and the Cheshire and Merseyside Integrated Care Partnership, the formal recognition of the 'Place' being coterminous with the local authority geography and the Care Communities operating at a local 'neighbourhood' level. It summarised the challenges faced as a system. There was focus on the wider determinants of health in recognition of the impact that those have and the need for the Health and Wellbeing Board to galvanise partners to work in partnership to address those. In addition, it set out the challenges for health and care providers and the aspirations to work together to improve services and outcomes for residents/patients through a more integrated approach.

The feedback from the public engagement undertaken in January 2023 demonstrated a good level of support for the vision, strategic outcomes and model of care.

Guy Kilminster was thanked by board members for his hard work in creating the document and the Board acknowledged that the challenge going forward would be how to deploy resources to those areas where there was greatest need and impact.

RESOLVED:-

That the Joint Local Health and Wellbeing Strategy and Five-Year Plan 2023-2028 be approved.

51 **CHESHIRE EAST DIGITAL INCLUSION PLAN 2023 - 2026**

The Board considered the refreshed Cheshire East Digital Inclusion Plan. The draft Plan was influenced by pre-engagement conversations with the public and voluntary and community sector organisations. The

draft Plan was subject to a public engagement exercise which had resulted in the broadening of the second of the three cohorts identified to include the digitally inexperienced.

It was proposed that the enhanced Cheshire East Digital Inclusion Task Force (CEDIT) who had drafted the plan would be renamed to the Cheshire East Digital Inclusion Partnership and would include a broader membership and would continue to feed in to the Cheshire East Health and Wellbeing Board to ensure it had a place in the system.

The benefits to being digitally enabled were set out within the Plan but in summary could lead to amongst other things: improved health and wellbeing; being better connected socially; assisting with education, learning or work (including securing employment); being able to access information, guidance and advice and to benefit from savings deals on services and shopping.

Further work would be undertaken on the draft implementation plan and further support provided for those people who through ill health or disability could not or were no longer able to access services online. The ongoing rollout of Connecting Cheshire would assist with improving access to broadband for those living in rural areas.

RESOLVED: That:-

1. the refreshed Cheshire East Digital Inclusion Plan be approved.

2. the Health and Wellbeing Board support the proposal that the Delivery Plan is implemented through the Cheshire East Digital Inclusion Partnership.

3. the Health and Wellbeing Board agree to have oversight of the progress made in delivering the action plan.

52 **GREEN SPACES SOCIAL PRESCRIBING PILOT**

The Board received a presentation on Greenspaces for Wellbeing which was a partnership between ANSA, the NHS, Cheshire East Council, Everybody Health and Leisure and the voluntary sector. The aim of the partnership was to improve the overall health and wellbeing of the local communities and reduce inequalities through the wider use of community assets including green space.

A 12 week wellness programme was part of an offer with a wide range of nature-based interventions to suit different needs along with five ways to wellbeing which included

1. Connect – nurture connection and provide an inclusive and welcoming environment.

2. Be active – enable people to get active through health walks, gardening and habitat management.
3. Take notice – encourage people to take notice of nature through creative activities, identifying wildlife and nature surveys.
4. Keep Learning- Create learning opportunities from identifying wildlife to horticultural skills, growing food and making crafts.
5. Give Back – Help people to contribute their time to meaningful activities that help nature, boost sustainability, and improve parks and open spaces.

Referral pathways would be through clinicians/health workers, practice staff, trusted partnerships (Pharmacy/LA), community organisations and self-referral.

Pilots had commenced in the Crewe and Macclesfield District and data would be analysed with a view to expanding the scheme across the borough. Health care professionals who had trialled the scheme had provided positive feedback and 100% would recommend the scheme to patients or community members.

Board members welcomed the scheme, acknowledging the benefits the scheme would provide. Although there was a desire to include parents with children and young people within the scheme the current model was not set up to do that and more funding and consideration of the model was required. However, the proposal to extend the scheme to care leavers was agreed and will be taken forward.

RESOLVED:

That the presentation be noted.

53 **DIRECTOR OF PUBLIC HEALTH PUBLIC HEALTH ANNUAL REPORT 2022**

The Board considered the Public Health Annual Report for 2022. The report highlighted the need for a sustained and coordinated response to climate change across Cheshire East. Addressing climate change could have the potential to: improve health and wellbeing and address inequalities; to improve quality of places and green infrastructure; and increase economic productivity and growth.

The report outlined the steps already being taken locally and recommended that continual progress be made to meet the pledge to make Cheshire East a carbon neutral borough by 2045 through:

- Continual progress to meet the pledge to make Cheshire East a carbon neutral borough by 2045 through:
- Public sector leading by example
- Working in partnership with NHS, businesses, voluntary sector to ensure that climate change and sustainability was a priority for all

- Developing multi-agency integrated sustainable policies across different sectors and departments
- Ensuring that policies address both climate change and health inequalities
- Engaging all stakeholders and public through information campaign and consultation exercises
- Monitoring and evaluating the implementation of policies and strategies
- In response to the recovery from the pandemic it was important to build on some of the positive changes seen during the response to the pandemic, such as the choice to work from home, enhancing the local opportunities for active travel and the reduction in traffic and air pollution.

RESOLVED: That:-

The Public Health Annual Report and the Executive Summary be approved for publication.

54 **JOINT STRATEGIC NEEDS ASSESSMENT CHAPTER APPROVAL PROCESSES**

The Board considered a report which outlined an alternative proposal to approval of JSNA reviews for publication and also of the work programme. The proposal was for the responsibility for sign off of the reviews for publication and of the work programme to be delegated to the Cheshire East Council Executive Director of Adults, Health and Integration or the Director of Public Health and to approve the work programme approval process.

After the information was presented to the Executive Director of Adults, Health and Integration or the Director of Public Health it would then be shared with elected members and a two week window would exist during which time any concerns or issues could be raised. After that (assuming no concerns are raised) it would be published on the website.

The process would enable more timely production and publication of JSNA reviews, enabling more prompt action across Cheshire East Place to improve health and wellbeing and address inequalities.

RESOLVED: That:-

The proposal to update the Joint Strategic Needs Assessment (JSNA) approval process and the work programme, in which responsibility for approval of the reviews and the work programme for publication will be delegated to the Cheshire East Council Executive Director of Adults, Health and Integration or Director of Public Health be approved.

55 **POVERTY JOINT STRATEGIC NEEDS ASSESSMENT**

The Board considered a report which outlined the findings and recommendations of the Cheshire East Poverty JNSA.

The Poverty JSNA had been completed as part of the 2022/23 JSNA work programme and following approval it would be added to the suite of current JSNA products on the Cheshire East Council JSNA website.

Key findings from the review included:

- The most deprived areas in Cheshire East were seen within Crewe and Macclesfield, but also within smaller areas of Congleton, Alsager and Handforth.
- People in households with disabilities, single parents, and single adults without children were more likely to experience poverty, there was also regional evidence to suggest that people from certain ethnic groups were more likely to experience food insecurity.
- Across Cheshire East, many food banks had seen an increase in demand. Decreases in food donations had also been seen. Food banks often support young men and single parent households.
- The condition of housing stock as well as access to affordable accommodation were challenges. There were currently thousands of applications for social housing.
- Residents with lived experience who use food banks reported that experiencing food poverty was extremely stressful and isolating. People might be reluctant to seek support due to a sense of stigma.

Following Board members comments officers reported that:

- There were some challenging recommendations, specifically around housing and long-term unemployment but that there were some very actionable recommendations as well. It would be important to be championing the messages around the JNSA and information sharing and making residents aware.
- The outcomes framework would set out the things that would be measured to demonstrate that the objectives were being achieved.
- The next step would be to decide on the prioritisation tool which would identify those activities that would be prioritised and give the biggest impact.

In respect of questions raised in relation to long term unemployment and the number claiming benefits it was agreed that a written response would be provided outside of the meeting.

RESOLVED:-

That the Poverty JSNA and the recommendations outlined in the report be approved for publication

56 **THE LOCAL GOVERNMENT ASSOCIATION FACILITATED REVIEW OF THE CHESHIRE EAST HEALTH AND WELLBEING BOARD**

The Board received a report which outlined the proposed changes that were recommended following a Local Government Association (LGA) facilitated review. In June 2022 the LGA were asked to support the Cheshire East Health and Wellbeing Board to review its role and responsibilities and ensure that it was fit for purpose with the introduction of Integrated Care Systems and Integrated Care Boards. Work had been underway since July 2022 with three workshops held to inform the recommendations set out within the report.

A number of recommendations had come out of the review work which were designed to ensure that the Board could fulfil its statutory responsibilities effectively – providing strategic leadership, driving integration and reducing inequalities.

The recommendations included:

- That the membership of the Board be widened to include additional representatives of the Council's Place Directorate; a representative of housing providers; a representative of community pharmacy and a representative of the business sector.
- That named individuals take the lead as *senior responsible owner* for each of the four Strategic Outcomes set out in the Joint Local Health and Wellbeing Strategy, and that if these individuals are not already members of the Board, they also join its membership.
- That a Reference sub-group be established to review certain 'standard' reports and escalate to the Health and Wellbeing Board any matters of concern.
- That the 'Informal meetings' of the Board are used to meet with other local Boards and Partnerships to discuss how we can work together more effectively to deliver the strategic outcomes set out in the Joint Local Health and Wellbeing Strategy.

RESOLVED: That:-

The recommended changes to the membership and ways of working of the Health and Wellbeing Board be approved.

57 **CHESHIRE EAST HEALTH AND CARE PARTNERSHIP UPDATE**

Mark Wilkinson, Cheshire East Place Director provided the board with an update on the Health and Care Partnership (HCP) and NHS Cheshire and Merseyside's team in Cheshire East.

At the last meeting of The Health Care Partnership Board items for discussion included:

- A presentation received from Care Communities. It was intended to focus on a different area at each meeting.

- The endorsement of the Joint Local Health and Wellbeing Strategy
- The approval of the Social Action Charter which set out the terms of its engagement with the voluntary community, faith, and social enterprise sector.
- A proposal to establish a quality and performance group which would enable the development of a place-based understanding of the quality of the health and care services that were delivered.
- A presentation on a programme of work called Sustainable Hospital Services which looked at the challenges in East Cheshire Trust in maintaining a viable range of acute hospital services on the Macclesfield site.

More general updates with the Partnership included:

- Home first collaboration – non recurrent sums of money had been received that had been provided across the winter period and those additional non recurrent allocations that had come from the government through the local authority would help to strengthen health and social care with the overall aim of accelerating discharges from hospital.
- The Integrated Cared Board (ICB) initiated work on accountability and delegation.
- Commissioning budgets were forecasting deficits for 2023/24. This was mirrored across the whole of Cheshire and Merseyside. Financial planning for the next year would remain a significant focus.

Developing the Cheshire and Merseyside Five Year Joint Forward Plan

The Board received a presentation which outlined the plans related to implementing the strategies as a health and care system, both at Place and Cheshire and Merseyside level.

In respect of the joint forward plans, there would be a particular role for the Health and Wellbeing Board as the ICB was required to involve each Health and Wellbeing Board and in June comments would be invited on the joint forward plan.

There was an ongoing piece of work in respect of the strategic objectives as they could be fairly broad and include lots of different things underneath them. A review of the data would identify where outcomes were the poorest.

A workshop had taken place to look at the overall priorities. Public engagement would continue and the ICB board would be doing further work to endorse the draft forward plan by the end of March. The plan would then be considered by the Health and Wellbeing Board at its next meeting.

Board members fed back their views which included:

- It was positive that there was the desire to tackle health inequalities and address the wider determinants of health.
- Resources should be allocated at place level
- It would be sensible for the budget to be set in advance.

RESOLVED:

That the update and presentation be noted.

The meeting commenced at 2.00 pm and concluded at 4.05 pm

Councillor S Corcoran (Chair)

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Agenda Item 7

Cheshire East Council

NHS
Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Associate Member Nominations 2023-2024
Report Reference Number	HWB29
Date of meeting:	27th June 2023
Written by:	Guy Kilminster
Contact details:	Guy.kilminster@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	The Chair

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision X
Why is the report being brought to the board?	To agree the Associate members of the Cheshire East Health and Wellbeing Board for 2023-2024		
Please detail which, if any, of the Health & Wellbeing Strategic Outcomes this report relates to?	1. Cheshire East is a place that supports good health and wellbeing for everyone ☐ 2. Our children and young people experience good physical and emotional health and wellbeing ☐ 3. The mental health and wellbeing of people living and working in Cheshire East is improved ☐ 4. That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place ☐ All of the above X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above X		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The Board is to agree the Associate membership for 2023-2024 to ensure that the Board can effectively fulfil its statutory responsibilities and support the delivery of the Joint Local Health and Wellbeing Strategy.		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	No
Has public, service user, patient feedback/consultation informed the recommendations of this report?	N/A
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	The Cheshire East Health and Wellbeing Board will function more effectively in its role to provide strategic leadership for integration and the reduction of inequalities.

1 Report Summary

1.1 The Cheshire East Health and Wellbeing Board's Terms of Reference require Associate Members to be nominated and agreed at the first meeting of the Municipal Year. This report proposes the Associate Members for 2023-2024.

1.2 Following the Local Government Association's facilitated review of the Board in 2022, it has been agreed that all Associate Members will be voting members. The current Terms of Reference allow for Associate Members to be appointed as voting members. It is therefore proposed that all appointees are made as voting members.

2 Recommendations

2.1 That the Cheshire East Health and Wellbeing Board agree the following individuals as voting Associate Members for 2023-2024:

Councillor Janet Clowes – Opposition Group representative
Peter Skates – representing the Executive Director of Place
Claire Jesson – representing the Police and Crime Commissioner
Victoria Elliott - representing the Chief Fire Officer
Kathryn Sullivan - representing the community, voluntary and social enterprise sector
Claire Wilkinson – an additional representative for Children and Families

A representative of housing providers – to be nominated
A Business representative – to be nominated

Reasons for Recommendations

3.1 To ensure that the Cheshire East Health and Wellbeing Board has a membership that will allow it to fulfil its statutory responsibilities and effectively support the delivery of the Cheshire East Joint Local Health and Wellbeing Strategy.

4 Impact on Health and Wellbeing Strategic Outcomes

4.1 The membership of the Cheshire East Health and Wellbeing Board will be critical to achieving the strategic outcomes of the Cheshire East Joint Local Health and Wellbeing Strategy. They will provide the strategic leadership required to take forward the work of the Board in supporting integration and reducing inequalities.

5 Background and Options

5.1 The Statutory (previously referred to as 'core') Membership of the Cheshire East Health and Wellbeing Board is set out in the current Terms of Reference. This includes those members that are set out in the legislation (Health and Social Care Act 2012).

5.2 The Statutory Members can elect voting and/or non-voting Associate Members on to the Board to assist with the work of the Board and the delivery of the strategic outcomes set out in the Joint Local Health and Wellbeing Strategy.

5.3 Following the Local Government Association facilitated review undertaken last year it was proposed that all Associate Members are elected as voting members. This is designed to ensure that their membership and contribution to the work of the Board is seen as being of equal value to that of the Statutory Members.

5.4 It is therefore proposed that all newly appointed Associate Members are appointed as voting Members.

5.5 The refreshed Terms of Reference (to be considered later in today's meeting) will change these arrangements and simplify the process. Those Terms of Reference will come into effect once full Council has approved them.

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

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Designation: Corporate Manager Health Improvement
Tel No: 07795 617363
Email: guy.kilminster@cheshireeast.gov.uk

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March

2023

Cheshire Youth Justice Services Health Needs Assessment – Executive Summary Report

Ellie McCoy, Charley Wilson, Rebecca Harrison, Chloe Smith, Nadia Butler, Ann Marie Farrugia, Faye Hellewell & Zara Quigg

Public Health Institute, Liverpool John Moores University, 3rd Floor Exchange Station, Tithebarn Street, Liverpool, L2 2QP

Contact: E.J.McCoy@ljmu.ac.uk / Z.A.Quigg@ljmu.ac.uk

Cheshire Youth Justice Services Health Needs Assessment – Executive Summary Report

Ellie McCoy, Charley Wilson, Rebecca Harrison, Chloe Smith, Nadia Butler, Ann Marie Farrugia, Faye Hellewell & Zara Quigg

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March 2023

This executive summary report provides an overview of the Health Needs Assessment key findings. This report sits alongside an in-depth full technical report.

Acknowledgements

The authors would like to thank the following individuals for their support and participation in the Health Needs Assessment (HNA):

- The commissioners of the HNA; Cheshire Youth Justice Services (including Cheshire East, Cheshire West, Halton & Warrington) and Dr Andrew Davies, Chair of the Health Subgroup to the Cheshire, Warrington, and Halton Youth Justice Board.
- The HNA steering group; Tom Dooks, Kerry Jackson, Dr Andrew Davies, Cheryl Cooper, Ann Wood and Steve Tatham
- Stakeholders from Cheshire and Merseyside Health and Care Partnership
- The wider team at Cheshire Youth Justice Services
- The wider research team at the Public Health Institute, Liverpool John Moores University including Dave Seddon, Evelyn Hearne, and Rebecca Bates.
- With a special thank you to the stakeholders, parents and young people who participated in the research.

Report contents

Introduction

Preventing children and young people's engagement in crime and violence are key public health issues at local and (inter)national level. In 2020/21, over 15,000 children (aged 10-17 years) were cautioned or sentenced across England and Wales (Youth Justice Board, 2021). The Youth Justice System (YJS) works to prevent offending and reoffending by children (aged 10-17 years), through providing a child-centred service, that is trauma-informed and focuses on assessing the needs of the child and supporting better outcomes for them. The YJS aims to work with children to help them to lead a life free from crime and reduce crime in the local area. The YJS is a statutory partnership that takes a holistic approach to working with children and young people. As such the partnership comprises several specialties such as police, probation, children's social care, health, education, and wider support services (e.g., substance misuse, mental health, housing). Local YJS partnerships/boards enable a place-based approach to supporting children. Across Cheshire, the YJS covers all four local authorities - Cheshire East, Cheshire West, Halton, and Warrington.

The Public Health Institute (PHI), Liverpool John Moores University (LJMU) were commissioned to undertake a Health Needs Assessment (HNA) for Cheshire Youth Justice Services (YJS). The HNA aimed to assess the health and wellbeing needs of the youth offender population across Cheshire East, Cheshire West, Halton, and Warrington. The key objectives included:

- Identify the health and wellbeing needs of children, and key factors that influence these needs.
- Map out the health service provision for children during (and prior to) their engagement with the YJS.
- Examine the impact of children's engagement with the YJS on their health and wellbeing (and wider outcomes relating to the social determinants of health).
- Identify key leverage points and mechanisms for supporting young people's health and wellbeing, prior to, during, and following YJS engagement (focusing on primary prevention and a life course approach).

Methodology

Health needs assessment (HNA) allows us to identify needs and assets for review, to help determine priorities to improve the health and wellbeing needs of young people involved in the Criminal Justice Service (CJS). For the Cheshire YJS needs assessment, the HNA framework developed by the National Institute for Health and Care Excellence (NICE, 2005) was used. This incorporated the cyclical five step methodology:

1. Getting started and the establishment of a project steering group.
2. Identifying health priorities through a desktop analysis of data and through engagement with the target population.
3. Assessing a health priority for action through a comprehensive review of all relevant literature.
4. Planning for change through the development of a series of evidence-based recommendations.
5. Moving on and review through the delivery of this report to allow providers and commissioners to learn from the findings and action plan for change.

2.1 Literature review

A literature review was undertaken to provide context to the research and aide the interpretation of research findings and development of recommendations. Existing documentation, data and information produced or collated by partners that detail the policies, processes, and support mechanisms in place for children at risk of, and/or engaged with the YJS, and/or the health and wellbeing needs, were also collated and explored to inform this HNA.

2.2 Secondary data analysis

Data from YJS case records were extracted from the Cheshire YJS system to identify the health and wellbeing needs of children in contact with the YJS. A data sharing agreement was developed with strict data protection processes to adhere to GDPR legislation. The secondary data sample included the full client caseload and included data on:

- Demographics - age; gender; ethnicity; responsible local authority; education profile (including any exclusions, and special educational needs).
- Neurodiversity and other needs - neurodiverse conditions; speech and language needs; difficulties with social skills; having had a traumatic brain injury.
- Health needs - physical health needs; mental health needs.
- Health risk behaviours - drug, alcohol, and tobacco use.
- Vulnerability and victimisation - social care needs; child exploitation; missing from home incidents; relationships with family; adverse childhood experiences (ACEs); violence victimisation; risk of future adverse outcomes and victimisation.
- Offending and violence perpetration, including the risk of future offending.

Data was extracted from completed Assetplus assessments for statutory cases. The sample included 122 young people, of these 97.5% had a completed Assetplus assessment at the time of extraction (November 2022). Assetplus assessments are comprehensive, containing data on all the above factors in the form of both drop down boxes and free text spaces.

Data was extracted from completed DIVERT assessments for DIVERT cases. The sample included 92 young people, of these 89.1% (n=82) had a completed DIVERT assessment at the time of extraction (November 2022). DIVERT assessments are less comprehensive than Assetplus assessments,

containing data on most of the above in the form of free text spaces primarily, however, tick boxes were used in the same fashion as the Assetplus assessment for data on physical and mental health outcomes, and for educational, social, and speech and language needs. DIVERT assessments did not contain some of the variables that were included in the Assetplus assessments, such as information on qualifications, numeracy and literacy levels, AUDIT assessment for alcohol use, and the Youth Offending Group Reconviction Scale (YOGRS) score.[1] Some young people did not have an assessment completed as data extraction was performed on a live system, as such at the time of extraction the young person was awaiting assessment.

Available national and local data was used as a comparison between the YJS cohort and young people in the general population, highlighting where different needs were overrepresented in the youth justice sample. The values for different variables in the youth justice sample were compared to the expected values that would be present if the YJS data matched data nationally or locally. National and local data sources included for example, surveys of young people and government data sets.

Some variables are based on case notes (e.g., ACEs) and not formally assessed or measured so they represent the minimum prevalence (i.e., a child might have had ACEs but if this does not come up in discussions then it won't be recorded). This is even more relevant for DIVERT cases where the formal Assetplus assessment is not conducted.

2.3 Engagement with stakeholders

Semi-structured interviews and focus groups were carried out with 43 key stakeholders, this included 26 staff members involved in the management and delivery of services at Cheshire YJS, and 17 wider stakeholders involved in the commissioning and delivery of services across Cheshire that support young people and their families.

Engagement with YJS colleagues (n=5 focus groups, n=4 one-to-one interviews, and n=1 paired interview) included case managers, support workers (including both DIVERT and statutory), child and adolescent mental health services (CAMHS), speech and language therapies (SLT), and substance use workers. Wider partner engagement (n=1 focus group and n=16 one-to-one interviews) included a geographical spread across Cheshire (Cheshire East n=2, Cheshire West n=6, Halton n=2, Warrington n=2, and Cheshire wide n=5). Stakeholders included strategic and commissioning, managerial, and operational positions, which focussed on early help, mental health, sexual health, community safety partnership, substance use, health protection, education, youth services, and health services. Interviews and focus groups were carried out using MS Teams and explored views on the health and wellbeing needs of children engaged in the YJS and key risk and protective factors, processes for, and outcome/impacts of identifying and responding to children's health and wellbeing (and wider) needs (both prior to and during engagement with the YJS). Further exploration focused on the key leverage points and mechanisms for supporting children's health and wellbeing, prior to, during, and following YJS engagement (focusing on primary prevention and a life course approach); and areas for transformation (at policy and/or practice level) to enhance children's health and wellbeing and prevent offending and reoffending.

[1] The Youth Offending Group Reconviction Scale (YOGRS) uses an algorithm to estimate the probability that youth offenders will be re-sanctioned for any recordable offence within two years of sentence, or release if sentenced to custody. This provides a percentage estimate of re-sanctioning compared to a similar cohort of individuals.

2.4 Engagement with young people and parents

The research team have engaged with seven individuals. This includes four young people and three adults, comprising of three paired interviews with a young person and parent, and a one-to-one interview with a young person. The young people who have engaged in the needs assessment so far have all been male and aged 10, 15, and two aged 17. They were engaged with Cheshire YJS through DIVERT (n=2) and statutory requirement (n=2), and represented Warrington, Chester, and Halton. Case managers and support workers supported the recruitment and facilitation of the interviews. Interviews were carried out using MS Teams or via telephone. Discussions explored views of the health needs of young people engaged in, or at-risk of engagement with the YJS, approaches to addressing and/or preventing these health needs (including prior to YJS engagement), and views on the YJS support and interventions, and the outcomes and impacts for health and wellbeing (and wider outcomes as relevant).

2.5 Stakeholder workshop

An online multi-agency workshop was held towards the end of the HNA to share key findings and facilitate a discussion around shaping the recommendations. The workshop was attended by 33 key partners from across the Cheshire footprint, including representation from Halton, Cheshire East, Cheshire West and Chester, and Warrington. A range of services and strategic and operational roles were represented including the YJS, Local Authority, Public Health, Safeguarding Children Partnership, Children's Services, Early Help, Integrated Care Partnership, CYPMH, CAMHS, and SEND service. The key findings and draft recommendations were presented to the group and discussions focused on:

- Do the key findings reflect your experiences?
- Are there further examples of best practice?
- What are the challenges?
- Are there any gaps within the HNA?
- Are the recommendations feasible?
- How do the findings/recommendations relate to the local children's strategies?

2.6 Analyses

All qualitative interviews were recorded, transcribed, and analysed using thematic analysis. Quantitative data was shared via a secure SharePoint and through secure access to the Cheshire YJS case management system and analysed using SPSS. All research activities were subject to ethical approval through the LJMU Research Ethic Committee (approval reference 22/PHI/011).

Key findings

Identifying need

Data analysis of Cheshire YJS case note data provided a wealth of data on the health needs for young people engaging with the YJS. This was supported and complimented by extensive engagement with key stakeholders across the YJS and wider services across Cheshire, and a small representation from young people and their parents who were engaged with the YJS. The data included 92 (82 with assessments) young people from DIVERT and 122 (119 with assessments) young people from the statutory YJS route. This data also informed the HNA to provide a clear overview of the characteristics and needs of young people entering the Criminal Justice System (CJS) and working with the YJS. Violence was the major contributing factor that had brought them into contact with the YJS, with 85.6% of statutory and 72.4% of DIVERT cases having perpetrated some form of violence (eight in ten statutory, and six in ten DIVERT had perpetrated youth violence). As expected the mean number of offences (7.7 vs 2.4) was higher and incidents (4.1 vs 1.6) were higher for statutory than DIVERT cases. Data also shows that violent related crime has increased since the first HNA which was completed in 2015, highlighting increased complexity (The Centre for Public Innovation, 2015)[2].

"Our kids are deliberately or otherwise, great at camouflaging their unmet health needs and they camouflage it typically through expressive behaviour that brings you into contact with the law" (Stakeholder)

Young people entering the YJS were predominantly males (90.2% statutory and 70.7% DIVERT), aged between 15-17 years (67.2% statutory and 59.8% DIVERT [although DIVERT were generally younger than statutory cases]) and high proportions were currently or had previously been identified as a child in need (75.4% statutory and 39.0% DIVERT). Compared to the national prevalence (3.2%), proportions of young people (15.3% statutory and 19.5% DIVERT) were significantly higher for those currently identified as a child in need. Whilst females were less represented within the YJS (and the CJS nationally), the data did show that they had higher risk factors for some areas, including exploitation, victimisation, and perpetration of child to parent violence. There were also more females engaged with the DIVERT route and some stakeholders reported seeing increased violence amongst this cohort.

"A lot of these kids are in care. We support the care homes because a lot of them have had no training and how to talk to a child for speech, language communication need, which is desperate seeing as most of them have them" (Stakeholder)

Through engagement with stakeholders and service users, multiple and complex issues were identified for the young people involved in the CJS. These issues were seen as both risk factors (and unmet health needs) for them becoming involved in crime, and as impacts of being involved in crime and the CJS. They also created additional barriers for young people and their families for engaging with services and with support services. The COVID-19 pandemic and cost of living crisis were both seen to have exacerbated health needs and negative impacts for young people and their families. Dahlgren and Whitehead (1991) termed the model of health determinants over thirty years ago to understand the factors that increase health inequalities, which included central factors, individual lifestyle factors, social and community networks and socio-economic, cultural, and environmental conditions. The Marmot review (Marmot, 2010), and subsequent 10-year review (Marmot, 2020) of

[2] The Centre for Public Innovation (2015). Health And Well-Being Needs Assessment of Young Offenders Across Halton, Warrington and Cheshire West & Chester. London.

health equity across England calls for action on the social these determinants of health with the aim of reducing inequalities.

"It took (YP) to get in trouble for us to meet the criteria" (Parent)

"You just think this child so vulnerable, and it's taken them committing an offence to get the health needs met" (Stakeholder)

Understanding the findings of the Cheshire YJS HNA, using the model of health determinants, we can see a number of factors that are increasing inequality and health and wellbeing needs for young people involved with the CJS. Stakeholders engaging in the research acknowledged that by the time a young person becomes involved with the YJS, they have usually had involvement with a number of other services. However, findings from the HNA suggest that young people enter the YJS with a number of unmet and unidentified health needs that may have contributed to the reason for needing YJS input, suggesting early intervention is critical.

"I think that's one of the biggest challenges for us, is that they are getting the help after they have committed something. So it's almost a little bit too late. Maybe if they had the right support in school etc. earlier when they were growing up then they might not have committed a crime and end up with our service at all so we're almost trying to go back in time, try and work it out. Look at the history; work out what is going on for that person. Then trying to put strategies and things in place and then start sharing that information with other professionals" (Stakeholder)

"Challenge is that we talk about early help and prevention but pathways/systems wait for things to get worse before services are accessible (parents have highlighted this here). Can't see how things will change until we collectively come together and resource/support universal services" (Stakeholder)

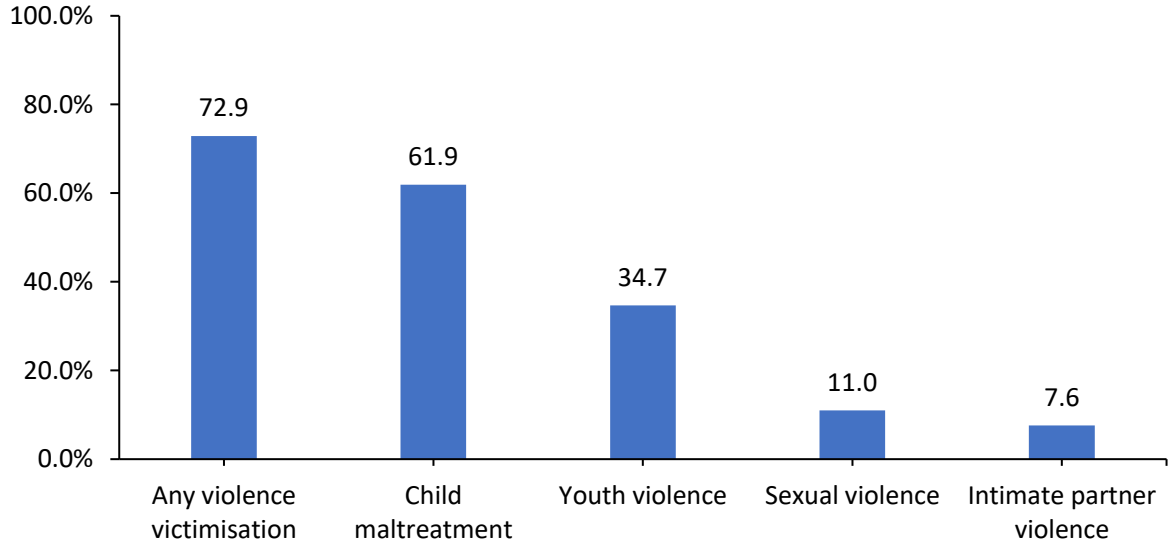
Additional data collected by the YJS, at assessment and during the time the young people were engaged, also provided wider context. This flagged risk factors that may have contributed to the crime and may also contribute to further offending behaviour. This data enables the YJS to work together to develop a tailored strategy and pathway of care for individual young people to help meet their needs and reduce health and re-offending risks (29.4% of statutory cases and 6.1% of DIVERT cases were assessed having a high likelihood of reoffending [27.1% and 1.2% posing a risk of serious harm to others]). Findings from the HNA add to the increasing evidence base for risks associated with young people becoming involved in criminal behaviour, including risk of criminal exploitation. Over half (59.5%) of statutory cases and nearly one third (32.9%) of DIVERT cases were considered vulnerable to criminal exploitation, with high proportions of young people experiencing violent victimisation (72.9% statutory and 59.5% DIVERT). Whilst offences were predominantly perpetrated against other young people, violence experienced by young people was primarily perpetrated by adults, with smaller proportions recorded as victims of youth violence (34.7% statutory and 23.8% DIVERT). Proportions of young people were also deemed at high risk (26.1% statutory and 7.3% DIVERT) and very high (1.7% statutory) of future risks to safety and wellbeing.

"There are a lot young people who are vulnerable, who are susceptible to getting involved in in gang culture, who are doing things because they're being told by others that they're going to have a better life because of it" (Stakeholder)

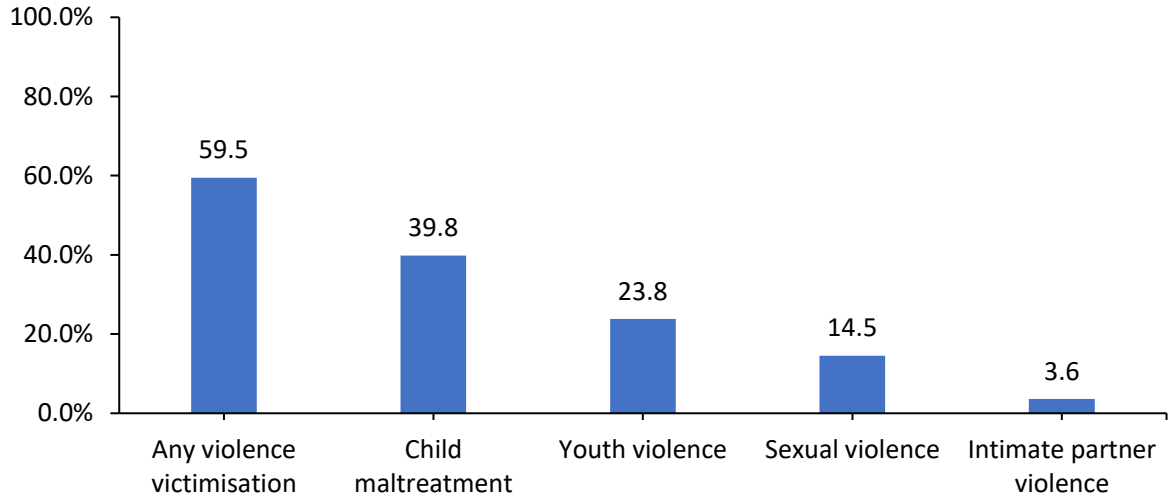
"The problem is if we don't give young people an opportunity to have a positive identity and some sense of self-worth of what they're good at and who they are. If they find themselves

excluded from the traditional system, they'll find other ways of gaining self-worth and self-esteem and identity and that's when often they can be preyed upon" (Stakeholder)

Prevalence of violence victimisation amongst statutory young people



Prevalence of violence victimisation amongst DIVERT young people



This HNA evidences significant unmet health needs in terms of three main areas; mental health, neurodiversity and SEND, and substance use. All of these are linked to additional needs related to the health, social care, criminal justice, and education sector. Stakeholders, parents, and young people provided examples of these health factors, suggesting young people are in need of support in these areas for some time before the criminal activity that had led to their work with the YJS. The quantitative data analysis further confirmed this, by demonstrating that high numbers of young people engaged with YJS had poor mental health, SEND requirements, and were using drugs and alcohol. These three key area all form part of the health offer provided by Cheshire YJS meaning that these needs could be identified, and support put in place to start to address them.

"Mental health needs especially are massively underfunded and under provided for" (Stakeholder)

For mental health, overall, 17.7% of young people had a formally diagnosed mental health condition (22.0% of statutory and 10.8% of DIVERT cases). Overall, 47.9% of young people were accessing mental health services (57.3% of statutory cases and 32.9% of DIVERT cases), suggesting more were engaging in support than had an official diagnosis, bringing into question the unidentified needs of those young people not engaging with any support (these were highlighted in the qualitative work). Of those with a diagnosed mental health condition, 97.1% were accessing mental health services (100.0% for statutory cases and 87.5% for DIVERT). Mental health needs were higher than presenting physical health needs, with one in ten for both statutory and DIVERT having needs in this area. Stakeholders gave examples of the increasing mental and emotional health needs for the young people they work with, as well as the increasing need for their parents and families in this area. The parents and young people participating in the research reported poor mental health, anxiety, low self-esteem and confidence, self-harm, and difficulty in accessing support, including long waiting lists and not meeting risk thresholds for CAMHS. The COVID-19 pandemic and cost of living crisis were seen to have exacerbated these mental health needs, with poverty being flagged as intrinsically linked to poor mental health and increased risk of offending.

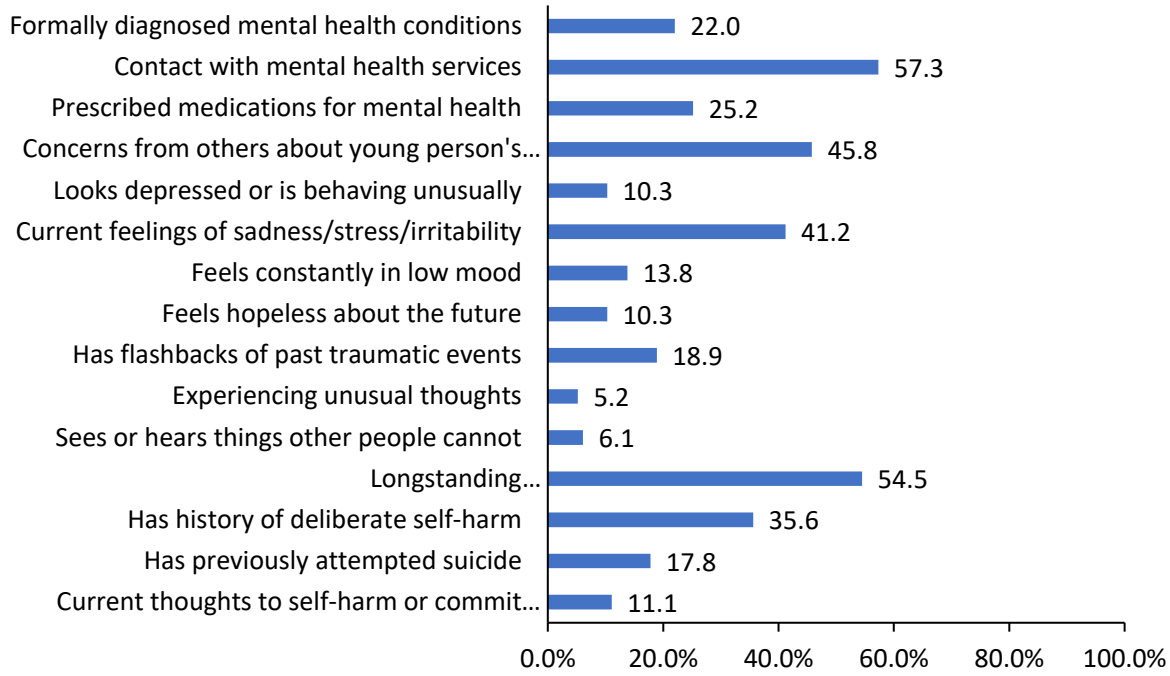
"I think sometimes when we refer our young children to like CAMHS, for instance, I think there's a gap in like counselling and waiting list for the kids, when they need it straight away" (Stakeholder)

"We've got to acknowledge that we've gone through, a very traumatic time for society with reference to the pandemic. But it's amplified a million times for a lot of our children" (Stakeholder)

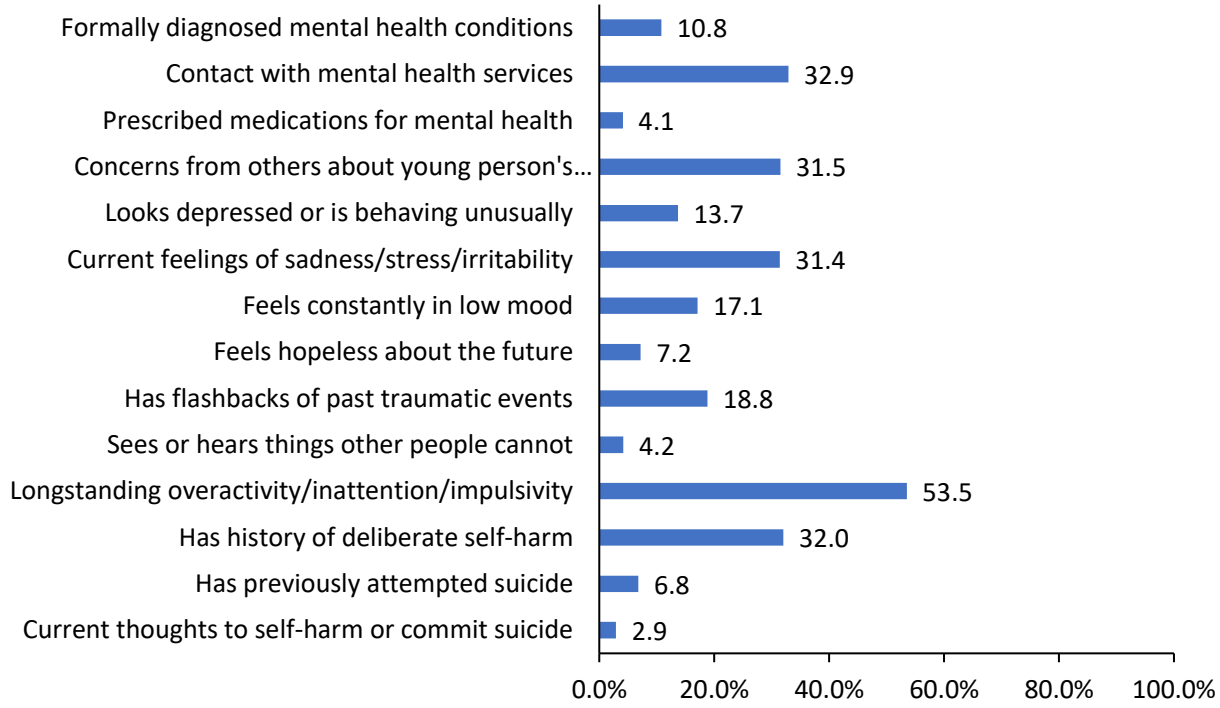
"With COVID as well, a lot more children slipped through the cracks because they've not been in school for us to pick it up" (Stakeholder)

"Mental health needs especially are massively underfunded and under provided for" (Stakeholder)

Prevalence of mental health needs of statutory young people



Prevalence of mental health needs of divert young people



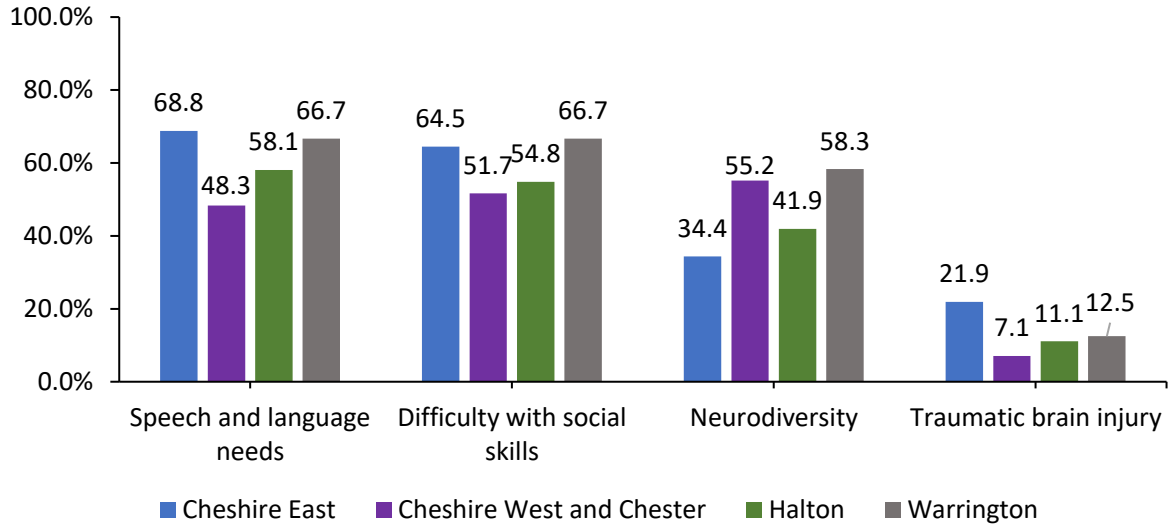
For neurodiversity and SEND, 63.4% of young people had some form of special educational need and disability (SEND) (67.8% for statutory cases and 56.2% for DIVERT), with 45.7% having a SEN that was identified (56.0% of statutory cases and 28.6% of DIVERT). Overall, 63.7% had some type of speech

and language needs (61.3% of statutory cases and 67.6% of DIVERT) and 12.5% of young people had a traumatic brain injury (13.2% of statutory cases and 11.4% of divert). High proportions of young people had social skills difficulties (58.5% statutory and 66.2% DIVERT). Overall, 42.2% of young people had a formal diagnosis of a neurodivergent condition (46.2% statutory, 36.3% DIVERT), while a further 15.6% were awaiting diagnosis or referral (13.4% statutory, 18.8% DIVERT). Prevalence of neurodiversity and other needs amongst young people differed across local authorities, with Warrington in general having higher levels of need. Across all qualitative data collection, SEND and neurodiversity were the most common theme discussed for risks associated with offending (including exploitation) and unmet health needs for this cohort of young people.

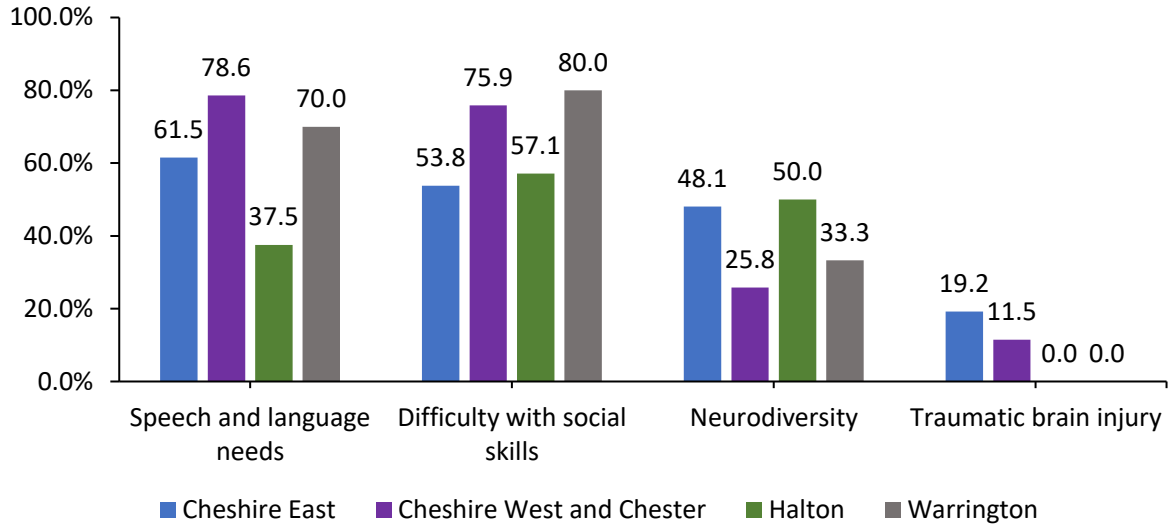
"Probably the biggest health need is in terms of ASD and ADHD, these kinds of diagnoses coming in quite late" (Stakeholder)

"We're missing out on some of the early diagnosis" (Stakeholder)

Prevalence of neurodiversity and other needs amongst statutory clients, by local authority



Prevalence of neurodiversity and other needs amongst divert clients, by local authority



Stakeholders discussed the difficulty and long waiting times for diagnosis and the impacts of this for young people for their behaviour (both inside and outside of school), and the impact of this in terms of their mental health, relationships, and ability to cope. Issues were also raised about wider professional awareness of conditions (especially where there is no diagnosis), and the negative impact this can have on a child throughout the CJS, healthcare and wider sector settings. Young people and parents discussed the struggles at school (and how they had disengaged from school), and the challenges with communication, difficulties in getting help (and a diagnosis) and the negative impacts this had on the young person's life.

"When we refer our young children to CAMHS… When they need it straight away, there's a long waiting list for some of our kids" (Stakeholder)

For substance use, higher proportions of young people had ever or were currently using drugs, alcohol, or smoked, when compared to the national averages for these health behaviours. Prevalence rates were higher for all three for young people on statutory orders compared to DIVERT cases. For statutory cases 79.0% (and 48.2% of DIVERT cases) had ever used drugs, and 58.0% (statutory), 32.5% (DIVERT) were currently using drugs (mixed drug use and cannabis were the highest reported). For alcohol 45.4% (statutory), 33.3% (DIVERT) had ever drunk alcohol, with less young people currently drinking alcohol compared to drug use (30.3% statutory, 28.6% DIVERT). Smoking prevalence was also high, with 31.1% (statutory), 12.0% (DIVERT) ever smoking, and of those, many young people were currently smoking tobacco (26.1% statutory, 9.6% DIVERT). The qualitative findings further evidence this with concerns raised about the increased prevalence of cannabis use among young people entering the CJS and the negative impact of this on their physical and mental health, communication, and relationships, and also the increased risks for criminal exploitation (including risks of county lines involvement).

"Kids using drugs and earlier age (since the pandemic) and then that impacting on their emotional health" (Stakeholder)

Risks for CJS involvement also included living in poverty, experience of trauma and ACEs, family and home life issues, and broader contextual safeguarding issues including risks within peer groups and the community (which were both linked to social media use). The majority of statutory (91.5%) and

DIVERT (86.7%) cases had at least one ACE (55.1% and 22.9% respectively had 4+ ACEs), which is significantly higher than the national average (based on a national retrospective study of adults in England; 47.9% one ACE and 9.0% 4+ ACEs) (Bellis et al., 2014[3]).

"We have a lot of families that we deal with who have generations of people who've been involved with the criminal justice system as well" (Stakeholder)

"We are all a product of our environment… if you grow up and that's your social norm, it's hard to escape that, isn't it? So if you grow up around those behaviours, then you're more likely to adopt them yourself" (Stakeholder)

"When somebody's living in a chaotic household, that we see so often in in some deprived areas. If parents don't engage with the services then the children and young people aren't going to engage" (Stakeholder)

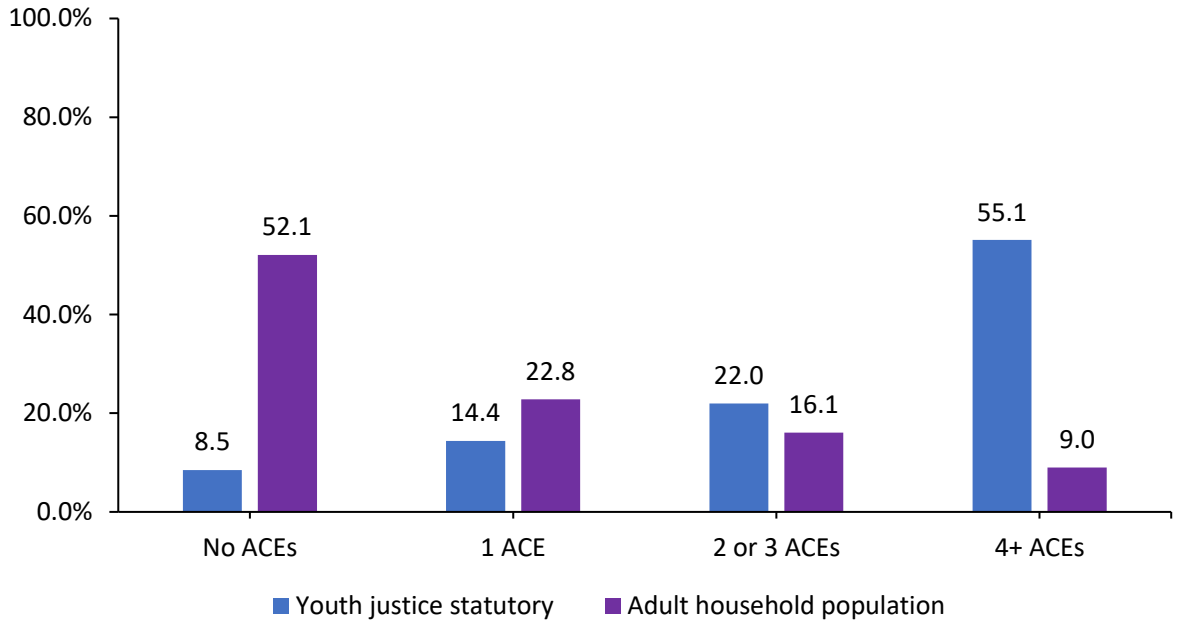
Half of all young people had caregivers who had underlying issues impacting the quality of care they provided for them and had experienced incidents involving their current caregivers that risked the young person's safety and wellbeing. There were also high proportions of young people who had perpetrated child to parent violence and abuse (39.0% statutory cases and 29.8% DIVERT). Transition to adulthood and adult service provision was highlighted as a critical point for young people, with gaps in services identified that put this age group at increased risk, both in terms of their health needs and risk of offending.

"They get to 1718. There's nothing for them really. They fall between the cracks" (Stakeholder)

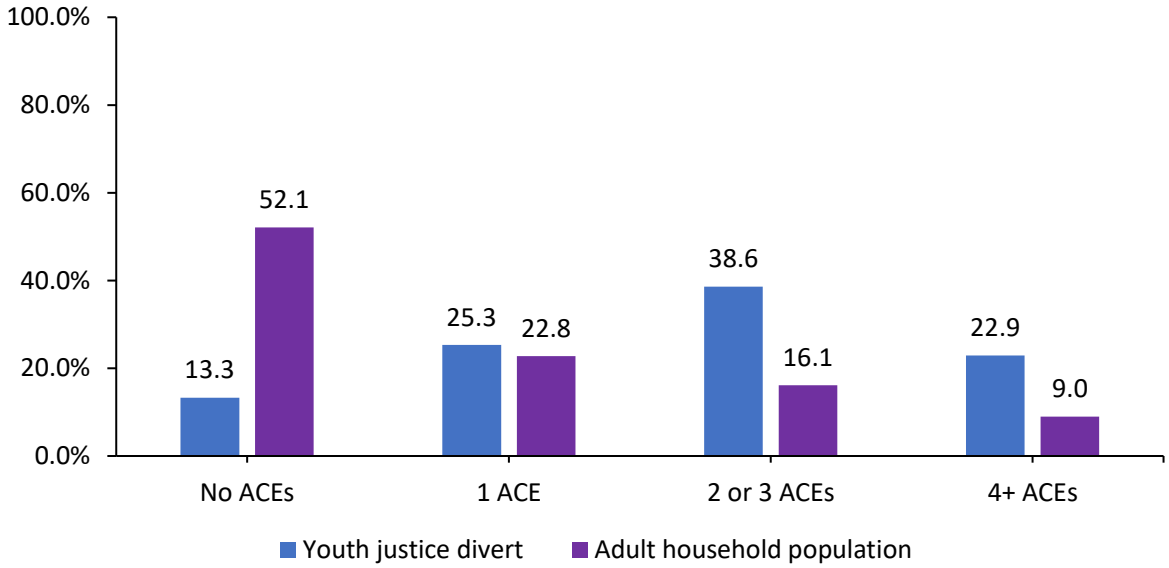
"I've had a few older ones and are really struggle to figure out what to do with them once they hit 18 because pretty much everything just disappears" (Stakeholder)

[3] Bellis, MA., Hughes, K., Leckenby, N., Perkins, C., & Lowey, H. (2014). National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviours in England. BMC Medicine volume 12, Article number: 72

Prevalence of ACEs amongst statutory clients/nationally representative population of adults in England



Prevalence of ACEs amongst divert clients/nationally representative population of adults in England



Disengagement from education was also evidenced within the quantitative and qualitative data analysis. Data showed that statutory cases were more likely to be disengaged from school compared to DIVERT cases, however, the other education related data was similar. With 35.6% of statutory cases (8.5% DIVERT) not in any form of education, employment, or training (NEET), and 21.2% of statutory cases (29.3% DIVERT) in alternative education provision (such as a Pupil Referral Unit). Around half of the young people had participation or attendance issues, and half had experienced some form of school exclusion (for both statutory and DIVERT). This is significantly higher than the 4.3% national

prevalence of school exclusions (ONS, 2022)[4]. This was further evidenced through the representation of the voice of four young people within the HNA, all of whom had been disengaged from school before they came into contact with the YJS. Stakeholders at the multi-agency workshop reflected on the barriers for neurodiverse children and young people. Recognising that through unmet need, late diagnosis and lack of education and awareness, that these young people are at risk of becoming marginalised and excluded from education and mainstream services and support, and ultimately excluded from society.

"One of the key flags for CSE (criminal or sexual exploitation) is low school attendance. If someone is going to school then that is a massive positive in their lives" (Stakeholder)

"I've been quite disappointed in what support the schools offer as well, and the amount of young people we're meeting, you know, 14/15. They've got through the 10 years of school and it's (neurodiversity) not picked up. That's quite sad because we all know that when it does, it can take a couple of years before they get their education and healthcare plan. That's quite sad really that it has to get to the point where the committing offence before somebody will really delve into what may be the issues with the behaviour" (Stakeholder)

Information provided by parents, young people and stakeholders suggested that high proportions of young people had co-morbidities, meaning that young people had multiple, complex needs and many of these health needs were interlinked and co-existing for many of them. This included, for example, young people who were neurodiverse, who were struggling with their social skills, experiencing poor mental health, and had disengaged from school. Other examples were provided for young people using cannabis to self-medicate (for both mental health and neurodiversity) or as a form of self-harm, and examples for looked after children and children in need, experiencing multiple risk factors and unmet health needs compared to their peers. The quantitative data confirmed this, showing that higher (and significantly higher) proportions of young people (compared to their peers and those in YJS without these needs), were more likely to have additional needs. A higher proportion of those with educational needs had been diagnosed with a mental health condition, were vulnerable to criminal exploitation, had a concern noted about their significant relationships, and had a higher mean number of incidents of offending and risk of re-offending. A higher proportion of those diagnosed with a mental health condition had also used drugs, had four or more ACEs, and a higher mean number of incidents of offending and risk of reoffending. A higher proportion of those with speech and language needs had experienced violent victimisation and also had perpetrated violence, had caregivers with underlying issues impacting the quality of care, had been excluded from school and had a higher mean number of offences and a higher risk of re-offending. A higher proportion of those who had difficulties with social skills had self-harmed and were more likely to have experienced violent victimisation. There were also significant associations between ever being a child in need and educational needs, neurodiverse diagnosis, and mental health condition.

"I think we struggle to reach them sometimes because they've met so many professionals and it's just another person. Their lives are often all over the place or they're not in a good place in with mental health issues or communication issues and neurodivergent young people as well, struggle to engage for that reason" (Stakeholder)

The unmet health needs and risk factors experienced by young people and their families, created barriers for them engaging in mainstream sectors such as education and barriers to engaging with

[4] Office for National Statistics (2022). Permanent exclusions and suspensions in England. Data collected by the school census. https://explore-education-statistics.service.gov.uk/find-statistics/permanent-and-fixed-period-exclusions-in-england

support from services. Additional barriers also included knowing where and how to access support, long waiting times and difficulty with diagnosis. Previous negative experiences or negative perceptions of services (for both young people and parents) also make it more difficult to engage, due to stigma and fear. Parents own health needs, capacity and barriers played a significant part of how well young people were able to engage with services. Families involved with multiple agencies also had increased challenges of navigating support if services were not well connected.

"Initial reflection is that we are in effect, punishing SEND and other childhood adversities" (Stakeholder)

Identifying assets

Findings from the HNA and the wider evidence base demonstrate that there are a number of protective factors that can reduce the risk of young people becoming involved in the CJS. These protective factors were seen to provide young people with better chances in life, have more positive experiences and help them make more positive choices. This in turn is thought to prevent and reduce offending behaviour and prevent re-offending.

Stakeholders and families participating in this HNA highlighted what young people and their families need from the YJS to meet their health needs and overcome some of the challenges that may have contributed to them entering the CJS, and the barriers they face in engaging with services. This included a trauma-informed system that understands the impacts of ACEs and trauma and looks beyond the presenting behaviour or crime, and also involves skilled and experienced staff who could build trusted relationships with them, with knowledge of wider support pathways for appropriate referral and signposting. This requires a system that puts the child first and provides a bespoke and tailored care for their individual needs, using a flexible and adaptable approach to develop a trusted relationship. Understanding complex health needs is important for preventing young people entering the CJS, and supporting those who do, through the system. This means working in a way to understand the context, help young people feel understood through listening to them, exploring their frustrations, and building trust with them. Providing a safe and non-judgemental space was key, as well as utilising innovative and accessible communication methods and activities. Understanding of the wider context and barriers for parents was also seen as essential in supporting them to support their children, as was understanding the challenges some people may have in attending appointments (and not closing these people off from support). Using this approach was seen as a way to not missed opportunities to engage families in timely and effective support best placed to meet their needs.

"You're going to be aware of trauma and the impacts of it on people's lives. But then there's been a journey to become more trauma informed and aware of evidence-based interventions for trauma. Best practises are really helpful way of operating with kids who have experienced trauma, rather than thinking clinically" (Stakeholder)

Supporting vulnerable children and young people through the CJS is a key priority, with the Health and Justice Specialised Commissioning Workstream, and other key initiatives in place across the CJS to meet the mental health and wider health needs of young people. Stakeholders involved in this research suggested that nationally, the Youth Justice Board is ahead of the curve with their child first approach. Cheshire YJS adopting the health offer was seen as a way to begin to address these unmet heath needs, and to better support young people to minimise further inequality for young people involved in the CJS and reduce the likelihood of them staying or returning to the CJS.

This pathway was seen as critical given the risk factors and unmet need associated with neurodiversity, coupled with findings from other research, evidencing that neurodiverse young people are

disproportionately represented within the YJS. Studies also suggest that aspects of the system including custody can be more traumatic and damaging for those who are neurodiverse. This highlights that system-wider change is needed to understand and treat this population with dignity and care, as well as support and understanding around their communication barriers, especially when it comes to sharing how they are feeling and being able to advocate for themselves in the CJS and other settings.

"That sort of multidisciplinary approach is it's really positive" (Stakeholder)

The health model at Cheshire YJS provides a good opportunity to bring specialist providers together to deliver a cohesive offer. This takes on board key findings and recommendations from the previous HNA (Centre for Public Innovation, 2015), which highlighted the unequitable access to healthcare for young people engaged in the CJS across Cheshire. The offer now provides that key link into mental health, substance use and SLT support, through an equitable healthcare assessment available to all young people entering the YJS. This provided a key opportunity to assess and identify any unmet health needs in these three areas (and wider health and safeguarding needs), which may not have otherwise been identified, and for many was the first time they had access to such healthcare screening. This multi-agency approach not only allowed for quicker identification during the healthcare screening, but it also meant more timely specialist support for families who would have otherwise had long waiting lists to see specialists from CAMHS and SLT. This was identified as an effective way to open the door to this pathway of wider support, recognising that these health needs were associated to the offending behaviour and need to be addressed to prevent further re-offending.

"Embedded teams that provide psychological support. So CAMHS workers, speech and language therapists looking at communication issues. We've provided training to the justice service around sort of trauma, informed practice, sensory processing disorder. Led to an increased recognition of healthcare as a risk factor for offending behaviour" (Stakeholder)

The Cheshire YJS model also provides an opportunity for multi-agency working, not only to provide that overarching multi-disciplinary offer for children and young people, but also in terms of how services work together across Cheshire. This was identified as good opportunity to create awareness across the area around the different pathways of support available with clear communication around signposting and referral, highlighting the impact across the system (which also included potential reduction in demand and increased awareness and training opportunities). Considering the health offer and the wider support beyond this, across Cheshire, findings suggest that there is good coverage of service provision to meet the healthcare needs for young people and their families. However, the high levels of risk and unmet need identified does highlight that more support is needed around early intervention within the system, and more capacity across the system for specialist services such as CAMHS and SLT. Parents also believed that not enough support was in place at earlier points for their child and family.

"I think we've come a long way from having the health workers in the team. The SLT are really keen to maybe get involved with more pre court stuff. To explain to children about the language that people use in court and what it means… Just embed that as usual practise and but that's only been because we've got the health workers in the team that we're able to even consider doing things like that. It's really, really beneficial. I think we've always been that advocate and we've always will" (Stakeholder)

For the healthcare model itself, there were a few challenges reported. Staff were able to identify where there are gaps in support, which was a positive, but it meant that services may use them as a 'fixing service' and often they would end up 'filling' these gaps which added additional pressures to

their workload. It was also agreed that a clearer pathway aid/resource would be useful in relation to the health aspect so that for someone looking in on the service from the outside (including quality assessors etc.) would be able to understand how it works. There were also complexities for staff working as part of the YJS services, but based within other areas of work across Cheshire, meaning that working policies and procedures are not consistent or equitable for key members with similar roles.

Concerns were also raised about the complexity of the DIVERT caseload. Whilst the DIVERT route provided a good opportunity to provide early intervention to prevent further offending and the young person receiving a criminal record. Stakeholders reported that there used to be a clear distinction between the differences in complexity (and resource required) for a DIVERT case compared to a statutory case which were deemed often more complex and resource intensive, but that DIVERT were now just as complex. The quantitative data does show high risks for both statutory and DIVERT cases. Stakeholders were unsure whether young people's needs were increasing and whether this was related to the pandemic and cost of living rise, but it does pose a question around the use of the DIVERT pathway (and resources available for this). Given the unmet need for these young people, findings suggest that this would be the appropriate pathway, although further longitudinal work would be needed around the outcomes for young people following DIVERT work.

"Parents that have come back and said 'I've been saying this for years, or you're doing assessment and your feedback and they say everything you've just said, fully described my child'" (Stakeholder)

Feedback from providers and engagement with young people and their parents (from both statutory and DIVERT cases) allowed the HNA to capture the outcomes and impact for some of the young people engaged with Cheshire YJS and what this involvement meant to them. Parents described the upset which had got to the point of offending, both in terms of the negative impact for any victims involved in the criminal behaviour, and the negative impact for the young person themselves and their family. It was, however, seen that this had led them to the YJS and the opportunity for much needed support. Engaging with the healthcare assessment had provided direct support around mental health and neurodiversity, the family had increased awareness around these issues and how they could impact on behaviour, and the staff had advocated for the young person in a number of settings. The young people had been supported to re-engage with education, training, and employment, with a place at a new school designed to support SEND, a training qualification, and employment, meaning that these young people felt they had future options they did not have beforehand. There were reports of increased confidence and self-esteem and reduced anxiety. Significant improvements in communication and improved relationships were also reported, with parents and young people feeling that the rusted relationship with YJS staff had helped them to open up, which had then impacted positively on wider relationships. The work carried out at YJS had also improved knowledge for young people around the impact of their crime and for any victims of this. Wider potential impacts for the community included increased feelings of safety and community cohesion, improved awareness (of the challenges faced by young people), and reduced anti-social behaviour, violence, and crime.

"I didn't know what to expect. I felt like we was going to be judged because of what's happened. But that's not what they've been about. Everybody has been fantastic. What's been a really awful experience personally for us, the help and support that's there and things that they've done with (YP) has been amazing" (Parent)

"I think it made him realise more what he done was wrong and it helped him move on from what he'd done and change his ways" (Young person)

"I look back at the memories on my phone and I don't know why I lived like that" (Young person)

Sustainable support for those completing their statutory and DIVERT order was also highlighted, and especially for those on the DIVERT pathway when support closes with YJS following completion of the 12 week scheme. Stakeholders reported more complex needs for DIVERT than previously, which is further evidenced by the high levels of risk and need within the quantitative analysis. This made it difficult to identify and address these issues (especially taking time into account to break down barriers and build trust) during the 12-week timeframe, meaning often more work was needed beyond this time. Whilst parents praised the wraparound support that the YJS offer provided, stakeholders reported concerns on having an influx of support available (often to families who do not have any other support) for it then to be removed at the end of the order, and the associated impacts of this.

Community based support was seen as key, not only in taking that support out to the young people (YJS using home visits was seen as key in breaking down attendance barriers), but also for linking in community organisations as way to provide local support and support families to feel more connected to their community. Involving grassroots organisations and the voluntary sector was identified as a gap in service provision linked to supporting young people with more community based diversionary activities. The YJS are piloting social prescribing based initiatives to try to bridge this gap and provide a more sustainable offer beyond the young person's time with the YJS. Linking young people into the appropriate healthcare pathways in a timely way, and having opportunities for ongoing statutory and mainstream support, as well as community-based support was identified as essential. A transparent exit plan and aftercare provision were seen as important for those completing their order or transitioning into adult services.

"What I worry about as well is when whilst our kids are on this order, they're getting lots of this specialist help and support and would go that extra mile, it's just that when they finish their order, that's what worries me most, can young people access these resources and get support? So then it's like, the circle, they reoffend again" (Stakeholder)

Determining priorities

The HNA provided an opportunity to engage with stakeholder and young people (and their parents) who were working with Cheshire YJS, to capture their voice and understand their experiences of support and any unmet health needs. Stakeholders who recognised the challenges of engaging young people in more formal feedback processes saw this as particularly important in understanding their needs, experiences and view of the support provided via the YJS, and more widely across Cheshire.

The HNA engaged with a wide range of professional stakeholders and brought partners together to share views and experiences, providing a forum for shared learning. This allowed stakeholders to help identify needs and assets and determine priorities together. The multiagency stakeholder workshop built on this, through shaping the recommendations for effective action. The HNA involved a multi-agency team of cross sector stakeholders who are able to undertake actions and take recommendations forward to improve delivery for the health and wellbeing of young people involved in the CJS. This highlights the importance of partnership working and strategic and operational buy in from partners to take these actions forward.

"We need to work more systemically with young people, don't we? We need to get much better at building that multidisciplinary, holistic kind of approach around schools and communities and families where we've got children who are presenting with risks or their families and we need to get have more capacity to do that and be better at it and understand what's going on for these kids, and clearly we need to be identifying those risk factors around speech and language and mental health and much earlier stage" (Stakeholder)

At the multi-agency workshop, stakeholders discussed the impact of the HNA key findings and agreed how that intelligence produced through the HNA should be used to raise awareness, promote action, and influence practice across partnerships. Stakeholders were appreciative that the HNA had enabled discussions and opportunity to promote change within the wider system across Cheshire, translate into practice and how services are delivered moving forward.

"We don't have to accept the criminalisation of kids in the way that it's happening, and that there are interventions that we can apply through our communities, support for families, local authorities, healthcare, education and policing and the justice system itself" (Stakeholder)

"The real challenge is how we 'tie in' other services… youth justice issues are everybody's business!" (Stakeholder)

"I think we kind of owe it to ourselves to get this information and research across Cheshire to think about what we can do to create even more opportunities for good practice. But that requires all partners to be around the table and all partners to commit to that, to try and change behaviour and change mindset and that also means we some of our parents as well as with our kind of our colleagues in schools, local authority colleagues, our police colleagues and those that are in our health system. So huge amount of work to be done really… There is something around a need to influence it at central government level as well" (Stakeholder)

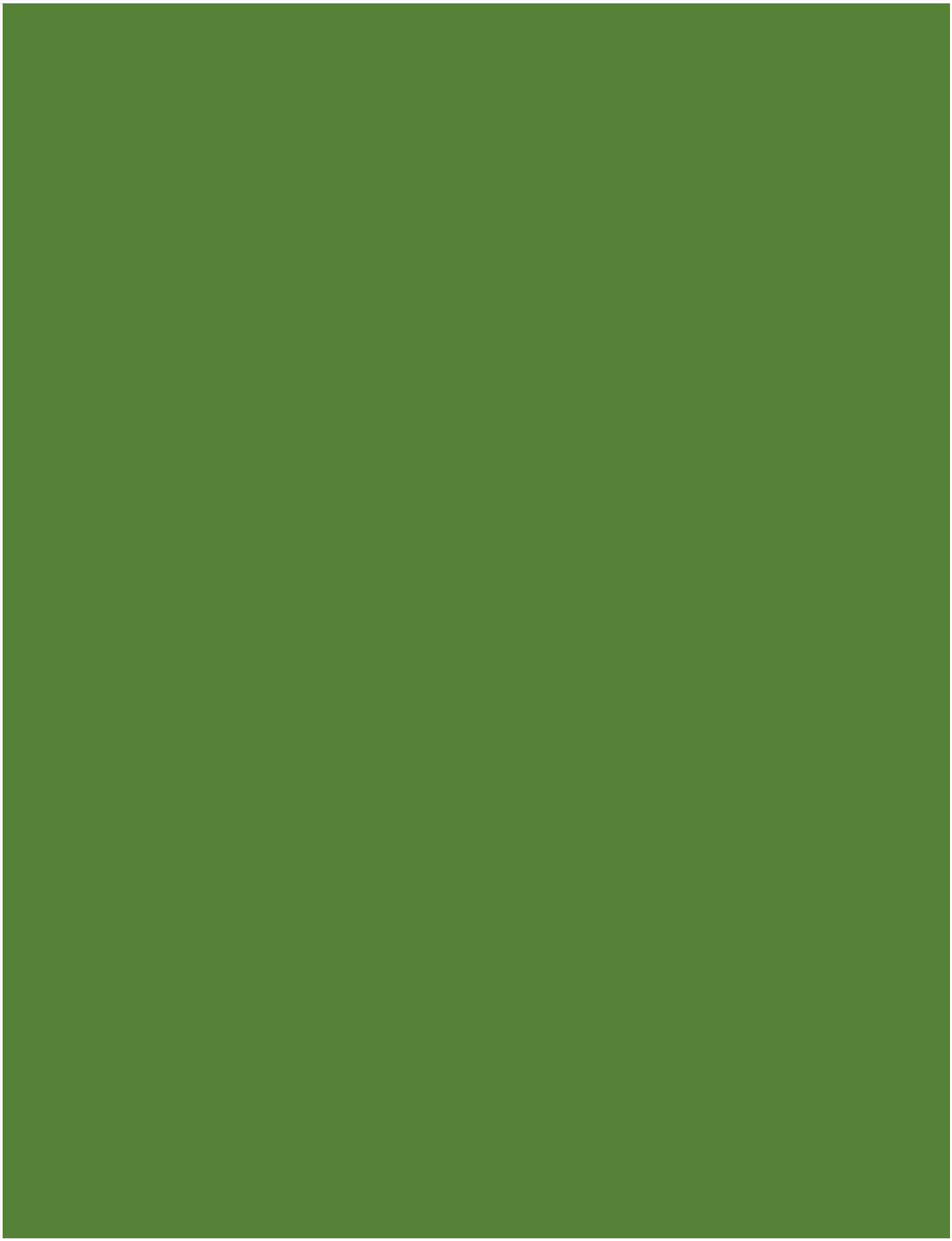
Considerations for dissemination of findings included:

- Share throughout Cheshire YJS and more widely across Northwest and national YJS, including publishing the HNA on the YJS Resource Hub and other YJS resources including Basecamp.
- Inform the forthcoming annual youth justice plan.
- Inform Joint Strategic Needs Assessment (JSNA) which will be carried out as part of the new Serious Youth Violence strategy requirements, including informing a public health approach to tackling serious violence
- Sharing with the Cheshire Early Help Boards, Children's Trust, and Starting Well Programme Boards.
- Data should be fed into the new pan-Cheshire extra familiar harms strategy which is being developed with Cheshire Constabulary.
- The health subgroup will support dissemination and sharing of findings across partners.

Recommendations

- The high levels of unmet need when entering the YJS is demonstrated throughout the HNA, and further work is needed externally to the YJS to ensure early intervention is prioritised. Cheshire YJS have highlighted a priority of further understanding unmet need in terms of diagnosis so they can work with partners to identify needs earlier, provide more timely support, and potentially prevent offending occurring in the first place. The data items within the case management system at the YJS provide good key indicators around this area, however, additional detail could be provided for a distinction between unmet and undiagnosed health needs prior to the young person coming into YJS. Measures and guidance need to be put in place to ensure consistency of reporting. This would firmly evidence the unmet need to lever changes within the wider system.
- The data set derived from the case management system provides a wealth of data and has allowed exploration of data around ACEs and contextual safeguarding that is not always possible to report on and therefore provides key insight. However, the majority of this data is not readily available to routinely monitor and much of this data was derived from individual case notes, which would be resource and time intensive outside of the HNA. Further exploration of how these data items could be more easily and routinely captured and monitored would be useful.
- Further data analysis is needed to explore changes in complexity of DIVERT caseloads cross time. Additional longitudinal research could be implemented to investigate the outcomes of these cases in relation to that wider healthcare need being met and the impact on re-offending. Exploration of the changing complexity would also be required. This would strengthen the evidence for the DIVERT pathway and argue the case for additional resource and funding to support the changing complexity.
- Findings demonstrate the high demand for SLT and CAMHS provision, linking into the wider CAMHS and SLT provision within the community beyond the YJS involvement. Additional capacity is required for cases that cannot be fully supported during the YJS timeframe (especially DIVERT cases). This is especially important given the high levels of co-morbidity in this cohort.
- Having SLT support to advocate for young people and explain their communication difficulties was seen as key in helping the young people navigate the system and understand their own feelings and behaviour. This would be beneficial in other settings of the CJS (and often before it reaches YJS), in settings such as arrest interviews, custody and court, as this may change the outcome of that process for some young people. Additional resource would be required for this.
- The YJS health offer has increased equity for healthcare screening in the CJS for young people across the four areas in Cheshire. However, there are still travel and accessibility issues for some young people from the more rural parts of Cheshire. YJS takes support directly to the young people with home visits, although this option is not always possible for diversionary activities that take place in other parts of Cheshire. To increase the equity of this offer additional support in terms of funding and buy in from other providers across the area (including grassroots organisations) could help facilitate more local access.
- Whilst incorporating key staff from each of the four areas ensures equitable access for young people, the working policies, and procedures within the four areas are not consistent or equitable for staff members with similar roles. YJS link in with each area to explore whether this can be streamlines, taking different working practices into account.

- The social prescribing pilot interventions offer a good opportunity to link in with community and grassroots services, to provide local aftercare and a more sustainable offer. This also enables the commissioning of services that are shaped by and for children and families to support engagement. YJS could look to extend the health offer to develop a structured key role for community services within this model. This is especially important for alternative holistic options and for aftercare and exit strategies as young people move on from YJS.
- The YJS healthcare specialists have been able to provide training within YJS and externally to wider services across Cheshire to upskill staff on key areas around young people's healthcare needs, in particular for SLT. This could be developed into a more formal offer, with pre and post evaluation to explore changes in knowledge, attitude and working practices.
- The HNA highlights the key work from YJS and wider services across Cheshire in support families to reduce inequalities, improve wellbeing, and reduce offending. This required skilled, experienced staff working in a trauma-informed way, using a child focused approach. Support for these staff should be recognised with further opportunity for training and supervision.
- HNA key findings and intelligence should be shared with relevant partnerships and board across Cheshire. Information should also be shared with partners as part of key safeguarding training for colleagues including education, healthcare including A&E and police (including neighbourhood policing teams) to support earlier identification of risk factors and neurodiverse condition. This would also enable other partners to advocate for children and young people, which in turn would reduce reliance on Youth Justice Services for this support.
- Further exploration around impacts of school exclusions and work alongside education to support teachers to recognise and support children and young people (and their families) with additional needs. Utilising the Thrive model for building mental health resilience across education and wider services would support a systemic approach to supporting families and reducing exclusion.
- The HNA highlights a significant level of trauma experiences by children and young people engaging with YJS. Supervision and support for staff, alongside ongoing training is essential.
- Partnership buy-in across Cheshire is required to mobilise change in practice and provide a multi-agency response in supporting families moving forward.



Agenda Item 9

Cheshire East Council

NHS
Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Cheshire and Merseyside Integrated Care Board Draft Joint Forward Plan
Report Reference Number	HWB28
Date of meeting:	27th June 2023
Written by:	Neil Evans
Contact details:	Neilevans@nhs.net
Health & Wellbeing Board Lead:	Mark Wilkinson

Executive Summary

Is this report for:	Information X	Discussion ☐	Decision ☐
Why is the report being brought to the board?	To ensure the Cheshire East Health and Wellbeing Board has the opportunity to comment upon the draft Cheshire and Merseyside Joint Forward Plan.		
Please detail which, if any, of the Health & Wellbeing Strategic Outcomes this report relates to?	1. Cheshire East is a place that supports good health and wellbeing for everyone ☐ 2. Our children and young people experience good physical and emotional health and wellbeing ☐ 3. The mental health and wellbeing of people living and working in Cheshire East is improved ☐ 4. That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place ☐ All of the above X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above X		

Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The Board is asked to: • Note the approach being taken in developing the Cheshire and Merseyside Joint Forward Plan • Provide feedback as to key areas of content and highlight any additions, or revisions, the Board would like to see in this plan, or which needs to be recognised in the next version of the plan (March 2024) • To confirm that the Board will provide a statement outlining whether the plan includes the relevant local priorities contained within the Joint Health and Wellbeing Strategy
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The report and draft Joint Forward Plan is being taken to all nine Local Authority Health and Wellbeing Boards in Cheshire and Merseyside and has also been shared with all Cheshire and Merseyside NHS Provider Boards. Cheshire and Merseyside ICB Board will consider the final Joint Forward Plan on 29th June.
Has public, service user, patient feedback/consultation informed the recommendations of this report?	The Joint Forward Plan has taken into account the nine local Health and Wellbeing Strategies, which have themselves been informed public engagement and consultation. In addition a public engagement survey related to the Cheshire and Merseyside interim draft Health and Care Partnership Strategy took place during March and April 2023 and the feedback has been incorporated into the Joint Forward Plan.

1 Report Summary

1.1 This report shares details in relation to the requirement for Integrated Care Boards, and NHS provider partners to produce a Joint Forward Plan by June 2023. It provides the draft content of the Cheshire and Merseyside Joint Forward Plan in advance of the final document being presented to the Integrated Care Board for approval on 29th June.

2 Recommendations

2.1 The Board is asked to:

2.1.1 Note the approach being taken in developing the Cheshire and Merseyside Joint Forward Plan

2.1.2 Provide feedback as to key areas of content and highlight any additions, or revisions, the Board would like to see in this plan, or which needs to be recognised in the next version of the plan (March 2024)

2.1.3 To confirm that the Board will provide a statement outlining whether the plan includes the relevant local priorities contained within the Joint Health and Wellbeing Strategy

3 Reasons for Recommendations

3.1 To ensure the Cheshire East Health and Wellbeing Board has the opportunity to comment upon the draft Cheshire and Merseyside Joint Forward Plan.

4 Impact on Health and Wellbeing Strategic Outcomes

4.1 The aspirations set out within the draft Joint Forward Plan ('We will' statements) align closely with the priorities set out within the Cheshire East Joint Local Health and Wellbeing Strategy. The Joint Forward Plan includes a summary describing the priorities for Cheshire East Place in delivering the Joint Local Health and Wellbeing Strategy.

5 Background and Options

5.1 This report shares details in relation to the requirement for Integrated Care Boards, and NHS provider partners to produce a Joint Forward Plan by June 2023. It provides the draft content of the Cheshire and Merseyside Joint Forward Plan in advance of the final document being presented to the Integrated Care Board for approval on 29th June. This includes:

- A Short summary outlining the Cheshire and Merseyside Joint Forward Plan
- The Joint Forward Plan Content – noting that behind this document there is more detailed content in support of the plans which the reader can access via "links" to the relevant section
- A copy of the high level summary describing our Cheshire East Health and Wellbeing Board Five Year Delivery Plan 2023-28

5.2 The Joint Forward Plan is presented today to describe, and gain feedback from the Health and Wellbeing Board, on the plan content and alignment with the existing Health and Wellbeing Board Strategies and Place Plans from across our nine Places.

5.3 It highlights the planned work that is required to finalise the Health and Care Partnership (HCP) Strategy, and a range of other supporting plans in advance of the Joint Forward Plan being republished in March 2024. The approach to the developing this "second" Joint Forward Plan will be to be more balanced on the delivery plan of the HCP with less direct content related to the national NHS priorities.

5.4 It is requested that the Health and Wellbeing Board provide a statement for inclusion in the plan to outline whether the document includes local priorities contained in the Joint Health and Wellbeing Strategy.

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:
Name: Neil Evans

Designation: Associate Director of Strategy and Collaboration, NHS Cheshire and Merseyside
Tel No: 07767 670497
Email: neilevans@nhs.net

NHS
Cheshire and Merseyside

Background to Cheshire and Merseyside Five Year Joint Forward Plan 2023-28

Health and Wellbeing Boards & NHS Boards – May 2023

Neil Evans
Associate Director of Strategy and Collaboration
NHS Cheshire and Merseyside ICB

What a Five Year Joint Forward Plan (JFP) is

NHS
Cheshire and Merseyside

- Led by the Place Health and Wellbeing Board Partners
- Duration: 5 years
- Informed by: Place priorities driven from evidence in JSNA
- Purpose: Strategy outlining the priorities for improving the health and wellbeing of local population, including addressing inequalities
- Review date varies by Place/HWB

Joint Local Health and Wellbeing Strategies

Health and Care Partnership Strategy

- Led by the HCP (ICP) partners
- Duration: 5 years
- Informed by: C&M wider partnership priorities; National Guidance; Health and Wellbeing Plans; Place plans
- Purpose: strategy for broad health, social care needs of the population including wider determinants of health
- Interim strategy published Jan 2023 with work to prioritise content happening through to summer 2023

- *JFP is a new joint statutory responsibility for ICB and NHS Trusts*
- *The JFP should describe, as a minimum, how the ICB and its partner trusts intend to arrange and/or provide NHS services… including delivery of the universal NHS commitments*
- *Systems are encouraged to use the JFP to develop a shared delivery plan for the Integrated Care Strategy*
- *JFP must cover the statutory duties of ICBs – e.g. duty to improve quality, duty to promote integration etc.*
- *Health and Wellbeing Boards are required to provide a statement confirming the plan reflects the priorities from their strategy (links to be added in publication)*

Five Year Joint Forward Plan

- **Statutory responsibility to produce plan sits with ICB and NHS Providers to develop document with input from HCP partners and local stakeholders**
- **Duration: 5 Years (greatest focus initial part of this period)**
- **Informed by: HCP (ICP) Strategy; National NHS Plans and Health and Wellbeing Strategies**
- **Purpose: Delivery Plan for HCP Strategy priorities, Health and Wellbeing Board (Place) plans, and NHS Universal priorities (Long Term Plan and Operational Planning)**
- **Ready by: Must be published by June 2023 (final)**
- **Has to be republished annually (next publication Mar 2024)**

NHS Operational Plan 2023/4

- Led by the ICB and NHS Providers
- Duration: 2023/24
- Informed by: NHS Priorities issued in national guidance
- Purpose: Detailed Delivery Plan for 2023/24 (finance and capital, workforce, activity and performance…..).
- Content in the form of national templates.
- Ready by: 23rd February (draft); 30th March (final).

Other content required in the NHS England Guidance

NHS Cheshire and Merseyside

In addition to the statutory duties of an ICB the JFP also includes content on:

- *Workforce (plans align with operational and financial plans)*
- *Performance (trajectories/milestones aligned to NHS operational planning requirements and NHS Long Term Plan)*
- *Digital/data (steps to increase digital maturity and reduce digital inequality in an integrated health and care system)*
- *Estates (plans for improved health and care infrastructure aligned with financial and capital plan)*
- *Procurement/supply chain (plans to deliver more efficient procurement and best value; can describe governance and supporting technology & infrastructure)*
- *Population health management (prevention and personalised care models through data, address inequalities and model future demand and service/financial impacts to support redesign and integrated models*
- *System development (How the system will operate e.g. governance, emphasising the importance of Place partnerships, provider collaboratives, clinical and care professional leadership, system OD)*
- *Supporting wider social and economic development (approach to social, environmental and economic factors impacting health and well being e.g. Anchor Institute plans within communities)*

We have also included:

- *A summary and link to a copy of each "Place Plan" reflecting the priorities agreed within each Place and aligned to the Place Health and Wellbeing Strategy*
- *Delivery plans in relation to a wider range of local programmes that are described in the interim draft Cheshire and Merseyside Health and Care Partnership Strategy e.g. existing C&M transformational programmes such as elective recovery, disease/condition specific programmes or priorities e.g. cardiovascular disease, mental health or carers*
- *Key ICB organisational programmes for example: NHS England delegation of Specialised Services to the ICB*
- *Links to partner strategic documents/sections on NHS provider and local authority websites*

The approach to developing the plan

NHS Cheshire and Merseyside

Context

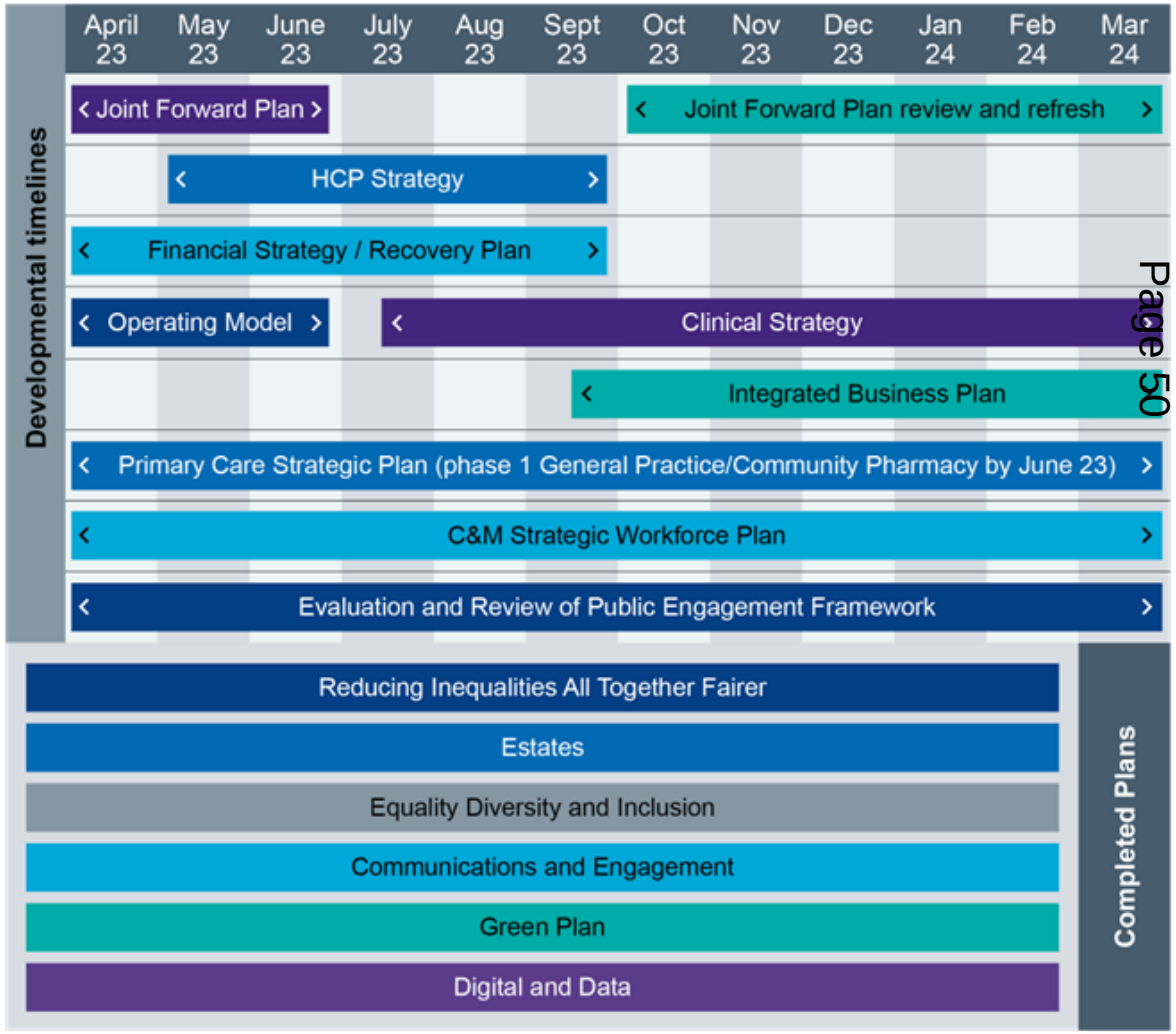
- Whilst the plan, and priorities contained within the JFP, are built from the draft interim HCP Strategy* it is recognised that the final HCP strategy won't be finalised until later in 2023:
  - As a system there are a number of key strategies and plans in development e.g. workforce, finance
  - Our final Cheshire and Merseyside HCP priorities will be agreed in the final HCP Strategy
- Over the course of this year the priorities and plans will mature and can be reflected in the updated JFP (March 2024) and will then reflect a more refined and mature system plan

Document Style

- A relatively short document is to be published (<30 pages) but developed to be interactive with links through to much more detailed content describing specific plans in areas that the reader may be interested in finding out more about
- This includes specific links to the local Place plans/priorities and drawn from the relevant Joint Health and Wellbeing Strategy

**alongside local Place Health and Wellbeing Board and NHS Operational Planning priorities*

Summary timeline for developing key strategic planning documents



Timeline for finalising the plan

NHS
Cheshire and Merseyside

- During March and April: Content has been developed with representatives from across the ICS, through a Planning Group who have overseen production of the NHS Operational Plan and JFP (includes NHS Provider/Provider Collaborative representatives, Champs Public Health Collaborative and ICS Programme Leads).
  - Public engagement survey undertaken on HCP Strategy which informed content of JFP

- Week of 2nd May: A draft document was shared with partners, including Place Partnerships, Health and Wellbeing Board members and NHS providers for feedback. This includes the supporting content which will be available by clicking through from the JFP and contains detailed plans and content (180 pages in total).

- Between 22nd May - 30th June - Final draft JFP shared reflecting feedback and in a "designed format"
  - Health and Wellbeing Boards asked to review and provide a statement confirming their opinion as to whether the JFP includes the priorities from their Joint Health and Wellbeing Strategy
  - NHS providers to share with Board members, and with relevant colleagues internally, to provide sight of the document content and to ensure providers have a further opportunity to provide feedback
  - Summarise JFP into a delivery plan (annual plan)
  - ICB Board asked to approve publication of JFP (29th June) and approve summary delivery plan

- 30th June - Publish Final 2023-28 JFP on ICB website (and link from Provider websites).
  This will include the JFP (circa 30 pages) and "click through" links to the detailed content on plans relating to the specific content areas.

- 31st March 2024 – Updated JFP published for 2024-2029; look to focus on HCP Strategy Delivery Plan with less focus on nationally set NHS content

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Cheshire and Merseyside

Joint Forward Plan

SUMMARY – DRAFT VERSION 1.6

Foreword

Joining up health and care is nothing new - we have been working towards this for many years however the creation of our Health and Care Partnership gives us the momentum to build on this excellent work to combine the efforts of health and care partners, and our collective resources, to work with our communities to make tangible improvements for our population.

Our Joint Forward Plan builds on the Cheshire and Merseyside Interim Health Care Partnership (HCP) strategy by setting out how we will work together to address the key challenges facing people across Cheshire and Merseyside.

Improving the health and wellbeing of our population whilst reducing inequalities in access, experience and outcomes drives our plans. We will ensure we invest our resources effectively to achieve this goal whilst supporting social and economic development in our communities.

We also strongly believe that it is our local communities and front-line teams who best know what issues they are facing, and how best to make improvements. We will support this by encouraging decisions to be made as locally as possible and ensuring that our plans are co-produced so they truly meet the needs of our population.

This said we also need to ensure that we benefit from the scale of our large Integrated Care System (ICS), which provides opportunities to work at scale where appropriate. This enables us to share our learning, best practice and to work collectively to deliver efficiencies and deliver change.

We know we need to be different and work differently; our plans describe our ambitions in a range of areas and based on what our population has said matters to them, including:

- Supporting all our children to have a good start to life both in terms of their health and wellbeing and educational attainment to enable them to go on to live long and happy lives
- Raising the number of years people live in good health whilst narrowing the gap we see between those in the most and least deprived communities
- Ensure that our care communities transform how services work for residents to offer world leading primary and community care
- Working with our provider collaboratives to build a strong and sustainable NHS provider sector that delivers services which offer consistently high levels of access and quality
- Making sure we maximise the positive role we play as employers and as anchor institutions in contributing to our local communities

We are already making significant progress but recognise that there is lots more we need to do collectively to further develop and implement the plans outlined so that our population feel the benefits of these changes.

INSERT SIGNATURES AND PICTURES OF CHAIR AND CHIEF EXECUTIVE

1. About this document

We know that people's lives are better when organisations that provide health and care work together, particularly at the times when people need care most.

This document – our Joint Forward Plan (JFP) – describes how Cheshire and Merseyside Integrated Care Board (ICB), our partner NHS trusts and our wider system partners will work together to arrange and provide services to meet our population's physical and mental health needs.

This Joint Forward Plan contains the actions we will take as an Integrated Care System (ICS) to deliver the priorities identified in:

- The Cheshire and Merseyside draft interim Health and Care Partnership Strategy
- The Joint Local Health and Wellbeing Strategies of our nine Place based Health and Wellbeing Boards
- The priorities outlined by NHS England in The NHS Long Term Plan and the national NHS Planning guidance for 2023-24 (Appendix 1)

Our Joint Forward Plan aims to:

- improve the health and wellbeing of our population.
- improve the quality of services.
- make efficient and sustainable use of our resources.

We are committed to working on all three of these aims simultaneously to best meet our population's needs and to reduce inequalities in access and outcomes.

These aims also align to our statutory duties as an ICB. The details of these statutory duties can be **found here**.

Our Joint Forward Plan aligns with the recently published Hewitt Review (April 2023), which considers the future development of Integrated Care Systems in England. The review supports taking a 'whole system approach' to addressing wider determinants of health, and a shift of focus away from treating problems towards maintaining good health. These two themes align with our statutory duty and also our local commitment to integrate services to benefit our population.

Our approach to developing this Joint Forward Plan

The Cheshire and Merseyside Integrated Care Board was formally established in July 2022. We have already made significant progress, but we are still in a developmental phase and we have considerable work to do to further develop our plans and priorities. This Joint Forward Plan should be read in this context.

Whilst the responsibility to develop this plan sits with NHS Cheshire and Merseyside, and our NHS Providers, we have adopted a collaborative approach to developing this plan. We drew on the wide range of expertise, knowledge, and experience of our health and care professional leaders and partners to help us identify ways to improve integration and innovation. This will help us to deliver better outcomes for our population.

This 2023-2028 Cheshire and Merseyside Joint Forward Plan describes at a summary level the approach we are taking to tackle the current challenges we face in recovering access to services following the Covid 19 pandemic.

It also outlines a programme of radical transformation across our health and care system to address longstanding issues of inequalities in outcomes and financial sustainability.

This JFP builds on our draft interim Health Care Partnership Strategy. The strategy is built around four core strategic objectives:

- Tackling Health Inequalities in outcomes, experiences and access (our eight Marmot principles).
- Improving population health and healthcare.
- Enhancing productivity and value for money
- Helping to support broader social and economic development.

These objectives support us to work towards achieving our vision and mission. The draft interim Health Care Partnership Strategy is broadly focused and contains many priorities. The HCP recognise the need to decide what to prioritise to enable progress to be made. Our residents provided feedback on the draft interim strategy during March and April 2023 which supported this view.

Figure 1: Cheshire and Merseyside Health Care Partnership Vision and Mission

The HCP Strategy is currently in draft form and will be finalised later in 2023, in recognition of this ongoing work we have identified a number of priorities which contribute to making early progress against the ambitions outlined in the draft interim Strategy.

When the priorities in the HCP Strategy are finalised, we will refresh these priorities in our updated Joint Forward Plan, which will be published in March 2024.

Figure 2: Cheshire and Merseyside Priorities

HCP Strategic Objectives	Cross reference to the HCP areas of focus	Priorities	Core plans *	Metric
Tackling Health Inequalities in outcomes, experiences, and access (our eight Marmot principles)	• Give every child the best start in life • Enable all children, young people and adults to maximise their capabilities and have control over their lives • Ensure a healthy standard of living for all • Tackle racism, discrimination and their outcomes • Pursue environmental sustainability and health equity together.	All our Places are actively engaged in the All Together Fairer Programme	**2**	Increase % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage Reduce hospital admissions as a result of self-harm (15-19 years)
		Supporting the safety of vulnerable Women and Children	**2**	Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing Violence Against Women and Girls
Improve population health and healthcare	• Improve early diagnosis, treatment and outcome rates for cancer • Improve satisfaction levels with access to primary care services • Provide high quality, accessible safe services • Provide integrated, accessible, high quality mental health and wellbeing services for all people requiring support.	In relation to preventing ill Health we will focus on: • Increase rates of Early detection of Cancer • Work towards MECC (Making Every Contact Count) • Encourage *'Healthy Behaviours'* with a focus on smoking/alcohol/ physical activity • Ensure access to safe, secure, and affordable housing	**1,2,3**	Core20PLUS5 priorities including cancer, cardiovascular disease and children and young people's mental health services
			2,3	Increased sign up to the NHS prevention Pledge
			2,3	Reduction in Smoking prevalence. Reduction in the % drinking above recommended levels. Increase the % who are physically active. TBD
Enhancing productivity and value for money	• Develop a financial strategy focused on investment on reducing inequality and prioritise making greater resources available for prevention and wellbeing services	Deliver our agreed financial plans for 23/24 whilst working towards a balanced financial position in future years	**1**	Financial strategy and recovery plan in place by Sept 2023
Helping to support broader social and economic developme nt	• Embed, and expand, our commitment to social value in all partner organisations • Develop as key Anchor Institutions in Cheshire and Merseyside, offering fair employment opportunities for local people • Implement programmes in schools to support mental wellbeing of young people and inspire a career in health and social care	Develop as key Anchor Institutions and progress advancing at pace the associated initiatives.	**2**	Grow the number of anchor framework signatories to 25
		Embed and expand our commitment to Social Value	**2**	Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%)
		• Developed focused work in schools around encouraging careers in Health and Social Care • Ensure a Health and Care workforce that is fit for the future.	**2**	To be finalised in advance of the final publication in June 2023 Publish a Strategic Workforce Plan by March 2024
		Achieve Net Zero for the NHS carbon Footprint by 2040	**2**	For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

***1. Delivery against NHS Operational plan and Long-Term Plan (See appendix 1)**

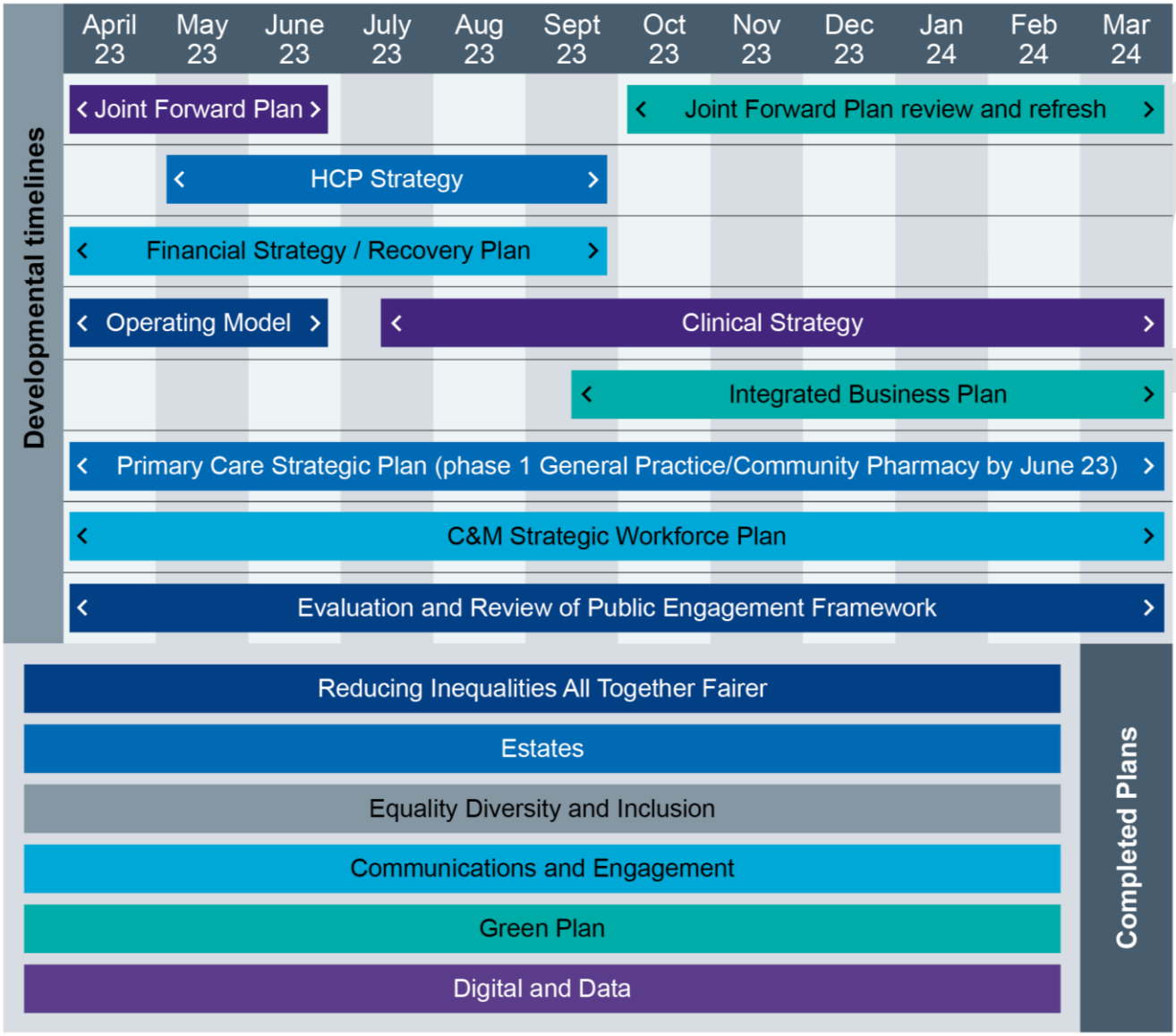
***2. Delivery against the Marmot Beacon Indicators / All Together Fairer (See appendix 2)**

***3. Core20PLUS5 (See appendix 3)**

Whilst this summary document is relatively short, it is underpinned by significant activity across all of the priorities included in the table above. There are various links within this document which provide access to more detail about specific work programmes.

In developing this Joint Forward Plan, we recognise that we are in a developmental phase as an Integrated Care System and that there are some key pieces of planning and strategy work which we will need to align.

We intend to develop a fully integrated business plan during 2023/24 that will incorporate the key strategic plans we have either already developed or intend to develop during this year. These will be reflected in the next iteration of this Joint Forward Plan in March 2024.The table below shows our completed plans and outlines our developmental timeline for 2023/24.



2. How we work as partners for the benefit of our population

Cheshire and Merseyside is one of the largest Integrated Care Systems in England, with a large number of stakeholders working together to improve the health and care of our population.

The figure below illustrates how we are configured at a Cheshire and Merseyside level. Some of the ways we come together in the Cheshire and Merseyside system are:

- The Cheshire and Merseyside Health and Care Partnership (HCP). This is a statutory joint committee between NHS Cheshire and Merseyside Integrated Care Board and our nine Local Authorities which also includes a wide range of partners from across the health and care system. This Board works together to support partnership working and is responsible for producing our Health and Care Partnership Strategy
- The NHS Cheshire and Merseyside Integrated Care Board. This is a statutory NHS organisation responsible for managing the NHS budget and arranging for the provision of health services whilst supporting the integration of NHS services with our partners.
- Our nine Place Based Partnerships. These work locally to support the integration of health and care services in support of local Joint Health and Wellbeing Strategies
- In 2023-24 we will work with Healthwatch to establish a Cheshire and Merseyside wide forum to ensure engagement with each of the 9 teams.

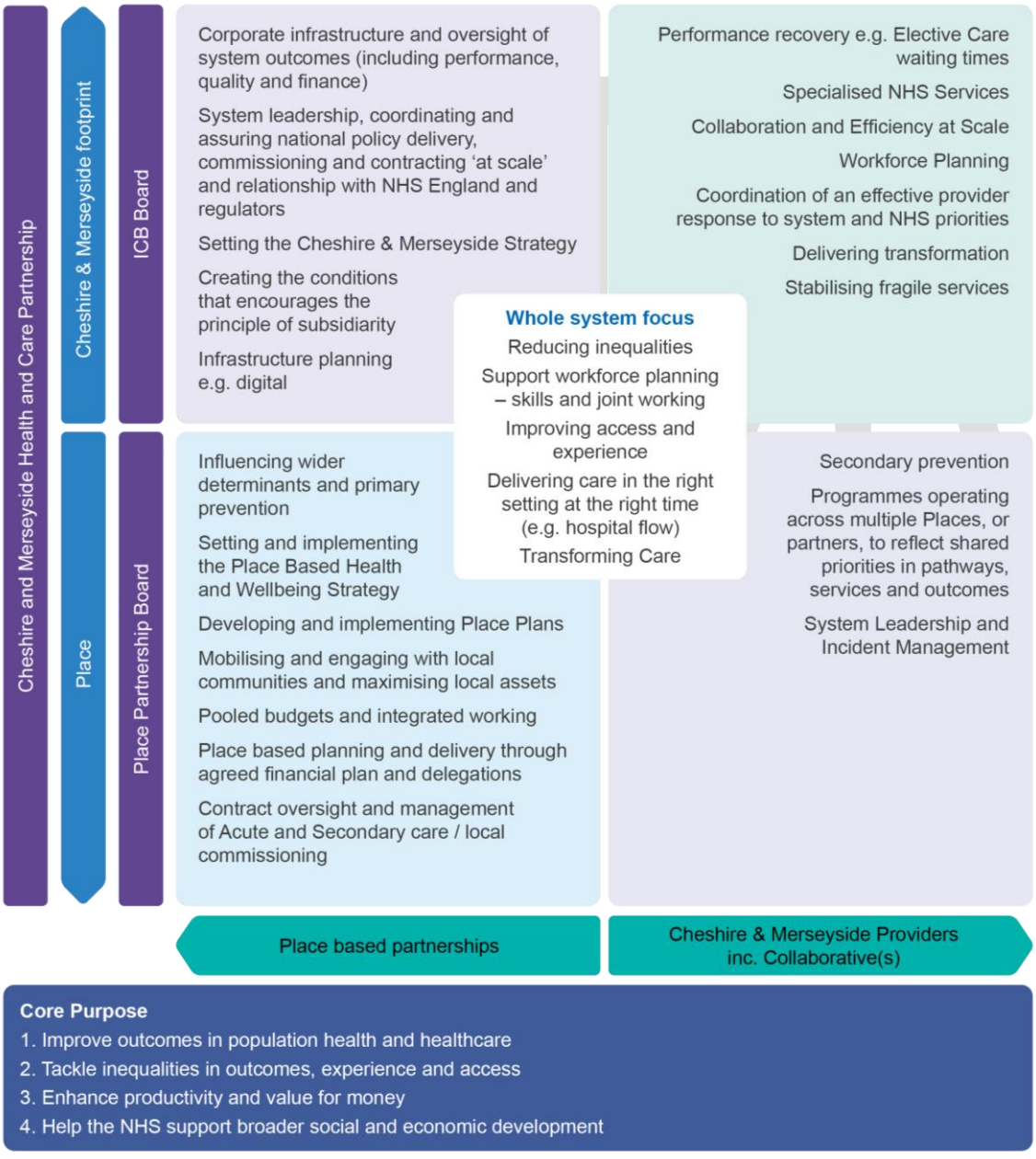
Figure 3: Cheshire and Merseyside Integrated Care System

Through our Place based partnerships and the communities within them we are committed to the principle of subsidiarity. This means that we want to make decisions as locally as possible. Our Places and communities are the 'engine room' which drive change by designing and delivering services around the needs of the local population.

Complementary to this principle of subsidiarity, our large ICS provides opportunities to work at scale where appropriate. This enables us to share best practice and to work collectively to deliver efficiencies and manage change. As an example, our two NHS Provider Collaboratives support our NHS providers to work together to deliver service improvement and enhance sustainability.

The picture below shows how we apply the principle of subsidiarity to decision making in our Places and the communities within them, whilst realising the benefits of working at scale in certain areas through our Health and Care Partnership, or ICS wide programmes or through our two Provider Collaboratives.

Figure 4: Decision making and subsidiarity in Cheshire and Merseyside



Communications and Engagement

As system partners we are committed to engaging with people and communities. We know that harnessing the knowledge and experience of those who use and depend on the local health and care system can help improve outcomes and develop better, more effective services including removing or reducing existing barriers to access.

We are committed to working with those with lived experience to understand the impact of health inequalities and to support us in designing and implementing solutions to address these. For example supporting unpaid carers is an essential contribution to narrow health inequalities in access, outcomes & experiences. Our vision is for all carers in Cheshire and Merseyside to have the support they need and recognition they deserve.

Our Green Plan

Climate change poses a threat to our health as well as our planet. Across Cheshire and Merseyside, we are committed to achieving net zero by 2040 (or earlier). The ICB and NHS Trusts and many Local authority partners have well established plans to achieve this.

Complementary to these local plans, NHS Cheshire and Merseyside has a strong system level Green Plan, and we work collaboratively as system partners to maximise the impact of our initiatives.

Our planet will continue to warm until circa 2060 we will continue climate adaptation / mitigation work to ensure we can continue to provide access to quality health and care for our population even as the climate changes. Including work to tackle air pollution, increased access to mental health services, coastal and other flooding, vector-borne diseases / prep for changing patterns of disease / sustained heat and high temperatures / impact on patients and on workforce, etc.

We will:

Reduce the emissions we control directly (the NHS Carbon Footprint), achieving net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

Supporting wider social and economic development

Supporting social and economic development is one of our strategic objectives. We are working together on a plan for improving health including addressing wider determinants. Wider determinants, also known as social determinants, are a diverse range of social, economic, and environmental factors which impact on people's health.

We can ensure we contribute both in terms of the services that are delivered but also as employers and as part of our local communities.

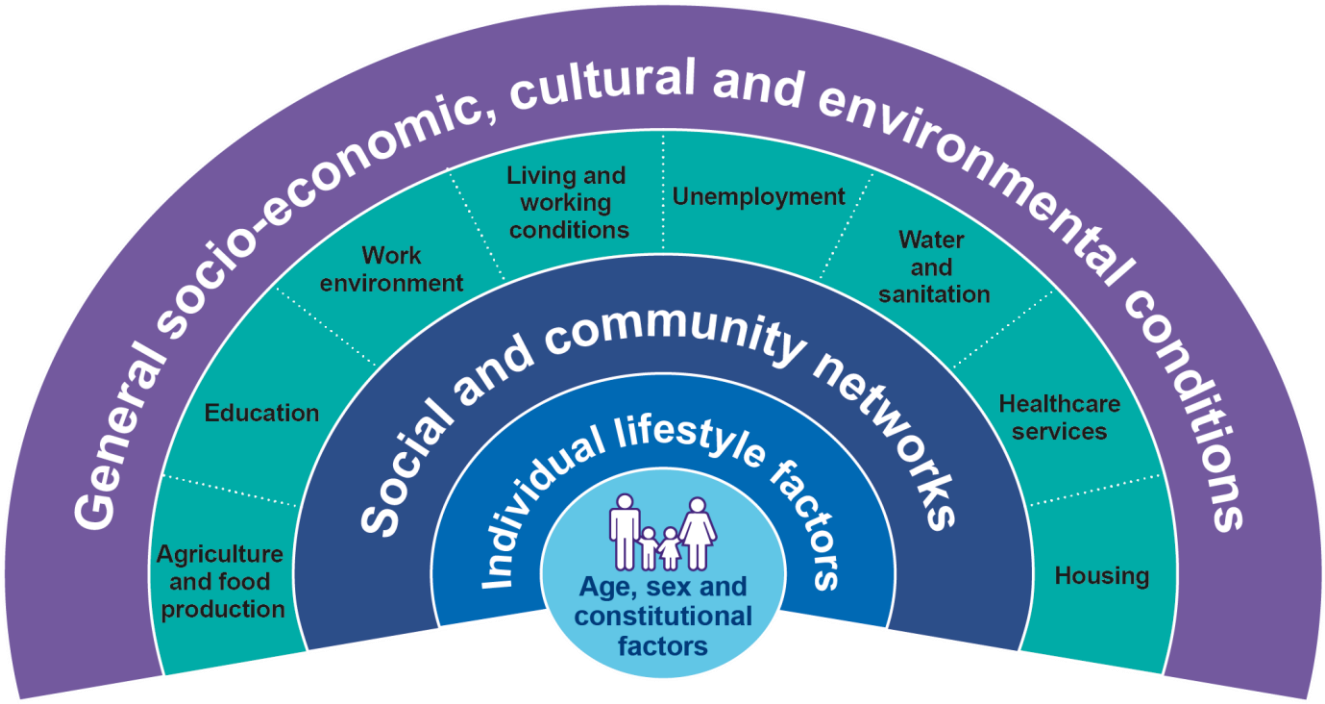
We will:

Increase the number of Anchor Framework signatories to 25 by the end of March 2024

And:

- **Embed, and expand, our commitment to social value**
- **Develop as key Anchor Institutions within Cheshire and Merseyside**
- **Use an asset and strengths-based approach to planning**
- **Share data and insights, so resource can be targeted**
- **Ensure service, pathway and care model redesign is undertaken in collaboration**
- **Develop outcomes-focused funding models and contracts**
- **Support health and care professionals to think about care and support holistically**
- **Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%).**
- **We will maximise our efforts in relation to regeneration and planning including work to support the levelling up agenda.**

Figure 5: Wider social determinants of health and health inequalities, Dahlgren and Whitehead 1991



Safeguarding our population

Safeguarding is a shared responsibility across the health and care economy. Our teams work with colleagues from across the NHS, Local Authorities, the Police, and other partner agencies to drive improvements through local and regional partnership working to embed responsive safeguarding practice. This enables us to address national and local priorities and influence safe and effective care and commissioning.

Effective safeguarding at both system and organisational levels relies on systems that ensure safeguarding is integral to daily business.

We are committed to:

- Strengthening Collaboration and Communication
- Improving Training and Awareness
- Early Identification and Intervention
- Strengthening Partnership Working
- Enhancing Monitoring and Evaluation
- Empowering Service Users
- Promoting a Culture of Safeguarding

We will:

Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing Violence Against Women and Girls.

3. Our approach to improving Population Health

Our established Population Health Board oversees our Population Health programme of work. The aims of this are to improve health outcomes and reduce health inequalities by embedding a sustainable system-wide shift towards focusing on prevention and reducing health inequality. Our newly appointed Director of Population Health plays a key leadership role in this work.

Figure 6 provides a summary of the areas which our analysis tells us that our population experience worse outcomes when compared to the "England average", and where our people have told us their experience of accessing care does not meet their expectations.

We know that it is often the wider social determinants of health which are the cause of these poorer outcomes and this is why we are committed to addressing these wider determinants and to promote good health.

In line with the Hewitt Review recommendations, as an ICB we intend to increase year on year the proportion of our budget being spent on prevention. Over time we expect that this will improve the health of our population, whilst helping to address the variation and inequality in access and outcomes we see across Cheshire and Merseyside.

The following programmes describe how we are approaching this.

Figure 6: Population Health needs and cross cutting prevention themes in Cheshire and Merseyside

Strategic Intelligence

Strategic business intelligence is vital to underpin, inform and drive a coordinated and sustainable population health management approach across ICS programmes.

As outlined in our Digital and Data Strategy, we will build on our CIPHA and System P Programmes to enhance our strategic intelligence functionality. This will enable us to better identify areas for targeted interventions and monitor progress.

All Together Fairer

The primary objective of the draft interim Health Care Partnership Strategy is to reduce health inequalities, this commitment is at the heart of all of our programmes of work. This includes through our established All Together Fairer programme where we aim to improve population health and reduce population level inequalities in health, by focussing on the social determinants of health across Cheshire and Merseyside and supporting action at Place level. The All Together Fairer programme supports the eight Marmot principles, which are to:

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 a 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.
7. Tackle racism, discrimination, and their outcomes.
8. Pursue environmental sustainability and health equity together.

An example is how we will work together to support our population to access safe, secure, and affordable housing.

We know that access to safe, secure, and affordable housing has a huge impact on the health of our population, and also that providing the right accommodation in the community supports people with a mental health condition or learning disability to access services in a more appropriate environment. A number of partners across our Health and Care Partnership provide excellent services which support our population to meet their housing needs.

Within the NHS many of our services such as community nursing services often involve visiting people at home. We can 'Make Every Contact Count' by using these interactions as opportunities to sign-post people to other local services which can help improve the environment they live in, impacting positively on their overall health and wellbeing.

We will measure the success of the All Together Fairer programme in the 2023-28 period against the 22 beacon indicators in the Marmot indicator set *(Appendix 2)*.

We will:

- **Increase the % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage**
- **Reduce hospital admissions as a result of self-harm (15-19 years)**

Core20PLUS5: System-wide action on healthcare inequalities

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities. It identifies focused clinical areas requiring accelerated improvement. Making progress against these areas is a cross-cutting, system-wide responsibility, and delivery against priority clinical area objectives sits with respective ICS programmes and workstreams.

Our Population Health Programme strategic intelligence and system leadership will strengthen the oversight and monitoring of progress against the Core20PLUS5 clinical priorities *(Appendix 3)*.

We will: Focus on delivery of the CORE20PLUS5 clinical priorities with an emphasis on:

- **Increasing the proportion of cancers diagnosed at an early stage (stage 1 or 2)**
- **Increasing the percentage of patients with hypertension treated to NICE guidance to 77% by March 2024**
- **Improving access, and equity of access, to Children and Young Peoples Mental Health services (0-17).**

System-wide action on Prevention and Making Every Contact Count

We are committed to working collaboratively as a system. As part of this commitment, we are embedding the philosophy of Making Every Contact Count. This is an approach to behaviour change that maximises the opportunity within routine health and care interactions for a brief discussion on health or wellbeing factors. This can support people in making positive changes to their physical and mental health and wellbeing.

We are also focusing on evidence-based and high impact interventions which include:

- Reducing smoking prevalence
- Reducing harm from Alcohol
- All Together Active Physical Activity Strategy
- Promoting Healthy Weight
- Increasing Health Checks
- Mental Wellbeing.

We will monitor our progress against key system objectives using an integrated framework that is currently being co-produced by system partners, and will incorporate key metrics in ICS, ICB and Marmot (All Together Fairer) dashboards.

We will:

- **Reduce smoking prevalence**
- **Reduce the % drinking above recommended levels**
- **Increase in the % who are physically active.**

NHS Prevention Pledge

Our providers are delivering against the 14 core commitments in the NHS Prevention Pledge. We are strengthening our focus on prevention, social value, and inequalities, embedding Making Every Contact Count (MECC) at scale, and supporting participating Trusts to achieve Anchor Institution charter status.

We are also exploring how we interpret the Pledge in a primary care setting, which involves considering how it may apply to colleagues such as GPs, dentists, optometrists, and pharmacists. This may provide further opportunities for partners to take early action to support health and wellbeing across a broader range of health and care settings.

We will:

Increase sign up to the NHS Prevention Pledge.

Screening, Immunisation and Vaccination

We plan to work with NHS England, UK Health Security Agency (UKHSA) and Place based commissioning teams to strengthen screening, vaccination and immunisation uptake, and to reduce inequalities.

We will:

Work with partners to strengthen screening, vaccination and Immunisation uptake and reduce inequalities.

4. How we will improve our services and outcomes

We have adopted a life course (starting well, living well, ageing well) approach to improving services and outcomes.

We are working hard to improve services and outcomes for our residents through a wide range of programmes. We want world leading services across our system, from GPs to highly specialised hospital care.

The table below summarises our core areas of focus. Further details of our work can be accessed by clicking against the appropriate link.

Theme	Heading	Focus	Drivers	Link	Cross Cutting
Starting Well	**Maternity & Women's Health**	Reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury. Deliver the actions from the Ockenden report Workforce development All women have personalised and safe care Reduce inequalities in access and outcomes Women's Health and Maternity (WHaM) programme Gynaecology Network Estate - Women's Health Hubs	Core20PLUS5 All Together Fairer Long Term Plan	Click to Access	Prersonalised Care and supporting Self Care Supporting Our Carers and Vulnerable Groups
	Children and Young People Beyond Programme	Emotional wellbeing and mental health Learning difficulties, disabilities and autism Diabetes Epilepsy Respiratory / asthma Healthy weight and obesity Oral health Estate - Women's Health Hubs	Core20PLUS5 All Together Fairer Long Term Plan	Click to Access	
Living Well Ageing Well	**Physical Health**	Cancer Cardiovascular Disease (CVD) Community health services Diabetes Elective Recovery Neurosciences Respiratory Stroke Urgent & Emergency Care Accessing Adult Social Care	Core20PLUS5 NHS Operational Plan Long Term Plan	Click to Access	
	Mental Health	Improving Mental health access and outcomes Continued investment in Mental Health Improved choice A new community-based Mental Health offer PCNs to have Mental Health Practitioners More comprehensive crisis pathways Improved access for children and young people Suicide Prevention Dementia	Core20PLUS5 NHS Operational Plan Long Term Plan	Click to Access	
	Neurodiversity	Learning Difficulties, Disability & Autism (LDDA) Attention Deficit Hyperactivity Disorder (ADHD)			
	End of Life Care (EOLC)	Access to information to support EOLC Access and sustainability palliative /EOLC services Specialist Workforce development Engaging with people	Long Term Plan	Click to Access	
Cross Cutting	Primary Care - General Practice / Dental / Optometry /Community Pharmacy Diagnostics - Priority supporting Recovery and Restoration				

5. Our Workforce

Our plans recognise the importance of investing in our workforce.

We recognise the skills, abilities and dedication that our staff show each day and the importance of maintaining their Health and Wellbeing.

To achieve Cheshire and Merseyside Health and Care Partnership's strategic priorities we need to change the way we work. We will have new teams, new roles, and we will need to work across multiple organisations and Places.

In 2022/23 the Cheshire and Merseyside People Board, which has a broad membership across Cheshire and Merseyside stakeholders, agreed a set of ambitious Workforce Priorities for 2022-25 (see below).

Our system Workforce Strategy and the programme to support delivery of these priorities will be further developed during 2023/24.

Systemwide Strategic Workforce Planning to:	Creating New Opportunities across C&M to:	Promoting Health and Wellbeing to:	Maximising and valuing the skills of our staff to:	Creating a positive and inclusive culture to:
• Ensure a health and care workforce that is fit for the future • Smarter workforce planning linked to population health need • Creation of a 5-, 10- and 15-year integrated workforce plan • Developing a greater triangulation and monitoring between workforce / productivity / activity / finance.	• Grow our own future workforce • Increased focus on apprenticeships • Embed New Roles • Review barriers to recruitment • Work with the further and higher education sector • PCN Development • Greater links with social care and primary care • Ensuring an effective student experience.	• Ensure appropriate health and wellbeing support for all staff • Ensure good working environment • Focus on retention. • Preventing burnout • Ensuring appropriate supervision and preceptorship is available.	• Understand the impact of 5 generations working together/ changing expectation of the workforce • Developing career options at different stages of our lives and across health and social care • Responding to reviews / staff surveys and recommendations in a positive manner.	• Ensure proactive support of inclusion and diversity as a priority • Collaborative and inclusive system leadership • Understanding the barriers for staff / future employees • Development of learning and restorative practice.

Developing our culture and leadership

We plan to adopt, apply, and invest in the following areas to develop our culture, workforce, and ways of working as a system.

We will:

- **Ensure a Health and Care workforce that is fit for the future.**

  And:

- **Publish a Strategic Workforce Plan by March 2024**
- **Create new opportunities across health and care providers**
- **Promote health and wellbeing of all our workforce**
- **Maximise and value the skills of our workforce**
- **Create a positive and inclusive culture**
- **Ensure digital upskilling for the whole workforce**
- **Further develop our partnerships with Health Education Institutes (HEI's), further education providers and school**

Cultural transformation

- Organisational and system redesign necessary for integration
- Competence and capability development to deliver integrated ways of working.
- Team cohesion to drive resource optimisation through sustainable collaboration.
- Growth mindset to stimulate systems leadership thinking and practice.
- A shared cultural identity values and behaviours premised on the principles of public service founded by the NHS Constitution, Equality Act and Nolan Principles

Talent management

- Talent management for effective capacity, demand and supply planning mapped to population health / market trends.
- Robust succession planning strategies for business-critical roles and hard to fill roles specifically.
- Reward and recognition strategies to ensure that success is rewarded and celebrated and improve staff engagement and retention.

Leadership development

- Resilient collective (systems) leadership evidenced in the continual enablement of integration for improved health and care integration.
- Compassionate and inclusive leadership cultures towards improving health inequalities.
- Culturally competent leadership to drive cultural competence in decision making for integration.
- Clinical leadership for integration towards health creation models of care

6. System development

Our Integrated Care System is geographically large and comprises a wide range of partners. This is reflected in how we apply our intention to distribute leadership to the most appropriate point in the system, which in many cases is as locally as possible.

In line with the concept of a "self-improving system" described in the Hewitt Review we intend to develop our capabilities and be ambitious in developing our leadership, workforce and improvement approaches alongside the plans already outlined in this document.

In early 2023/24 we will be delivering work to develop and embed an agreed operating model for our system, working alongside system partners. Part of this will involve considering how we can work more efficiently as a system to enable the integration of services across health, care and our wider partners and communities, within our Places and our communities to prosper whilst working collectively at a Cheshire and Merseyside level when it makes most sense to do so.

Clinical and Care Professional leadership

We have developed a Clinical and Care Constitution which describes a set of principles that underpin all we do. It has been written by clinicians with input from clinical and care colleagues to support Cheshire and Merseyside ICS develop with our partners, an overarching population health approach, driven by the needs of our communities with a clear focus on addressing Health Inequalities.

It will:

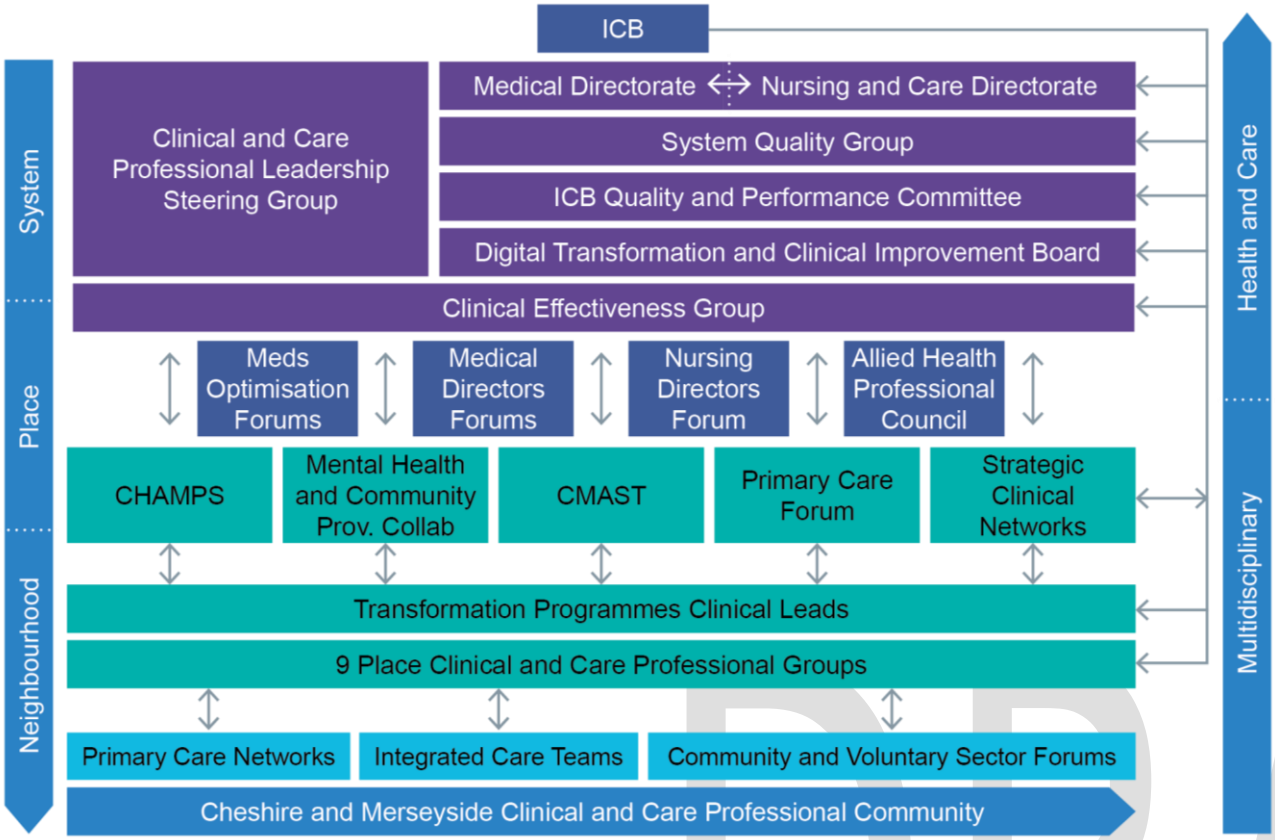
- **shift the paradigm from reactive to proactive healthcare**
- **integrate clinical and care professionals in decision-making at every level of the ICS, creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities**
- **provide a return on our investment in improving health will be evidenced through measures of both quality and effectiveness**
- **influence the wider determinants of health through collaboration, education and modernisation**

Our Constitution sits alongside our established Clinical and Care Leadership Framework (see figure 7) which outlines how clinical and care leaders across Cheshire and Merseyside will be involved in the key aspects of ICS decision making.

We will:

Implement the commitments and pledges within our Constitution .

Figure 7: Clinical and Care Leadership in Cheshire and Merseyside



Quality Improvement

The government and public rightly expect Integrated Care Boards and their respective systems to ensure that the services we commission provide the highest standards of care. The development of our system quality strategy is being informed by the National Quality Board (NQB) guidance. The NQB publication 'Shared Commitment to Quality' provides a nationally agreed definition of quality and a vision for how quality can be effectively delivered through ICSs.

Quality Principles

We will work together as a system to improve quality and use the key principles for Quality Management, as set out by the NQB, in developing our approach to deliver care that is:

- Safe
- Effective
- A Positive Experience
- Responsive and Personalised
- Caring
- Well-led
- Sustainably Resourced
- Equitable

Our Provider Collaboratives

Effective collaboration and system working provides us with an opportunity to continually evolve, develop, improve and partner to further embed progress and capacity within the ICS and ultimately to provide extended and better care to our residents and patients.

In Cheshire and Merseyside, we have two provider collaboratives:

- Cheshire and Merseyside Acute and Specialist Trusts Collaborative (CMAST)
- Mental Health, Community and Learning Disability and Community Provider Collaborative (MHLDC)

Our collaboratives are leading a range of work programmes which support delivery of the Cheshire and Merseyside HCP strategic priorities.

Our Cheshire and Merseyside Acute and Specialist Trusts Collaborative (CMAST) programmes and key areas of focus are listed below:

- Elective Recovery and Transformation
- Clinical Pathways
- Diagnostics
- Finance, Efficiency and Value
- Workforce

Our Mental Health Learning Disabilities and Community Provider Collaborative (MHLDC) is a joint working arrangement between the nine providers of community, mental health and learning disabilities services. The work programme priorities for 2023/24 are:

- Community urgent care:
  - Urgent community response teams
  - Intermediate care
  - Roll out of Urgent Treatment Centre specification
  - Virtual Wards
- Community services for children and young people
- Access to care, fragile services and community waiting times
- Population health and prevention
- Mental health transformation
- Workforce transformation

We will:

Work with Our collaboratives on a range of work programmes which support delivery of the HCP strategic priorities.

Our VCFSE Transformation Programme

In Cheshire and Merseyside we are fortunate to have a strong and engaged Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector across our nine Places. This is supported by established local infrastructure organisations providing skills, knowledge, and capacity to enable two-way communications and engagement between local neighbourhoods and the health and care system.

The new health and care structures which have recently been established provide an opportunity to transform services and make a lasting difference to patients and communities. VCFSE partners will play a vital role in transformation programmes.

NHS Cheshire and Merseyside's draft Public Engagement Framework was co-produced with Healthwatch and the Voluntary, Community, Faith and Social Enterprise Sector and published in July 2022.

We will:

Focus on embedding the VCFSE as a key delivery partner.

And

- **Supporting investment in the VCFSE both financially and organisationally**
- **Building on VCFSE infrastructure and assets**

Our Places

Our nine Cheshire and Merseyside Places have been working collectively since before the formation of ICS in 2022, working through local partnership arrangements to deliver against the priorities in their local joint health and wellbeing strategies.

We have used a 'Place Development Assessment Framework' to support our Place Partnerships in their development, applying learning from other geographies. There are 4 key domains:

- Ambition and Vision
- Leadership and Culture
- Design and Delivery
- Governance

Place Partnerships have developed detailed plans to improve local services and outcomes.

We will:

As part of our Operating Model, we will enable our nine Places to most effectively deliver functions and decision making at a local level.

Evolving our Commissioning and Corporate Services

We are developing a single suite of commissioning policies across Cheshire and Merseyside by March 2024, and we will publish new policies as soon as these are completed and have been through the relevant engagement and governance processes required.

The Health and Care (2022) Act has created provisions for NHS England to delegate functions relating to the planning/commissioning of certain services to Integrated Care Boards. In April 2023 the ICB took on responsibility for dental, ophthalmic and pharmacy services, and we are planning for future delegation of Specialised Services from April 2024.

We have a number of programmes of work designed to support our system to improve consistency and value for money as its functions evolve. These include:

- Corporate infrastructure: we are reviewing the licenses and applications in use across our nine places, to improve consistency and realise operational and financial efficiencies.
- Commissioning support functions: we are reviewing all services currently provided to the ICB by Midlands and Lancashire Commissioning Support unit for consistency and value for money.

Research and Innovation

As described in our draft interim Health Care Partnership Strategy we have an ambitious vision for research in Cheshire and Merseyside. Our ICS is investing in the clinical leadership to realise this ambition with Director and Deputy Director of Research to work closely with our stakeholders to develop the best performing research network in the country.

We are working closely as a system involving the CHAMPS public health collaborative, our academic institutions, HCP partners (including population health), research partners (including National Institute for Health and Care Research, National Cancer Research Institute and Academic Health Science Network) and industry.

We will:

- **Establish a Cheshire and Merseyside Research Development Hub**
- **Create a network of research champions across our system**
- **Deliver annual learning events to showcase latest research and to enable the sharing of skills, toolkits and research to support in-house evaluation of projects**
- **Contribute to the development of a North West Secure Data Environment for research.**

Digital and Data

Cheshire and Merseyside ICS published its three year Digital and Data Strategy in November 2022 following endorsement from the NHS Cheshire and Merseyside Board. We are committed to using digital and data to improve outcomes and services for our residents.

The strategy describes an ambition to improve the health and well-being of our region now and into the future by incorporating digital and data infrastructure, systems, and services throughout the pathways of care we provide.

This requires 'levelling up' our digital and data infrastructure to help address the significant inequalities so clearly faced by parts of our population and to ensure we successfully support all we serve.

We are committed to turning 'intelligence into action' by using increasingly sophisticated ways of understanding the health and care needs of our population, and then finding and intervening for those in greatest need to improve their health and care outcomes in an equitable way.

We will:

Work in partnerships to deliver the goals outlined in the Digital and Data Strategy, including making the Share2Care (shared care record) platform available in all NHS and Local Authority Adult Social Care providers, by March 2024.

Effective use of resources

In line with many other systems Cheshire and Merseyside faces significant financial challenges. As a system, we are spending more money on health and care services then we receive in income. We must take action to improve the long-term sustainability of the Cheshire and Merseyside health and care system by managing demand and transforming the way we use services, staff, and buildings.

As part of the Cheshire and Merseyside draft interim Health Care Partnership Strategy there is a commitment to developing a system-wide financial strategy during the first half of 2023-24 to:

- Determine how we will best use our resources to support reduction in inequalities, prevention of ill health and improve population health outcomes
- Support health and care integration
- Identify key productivity and efficiency opportunities at both a Place and ICS footprint
- Outline system-wide estates and capital requirements and plans

As recommended in the Hewitt Review, we are focussed on ensuring we are getting best value from our investments and increasing the proportion of our ICB budgets allocated to prevention of ill health.

We will:

Agree a financial strategy and recovery plan by September 2023 which details how we will move to a sustainable system-wide financial position in Cheshire and Merseyside.

Finance Efficiency and Value Plans

As part of our wider development of a system financial strategy, we have established an Efficiency at Scale programme. One of our provider collaboratives, CMAST, is hosting the programme on behalf of the ICB. The programme works across the NHS and links with partners from the wider system as appropriate.

The key areas of focus for the Efficiency at Scale programme are:

- Consolidating financial systems, approaches and capacity across organisations where appropriate, including financial ledgers.
- Delivering a structured procurement workplan to reduce influenceable spend across all providers.
- Building on existing medicines optimisation projects to deliver a more sustainable approach to pharmacy capacity and resourcing across Cheshire and Merseyside.
- Specific discrete workforce projects, for example a collaborative staff bank for Health Care Assistants.

This complements wider work on our financial strategy and recovery plan where system partners work to reduce costs, through ICB, Place, provider and partner led plans.

Capital plans

We have developed a Capital Plan which describes how we will use available capital funding to invest in our buildings and infrastructure. The dedicated page is publicly available to view at: Capital Plan

Our capital plans will be routinely shared with members of the Cheshire and Merseyside Health and Care Partnership and the nine Health and Wellbeing Boards in Cheshire and Merseyside.

We will:

Continue working in partnership to deliver against our Capital plans.

Estates

Cheshire and Merseyside Health and Care Partnership's Estates Strategy sets out our system commitment for the next five years. We are committed to the NHS, local government and other agencies working together to deliver our Estates Plan and take steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them.

Our focus for delivery will primarily be in eight key areas:

- Fit for Purpose
- Maximising Utilisation
- Environmentally Sustainable
- Value for Money and Social Value
- Services and Buildings in the right place
- Flexibility
- Technology
- Working in Partnership

We will:

Support our nine Place Partnerships and Primary Care Networks to ensure our focus areas translate into deliverable local plans.

All Age Continuing Health Care

The ICB is accountable for the fair and equitable commissioning of NHS All Age Continuing Health Care (AACC) to support the assessed needs of our residents. We are accountable for the quality, safety and financial assurance of the continuing care provided.

We have recently reviewed the services we provide to people who receive Statutory funded continuing care. This review will have a range of benefits. It will improve the appropriateness of the care provided, meaning care is of higher quality. By providing more appropriate solutions, we also expect to improve the value for money of the services we provide meaning our funding can go further.

We will:

Complete the review and work with partners to establish an equitable model for delivery of services across Cheshire and Merseyside.

7. Our Place Plans

Click her to see our Place plans. (link to be added).

8. Glossary

An online glossary of terms has been developed by NHS Cheshire and Merseyside and can be accessed through this link:

cheshireandmerseyside.nhs.uk/get-involved/glossary/

9. Summary of Outcomes

In addition to the priorities outlined in Section 1 there are a range of additional outcomes the plans outlined in this document will deliver and can be accessed by clicking here (link to be added).

10. Links to our partners plans

Click here to find links to the strategic plans of our NHS Provider and Local Authority Partners. (link to be added).

Appendix 1 NHS Operational Plan and Long-Term Plan

NHS Operational Plan and Long-Term Plan Objectives and Metrics				
Area	**2023/24 Planning Objective**	**Metric**	**Target Value**	**Cheshire and Merseyside position**
Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25	Percentage of attendances at Type 1, 2, 3 A&E departments, excluding planned follow-up attendances, departing in less than 4 hours	76%	76.9%
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 (NWAS target set at 33 mins)	Ambulance Response Times - Category 2	National 00:30:00 NWAS 00:33:00	N/A
	Reduce adult general and acute (G&A) bed occupancy to 92% or below	Average number of overnight G&A bed occupancy - adult	92%	94.3%
		Average number of overnight G&A bed occupancy - Total (Adult & Paediatrics)		92.8%
Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard	Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	70%	2022/23 YTD = 74%. 14,985 UCR Contacts planned, 36% increase compared to 2022/23 FOT
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	No specific metric defined		
Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	% Appointments booked same day		Total GP Appoints 14.98m. Increase of 4.9% compared to 2021/22
		% Appointments booked within 1-14 days		
		% Appointments booked over 14 days		
	Continue the trajectory to deliver 50 million more appointments in general practice by the end of March 2024	Current gap to local ambition (down arrow indicates closing the gap)		
	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024	Direct Patient Care (DPC) Roles in General Practice and PCNs (NB - manifesto commitment changed from ARRS to DPC roles, trajectory only available at region level)		57.9%
	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	2019/20 Baseline scheduled monthly % of usual annual contracted UDAs		83% below 19/20
		2022/23 scheduled monthly % of usual annual contracted UDAs		

Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)	Total waiting over 65 weeks	0	0
	Deliver the system- specific activity target (agreed through the operational planning process)	2022/23 Value Weighted Activity including adjustment for advice and guidance (NB - this measure will change for 2023/24)	105%	108.5%
Cancer	Continue to reduce the number of patients waiting over 62 days	The number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site-specific symptoms		1,095
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	% Patients with diagnosis communicated within 28 days	75%	75.1%
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Percentage of stageable cancers diagnosed at stage 1 and 2 (NB - data are Cancer Alliance not ICB footprint)	75%	80.0%
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	% Patients receiving diagnostic test within 6 weeks	95%	89.5%
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Acute Trust Diagnostic activity as % of baseline (current month v baseline month for 15 tests in DM01)		116.4%
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury	Stillbirths per 1,000 total births		
		Neonatal deaths per 1,000 total live births		
	Increase fill rates against funded establishment for maternity staff	Workforce data		
Use of Resources	Deliver our agreed financial plans for 23/24 whilst working towards a balanced financial position in future years	Financial strategy and recovery plan in place by Sept 2023		
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	Total workforce	Publish a Strategic Workforce Plan by March 2024	
Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact		23/24 = 135,601 Q4 = 37,590
	Increase the number of adults and older adults accessing IAPT treatment	Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period.		23/24 = 72724. 100% of target

	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses	5%	Q4 23/24 = 20,600 Target achieved
	Work towards eliminating inappropriate adult acute out of area placements	Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider		Q4 23/24 = 900
	Recover the dementia diagnosis rate to 66.7%	Dementia Diagnosis Rate	66.7%	66.7%
	Improve access to perinatal mental health services	Number of women accessing specialist community PMH and MMHS services in the reporting period		Q4 23/24 = 2,357 372 short of ambition
People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024	% of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register in the period	75%	75.0%
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults are cared for in an inpatient unit	Learning Disability Inpatient Rate per Million ONS Resident Population.	<30	**36.5**
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit		12 to 15	14.0
Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024		77%	
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%		60%	
	Continue to address health inequalities and deliver on the Core20PLUS5 approach	No specific metric defined		
Activity	Elective day case spells	Planned Activity Volumes 23/24		363,244
	Elective ordinary spells	Planned Activity Volumes 23/24		54,466
	RTT Clock Stops (admitted and non-admitted)	Planned Activity Volumes 23/24		879,054
	Number of requests for A&G	Planned Activity Volumes 23/24		417,246
	Outpatient attendances (all TFC; consultant and non-consultant led) - First attendance	Planned Activity Volumes 23/24		1,330,322
	Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance	Planned Activity Volumes 23/24		3,357,568

	Follow Up Outpatient Attendances without procedure	Planned Activity Volumes 23/24	Reduce by 25%	2,487,559
	Number of episodes moved or discharged to PIFU pathway	Planned Activity Volumes 23/24		171,366
	Number of attendances at all type A&E departments.	Planned Activity Volumes 23/24		1,181,165
	Non-elective spells	Planned Activity Volumes 23/24		398,629

Appendix 2 Marmot 8 principles and 22 Beacon indicators

The tables below highlight the principles describing how we intend reducing inequalities and the indicators we will use to measure progress.

Marmot 8 principles	
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 a 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.
7	Tackle racism, discrimination, and their outcomes.
8	Pursue environmental sustainability and health equity together.

22 Beacon Indicators

Life expectancy		Frequency	Level	Disagg.	Source
1	Life expectancy, female, male	Yearly	LSOA	IMD	ONS
2	Healthy life expectancy, female, male	Yearly	LA	IMD	ONS
Give every child the best start in life					
3	Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development)*	Yearly	LA	NA	DfE
4	Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception)	Yearly	LA	FSM status	DfE
Enable all children, young people and adults to maximise their capabilities and have control over their lives					
5	Average Progress 8 score**	Yearly	LA	FSM status	DfE
6	Average Attainment 8 score**	Yearly	LA	FSM status	DfE
7	Hospital admissions as a result of self-harm (15-19 years)	Yearly	LA	NA	Fingertips, OHID
8	NEETS (18 to 24 years)	Yearly	LA	NA	ONS
9	Pupils who go on to achieve a level 2 qualification at 19	Yearly	LA	FSM status	DfE
Create fair employment and good work for all					
10	Percentage unemployed (aged 16-64 years)	Yearly	LSOA	NA	LFS
11	Proportion of employed in permanent and non-permanent employment	Yearly	LA	NA	LFS
12	Percentage of employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter***	-	-	-	NHS, local government
13	Percentage of employees earning below real living wage	Yearly	LA	NA	ONS
Ensure a healthy standard of living for all					
14	Proportion of children in workless households	Yearly	LA	NA	ONS
15	Percentage of individuals in absolute poverty, after housing costs	Yearly	LA	NA	DWP
16	Percentage of households in fuel poverty	Yearly	LA	NA	Fingertips OHID
Create and develop healthy and sustainable places and communities					
17	Households in temporary accommodation****	Yearly	LA	NA	MHCLG / DLUHC
Strengthen the role and impact of ill health prevention					
18	Activity levels	Yearly	LA	IMD	Active lives survey
19	Percentage of loneliness	Yearly	LA	IMD	Active lives survey
Tackle racism, discrimination and their outcomes					
20	Percentage of employees who are from ethnic minority background and band/level***	-	-	-	NHS, local government
Pursue environmental sustainability and health equity together					
21	Percentage (£) spent in local supply chain through contracts***	-	-	-	NHS, local government
22	Cycling or walking for travel (3 to 5 times per week)~	Yearly	LA	IMD	Active lives survey

** Children achieving a good level of development are those achieving at least the expected level within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.*

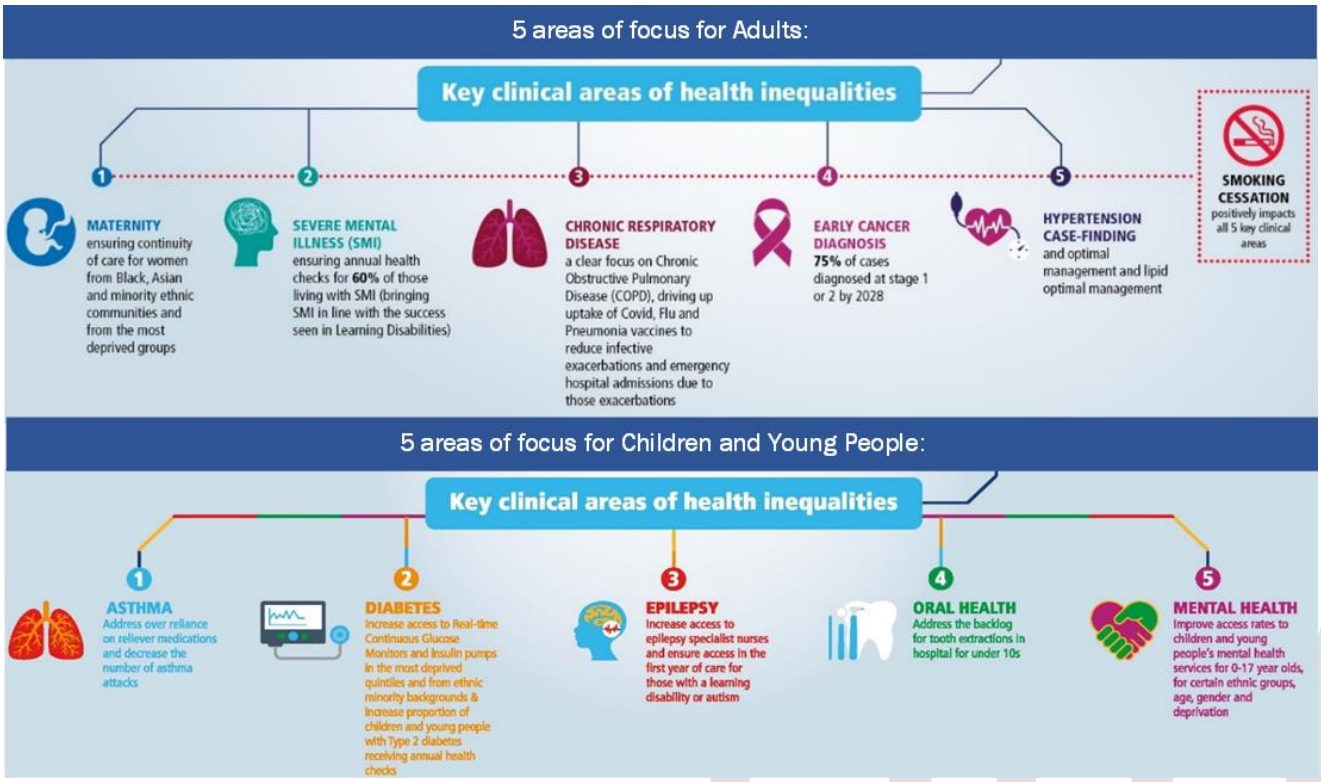
*** Both the Progress 8 and Attainment 8 scores are proposed for inclusion. Progress 8 scores at local authority level demonstrate that schools with a neg ative average score require systematic intervention. Attainment 8 shows the percentage achievement of school-leavers and is a more sensitive measure of annual change within schools.*

**** These indicators will require the NHS and local authorities to establish new data recording and collection methods. We have factored the social value indicators into the 2022/23 work programme to align with the rollout of the Anchor Institute Charter. It will also require definitions of "local" in both the local supply chain and employment. All contracts, direct and subcontracted, should be analysed and included. This should be reviewed after the first year of implementation. Collecting ethnicity data related to employment should also be reviewed after the first year of implementation.*

***** To be used to demonstrate annual changes, interpretation to factor in population changes.*

~ Active Lives Survey states the length of continuous activity is at least 10 minutes.

Appendix 3 Core20PLUS5



Appendix 3 – 1 page summary of
Cheshire East Health and Wellbeing Board Five Year Delivery Plan 2023-28

Cheshire East

Vision:

To enable people to live a healthier, longer life; with good mental and physical wellbeing; living independently and enjoying the place where they live

In Cheshire East we have defined 4 core outcomes we are committed to delivering:

1. Cheshire East is a place that supports good health and wellbeing for everyone
2. Our Children and Young People experience good physical and emotional health and wellbeing.
3. The mental health and wellbeing of people living and working in Cheshire East is improved
4. That more people live and age well, remaining independent and that their lives end with peace and dignity in their chosen place

To maximise the health and wellbeing of Cheshire East's residents, we have identified a number of core principles underpinning the Joint Local Health and Wellbeing Strategy (2023-28). These principles focus around providing value for money, improving population health and decreasing unwarranted variation, alongside delivering the best individual and Carer experience. The plan recognises that staff must also be supported ensuring that they also have a positive experience. In Cheshire East we have adopted a number of 'Golden Threads' that support these principles: -

- Place – improving the environment and making the healthy choice the easy choice.
- Prevention – tackling the risk factors that lead to poor health.
- Proportionate universalism – tackling inequalities with an offer for all but the greatest efforts focussed on those with the greatest need.
- Partnership working – public and VCFSE services working together closer to where people live.
- Proactive care – early diagnosis and intervention.
- Person-centred approaches – looking at the whole person and prioritising what matters to them through shared decision making.
- Production through engagement – reviewing programmes and allocating resources across the whole system to where they will help most.

We have threaded tackling health inequalities throughout place plans and there will be a focus on the recommendations in the Marmot report 'All Together Fairer'. This will be supported by additional work around Core20PLUS5 and Population Health Management with targeted interventions to support vulnerable groups. We will continue to radically reshape the care delivered, to empower residents and place them at the centre of a seamless, integrated system of support. In doing this, we will

co-design and co-produce these changes with residents and frontline staff to ensure they work for all.

There are a number of enablers that will support the work these are: People and Leadership (Workforce), Digital Solutions, Business Intelligence, Communications and Engagement, Estates and Finance.

In Place we have identified a number of priority core themes for example Urgent and Emergency Care, Planned Care, Mental Health, Social Care, Frailty and Falls prevention, Cancer care, Healthy Weight. Work across these areas will include a focus on:

- Further development of our Care Communities
- Improving Diagnostics
- Maintaining Acute sustainability (Including the work relating to East Cheshire NHS Trust and plans to reopen to births at Macclesfield Hospital and Sustainable Hospitals Services Programme)
- Ensuring Elective Recovery

Link to Local Plan (Note: Links to local plans to be added as they are published.)

Title of Report:	Cheshire East Joint Outcomes Framework Update
Date of meeting:	27 June 2023
Written by:	Dr Susan Roberts, Consultant in Public Health, Cheshire East Council and lead for the Cheshire East Place BI Enabler Workstream
Contact details:	Susan.roberts@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Dr Matt Tyrer, Director of Public Health, Cheshire East Council

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision ☒
Why is the report being brought to the board?	To update the Health and Wellbeing Board of the development of the Joint Outcomes Framework and plans for next steps, including publication of the Phase One indicators and commencement of Phase Two (Appendices A and B).		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☐ Improving the mental health and wellbeing of people living and working in Cheshire East ☐ Enable more people to live well for longer ☐ All of the above ☒		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☒ Accessibility ☐ Integration ☒ Quality ☒ Sustainability ☒ Safeguarding ☐ All of the above ☐		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The BI Enabler Workstream Group ask the Health and Wellbeing Board to: • Note the finalised Phase One Joint Outcomes Framework and the consensus building process undertaken to agree this. • Note the plans for Phase Two.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The content of this report and presentation are a summary of partnership working and involves representatives from Cheshire East Council, the NHS and the Voluntary Community Faith and Social Enterprise sector. The finalised framework was presented to the Strategic Planning and Transformation Group in January 2023. The framework has also been shared with the Joint Strategic Needs Assessment Steering Group.		
Has public, service user, patient feedback/consultation informed the recommendations of this report?	Members of Healthwatch, Cheshire East Social Action Partnership, and Voluntary, Community, Faith and Social Enterprise representatives have been involved in Phase One. However, it is recognised that further engagement over the second phase will be essential.		

If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	The Cheshire East Joint Outcomes Framework is being developed to be used in conjunction with the Joint Strategic Needs Assessment (JSNA) and relevant Integrated Care System and national tools to: • Inform and monitor health and care transformation towards closer integration and summarise progress in relation to the Place Plan through a Joint Outcomes Framework • Optimise primary, secondary, and tertiary prevention and wellbeing • Address inequalities.

1 Report Summary

1.1 The Cheshire East Joint Outcomes Framework is being developed to inform and monitor health and care transformation towards closer integration, and to summarise progress in relation to the Joint Health and Wellbeing Strategy/ Place Plan and Place-level Delivery Plan.

1.2 Progress on the Joint Outcomes Framework has been summarised at Appendix A, along with continued challenges and considerations.

1.3 It is proposed that the first phase of indicators are published as an interim measure (Appendices B and C), however, in the longer term, a dashboard would be developed.

2 Recommendations

2.1 The Health and Wellbeing Board is asked to:

- Note the finalised Phase One Joint Outcomes Framework, and the consensus building process undertaken to agree this.
- Note the plans for Phase Two.

3 Reasons for Recommendations

3.1 Using a single outcomes framework to monitor the progress in the Joint Health and Wellbeing Strategy/ Place Plan and Place-level Delivery Plan will help to unify approaches and collaboration between partners across Place towards the agreed common goals.

3.2 It is likely that there will be a national requirement to produce a framework in future.

3.3 Production of a single series of indicators that incorporates articulation of health inequalities through an automatically refreshing dashboard will help to streamline Business Intelligence requirements across Cheshire East Place. It will also help to ensure that progress against health inequalities is considered, as well as overall progress at Place-level against regional and national averages.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The Joint Outcomes Framework aims to monitor progress in relation to the Health and Wellbeing Board strategic goals.

5 Background and Options

5.1 The Health and Care Act received Royal Assent in April 2022. This has resulted in substantial changes to how the NHS in England is organised from 1 July 2022. Clinical Commissioning Groups have been abolished and now Integrated Care Boards (ICB) perform this role in their place. The changes aim to promote closer collaboration, rather than competition between, partners in driving improvements in population health and care integration, and in addressing inequalities. The Act promotes collaboration at Integrated Care System, "Place", and smaller area ("neighbourhood" or Care Community) levels. The Act provides local leaders with flexibility regarding local arrangements[1].

5.2 Cheshire East is a Place within the Cheshire and Merseyside Integrated Care System. Within Cheshire East, there are 8 smaller areas known as Care Communities.

5.1 A Business Intelligence (BI) Enabler Workstream Group has been convened to guide the development of Place-level BI that can:

- Optimise primary, secondary and tertiary prevention and wellbeing
- Address inequalities
- Inform and monitor health and care transformation towards closer integration, and to summarise progress in relation to the Joint Health and Wellbeing Strategy/ Place Plan and Place-level Delivery Plan through a Joint Outcomes Framework.

5.2 Key objectives of the BI Enabler Workstream are:

- To develop the Cheshire East Joint Outcomes Framework
- To consider the implications of findings from the JSNA work programme in relation to health and care transformation
- To consider the implications of Cheshire and Merseyside population health and population health management programmes (for example, System P)
- Sharing learning/best practice from local population health management programmes.

5.3 The BI Enabler Workstream Group conversation has included input from strategic and BI representatives from:

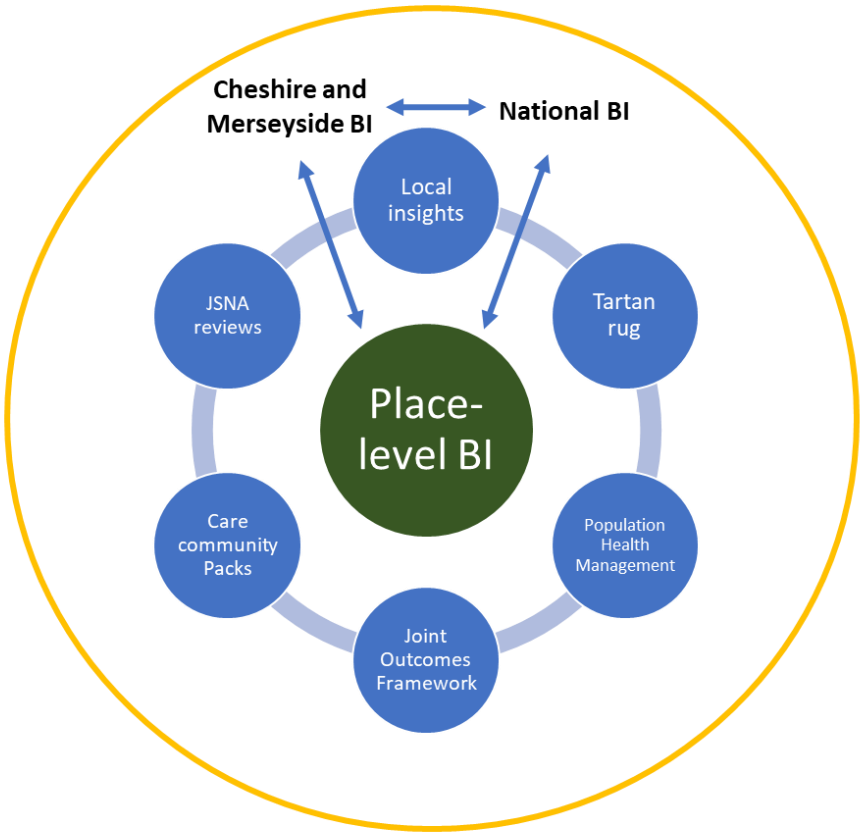
- The Cheshire and Merseyside Integrated Care Board
- Cheshire East Council
- NHS Providers
  - East Cheshire NHS Trust
  - Mid Cheshire Hospitals NHS Foundation Trust
  - Cheshire and Wirral Partnership NHS Foundation Trust
  - General practice
- Healthwatch

[1] Kings Fund (2022) The Health and Social Care Act: six key questions. 17 May 2022. Available from: https://www.kingsfund.org.uk/publications/health-and-care-act-key-questions (Accessed 13 September 2022).

- Cheshire East Social Action Partnership and the Voluntary, Community, Faith and Social Enterprise Sector representatives (who have been sighted on the work and a single representative has contributed to the consensus building process).
- Transformation, including leads involved in developing Care Community approaches at Place level.

5.4 In considering the development of BI capabilities to inform transformation across Cheshire East Place, and in particular, the development of a Joint Outcomes Framework, there are a wide variety of alignment considerations at local, Integrated Care System and national level (Figure 1).

Figure 1- Place-level Business Intelligence (BI) considerations



5.5 These considerations include, but are not limited to:

at Cheshire East Place level:

- Refresh of the Joint Health and Wellbeing Strategy/Place Plan
- Development of a Place-level delivery plan aligning with the proposed care models
- The Joint Strategic Needs Assessment (JSNA) work programme
- Development of Care Community packs and local insights from Care Community conversation
- The existing Integrated Care System workstreams: mental wellbeing and social prescribing; children's; cardiovascular health; and respiratory health
- Social impact and wider determinants work
- Home First and Family Hubs developments (as the agreed first key priorities for Place)
- Cheshire East Council corporate performance dashboard.

at Cheshire and Merseyside Integrated Care System level:

- Cheshire and Merseyside programmes: particularly Population Health (including System P population health management work); Women's Health and Maternity; Mental Health; Beyond (Children and Young People's); Ageing Well; Cardiac; Medicines and Pharmacy Optimisation; Neurosciences; Elective Recovery; Diagnostics; and Digital
- Marmot Community programme: All Together Fairer, progress through which is being measured by the "Marmot Beacon Indicators".

Nationally:

- Recommendations from the Fuller Stocktake report[2]
- Core20PLUS5[3]
- Social Care Quality Assurance Frameworks
- "Tackling Neighbourhood Inequalities" Directed Enhanced Service (DES)
- "Making it real: how to do personalised care and support" agenda[4]
- National guidance on Place-level outcomes frameworks.

Due to the complexity of alignment required, the development of the joint outcomes framework is being undertaken over a series of phases, initially phases one and two.

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

Name: Dr Susan Roberts
Designation: Consultant in Public Health, Cheshire East Council and Place Lead for Business Intelligence
Email: susan.roberts@cheshireeast.gov.uk

[2] NHS England and NHS Improvement (2022). Next steps for integrating primary care: Fuller Stocktake report. May 2022. Available from: https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf (Accessed 29 September 2022).

[3] NHS England. Core20PLUS5 – An approach to reducing health inequalities. Available from: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/ (Accessed 13 September 2022).

[4] Think local act personal. Making it Real - how to do personalised care and support. Available from: https://www.thinklocalactpersonal.org.uk/Latest/Making-it-Real-how-to-do-personalised-care-and-support/ (Accessed 29 September 2022).

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The Cheshire East Joint Outcomes Framework

Update for the Health and Wellbeing Board

Slides prepared by: Dr Susan Roberts, Consultant in Public Health, Cheshire East Council

Lead for the BI enabler workstream

17 April 2023

Cheshire East Integrated Care Partnership

Introduction

The Cheshire East Joint Outcomes Framework is being developed to inform and monitor health and care transformation towards closer integration, and to summarise progress in relation to the Joint Health and Wellbeing Strategy/ Place Plan and Place-level Delivery Plan.

The **Cheshire East Health and Wellbeing Strategy 2018-2021 has recently been refreshed**. This strategy will also act as the Place Plan and will run from **2023-2028.**

A **Place-level Delivery Plan** is also being developed in parallel. This will run from 2023-2028 and focus on **implementation** of the Strategy and health and care transformation.

The Joint Outcomes Framework is being developed alongside these two documents and through **two initial phases.**

The work is being led by the BI Enabler Workstream Group which reports to both

- **The Cheshire East Strategic Planning and Transformation Group**
- **The Cheshire East Joint Strategic Needs Assessment Steering Group**

Aims of Phase One

The aim of Phase One was to agree up to ten key outcome indicators for Cheshire East across the four outcomes outlined within the Health and Wellbeing Strategy that:

- Require system-level solutions across multiple partners
- Positively impact on system pressures and the extent to which the Place thrives
- Align with Cheshire and Merseyside Integrated Care System-level priorities, where feasible and appropriate.

Phase One focused on indicators within the Office for Health Improvement and Disparities **Public Health Fingertips tool**.

- This tool was chosen to simplify the process of developing the first phase of the tool by utilising a single data source.

This process was a pragmatic approach that recognised the time frame requirements. Further iterations of the framework will follow in Phase 2.

The Health and Wellbeing Strategy 2023-2028 proposed outcomes, November 2022

At the time of the consensus building process, the four outcomes within the draft Health and Wellbeing Strategy were:

Create a place that supports health and wellbeing for everyone living in Cheshire East

Ensure that children and young people are happy and experience good physical and mental health and wellbeing

Improve the mental health and wellbeing of people living and working in Cheshire East

Enable more people to Live Well for Longer in Cheshire East

The wording of these outcomes has been further refined in the finalised version of the Health and Wellbeing Strategy, however the outcomes are broadly the same.

Phase One methodology (1)

The consensus building event took place on 30 November 2022 via Microsoft Teams and included representatives from:

- **Cheshire East Place BI enabler workstream**
- **Cheshire East Joint Strategic Needs Assessment (JSNA) Steering Group**
- **Cheshire East Health and Wellbeing Board (HWB)**
- **Cheshire East Strategic Planning and Transformation Group (SPTG)**

17 attended the event including

	Admin	BI**	Commissioning	Communities	Other	Public Health	**Grand Total**
Cheshire East Council	1	1	3	1		5	**11**
NHS		2			3		**5**
VCFSE*					1		**1**

Phase One methodology (2)

In advance of this event, we invited representatives from the above groups to contribute to an online **pre-event poll** (between 24 November and 29 November 2022) on what they felt were the most important indicators to include. We asked contributors to select up to 10 key indicators, ideally with an even spread of indicators across each of the four Health and Wellbeing Strategy outcomes. People who were unable to attend the event itself could still contribute to the poll.

All contributors were encouraged to **review a series of overviews of health and wellbeing indicators** and Cheshire East's performance against these, prior to polling.

Healthy life expectancy and life expectancy were not included as part of the consensus building as we proposed that they should be included as key overarching indicators.

At the event on 30 November 2022, the **pre-event poll results were reviewed** (this included 21 responses), **a small group discussions** led to a **second poll** after which, the indicators were agreed through a **final discussion.**

The agreed indicators were circulated back to the SPTG, HWB and JSNA steering group, and after feedback from the SPTG, an additional indicator was included:

- **Smoking at time of delivery**

The Cheshire East Joint Outcomes Framework (Phase One)

Data view ▼
Area profiles

Geography ▼
Cheshire East
Counties & UAs in North West region

Indicator list
Cheshire East Joint Outcomes Framework (Phase 1)

Show me the profiles these indicators are from

▶ Legend ▶ Benchmark ▶ More options

Geography version: Counties & UAs (from Apr 2021)

☐ CIPFA nearest neighbours to Cheshire East

Indicator	Period	Chesh East			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Life expectancy at birth, (upper age band 90 and over) (Female, All ages)	2016 - 20	–	-	83.8	-	83.2	79.3		90.7
Life expectancy at birth, (upper age band 90 and over) (Male, All ages)	2016 - 20	–	-	80.3	-	79.5	74.3		90.4
Healthy life expectancy at birth (Female, All ages)	2018 - 20	–	-	67.4	62.4	63.9	54.3		71.2
Healthy life expectancy at birth (Male, All ages)	2018 - 20	–	-	67.4	61.5	63.1	53.5		74.7
Long-Term Unemployment- rate per 1,000 working age population (Persons, 16-64 yrs)	2021/22	–	190	0.8*	-	1.9*	7.5		0.0
Modelled estimates of the proportion of households in fuel poverty (%)	2020	–	18,457	10.8%	-	13.2%	22.4%		4.4%
Smoking status at time of delivery (Female, All ages)	2021/22	→	243	11.7%	10.6%	9.1%	21.1%		3.1%
Child development: percentage of children achieving a good level of development at 2 to 2½ years (Persons, 2-2.5 yrs) ⚠	2021/22	→	2,778	81.2%	79.2%	81.2%	43.5%		95.3%
Year 6: Prevalence of overweight (including obesity), 3-years data combined (Persons, 10-11 yrs)	2019/20 - 21/22	–	-	33.0%*	37.5%	35.8%	46.2%		23.1%
Social Isolation: percentage of adult social care users who have as much social contact as they would like (Persons, 18+ yrs)	2021/22	–	-	47.2%	40.7%	40.6%	24.3%		52.5%
Social Isolation: percentage of adult carers who have as much social contact as they would like (Persons, 18+ yrs)	2021/22	–	55	25.5%	28.7%	28.0%	16.0%		43.2%
Emergency hospital admissions for intentional self harm, standardised admission ratio (Persons, All ages) ⚠	2016/17 - 20/21	–	-	117.6	-	100.0	229.7		19.2
Percentage of physically active adults (Persons, 19+ yrs)	2020/21	–	-	70.6%	64.5%	65.9%	48.8%		83.6%
Admission episodes for alcohol-specific conditions (Persons, All ages) New data	2021/22	–	2,745	668	815	626	2,514		255

Overarching

Healthy places

Happy Healthy Children

Good mental wellbeing

Living well for longer

Phase Two: next steps

Building on Phase One by:

- **Developing a Microsoft Power BI Dashboard**
- **Improving the ability to drill down to ward / care community level**
- **Considering some additional / positive markers from initial list e.g. Thriving Places Index**
- **Raising awareness of Phase One indicators with Care Communities.**

Agreeing a second set of indicators to monitor against the Place-Level Delivery Plan that will sit along side the Joint Health and Wellbeing Strategy/ Place Plan, aiming for more timely and regularly updated metrics than in Phase One.

Actions for the JSNA Steering Group

- **To create a joint action plan to make the outcomes framework and wider JSNA relevant / real for all**
- **To consider making changes to strategic reporting documents e.g. SPT, ICB report templates, to ensure Place Plan and JSNA are reflected and linked to in each officers work.**

Continued challenges and considerations

- Challenges with **capacity** across all partners and changes to the workforce associated with Integrated Care System evolution and system pressures
- Current and anticipated **financial position**
- The proposed indicators are in very technical language. Translating these into **plain English** is an important step in being able to articulate progress to local communities. Furthermore, **community engagement** is important in ensuring that the correct measures are in place to monitor progress
- **Regional and national programmes and guidance/monitoring expectations will continue to emerge** and evolve and the Framework must be responsive to this
- Developing **lines of responsibility for monitoring and actioning the intelligence** presented
- **Information governance**: challenges will be in part mitigated by using publicly available sources for Phase 1, where they are sufficiently timely and available. However, information governance will require careful consideration in relation to Phase 2
- **Conflicting priorities** between individual agencies, for example different statutory return requirements
- Recent and potential future change in **political landscapes**
- **Ensuring that metrics are realistic**, with the potential to be improved by work that will be undertaken by the Place. Also, that they allow partners to take meaningful action based on the metrics.

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The Cheshire East Joint Outcomes Framework

The Cheshire East Joint Outcomes Framework aims to monitor progress against the Joint Health and Wellbeing strategy and Place Delivery Plan (under development) towards improved health and wellbeing, reduced inequalities and further integration between services.

Please note: the Joint Outcomes Framework is not a tool to monitor how individual services are performing.

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The Phase One Joint Outcomes Framework

Better 95% | Similar | Worse 95% | Not applicable | Quintiles: Best ○ ○ ○ ○ ● Worst ○ Not applicable | Data quality concerns

Recent trends: – Could not be calculated | No significant change | Increasing & getting worse | Increasing & getting better | Decreasing & getting worse | Decreasing & getting better | Increasing | Decreasing

Data view ▼
Area profiles

Geography ▼
Cheshire East
Counties & UAs in North West region

Indicator list
Cheshire East Joint Outcomes Framework (Phase 1)

Show me the profiles these indicators are from

▶ Legend ▶ Benchmark ▶ More options

Geography version: Counties & UAs (from Apr 2021)

☐ CIPFA nearest neighbours to Cheshire East

Indicator	Period	Chesh East			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Life expectancy at birth, (upper age band 90 and over) (Female, All ages)	2016 - 20	–	-	83.8	-	83.2	79.3		90.7
Life expectancy at birth, (upper age band 90 and over) (Male, All ages)	2016 - 20	–	-	80.3	-	79.5	74.3		90.4
Healthy life expectancy at birth (Female, All ages)	2018 - 20	–	-	67.4	62.4	63.9	54.3		71.2
Healthy life expectancy at birth (Male, All ages)	2018 - 20	–	-	67.4	61.5	63.1	53.5		74.7
Long-Term Unemployment- rate per 1,000 working age population (Persons, 16-64 yrs)	2021/22	–	190	0.8*	-	1.9*	7.5		0.0
Modelled estimates of the proportion of households in fuel poverty (%)	2020	–	18,457	10.8%	-	13.2%	22.4%		4.4%
Smoking status at time of delivery (Female, All ages)	2021/22	→	243	11.7%	10.6%	9.1%	21.1%		3.1%
Child development: percentage of children achieving a good level of development at 2 to 2½ years (Persons, 2-2.5 yrs) ⚠	2021/22	→	2,778	81.2%	79.2%	81.2%	43.5%		95.3%
Year 6: Prevalence of overweight (including obesity), 3-years data combined (Persons, 10-11 yrs)	2019/20 - 21/22	–	-	33.0%*	37.5%	35.8%	46.2%		23.1%
Social Isolation: percentage of adult social care users who have as much social contact as they would like (Persons, 18+ yrs)	2021/22	–	-	47.2%	40.7%	40.6%	24.3%		52.5%
Social Isolation: percentage of adult carers who have as much social contact as they would like (Persons, 18+ yrs)	2021/22	–	55	25.5%	28.7%	28.0%	16.0%		43.2%
Emergency hospital admissions for intentional self harm, standardised admission ratio (Persons, All ages) ⚠	2016/17 - 20/21	–	-	117.6	-	100.0	229.7		19.2
Percentage of physically active adults (Persons, 19+ yrs)	2020/21	–	-	70.6%	64.5%	65.9%	48.8%		83.6%
Admission episodes for alcohol-specific conditions (Persons, All ages) New data	2021/22	–	2,745	668	815	626	2,514		255

Comparison of outcome indicator with other local authorities across Cheshire and Merseyside

Indicator	Period	England	Cheshire and Merseyside	Cheshire East	Cheshire West and Chester	Halton	Knowsley	Liverpool	Sefton	St. Helens	Warrington	Wirral
Life expectancy at birth, (upper age band 90 and over) (Female, All ages)	2016 - 20	83.2	-	83.8	83.1	81.3	80.1	80.0	82.4	81.0	82.4	81.8
Life expectancy at birth, (upper age band 90 and over) (Male, All ages)	2016 - 20	79.5	-	80.3	79.7	77.2	76.4	76.1	78.3	77.5	79.0	78.0
Healthy life expectancy at birth (Female, All ages)	2018 - 20	63.9	-	67.4	67.9	58.0	60.0	57.9	63.8	61.9	64.8	63.1
Healthy life expectancy at birth (Male, All ages)	2018 - 20	63.1	-	67.4	63.1	61.4	58.7	58.3	63.6	59.3	64.6	60.8
Long-Term Unemployment- rate per 1,000 working age population (Persons, 16-64 yrs)	2021/22	1.9*	-	0.8*	0.9*	0.9*	2.8*	3.9*	2.3*	2.5*	0.7*	1.7*
Modelled estimates of the proportion of households in fuel poverty (%)	2020	13.2	-	10.8	11.9	13.8	14.9	18.7	13.9	13.9	11.3	14.4
Smoking status at time of delivery (Female, All ages)	2021/22	9.1	-	11.7	11.7	14.2	11.5	9.6	9.0	13.4	8.9	11.4
Child development: percentage of children achieving a good level of development at 2 to 2½ years (Persons, 2-2.5 yrs) ⚠	2021/22	81.2	-	81.2	84.4	84.1	85.1	78.0	75.5	86.1	87.2	83.5
Year 6: Prevalence of overweight (including obesity), 3-years data combined (Persons, 10-11 yrs)	2019/20 - 21/22	35.8	-	33.0*	34.6*	40.4	42.8	41.9	37.5	40.5	33.8	35.1
Social Isolation: percentage of adult social care users who have as much social contact as they would like (Persons, 18+ yrs)	2021/22	40.6	-	47.2	45.8	37.0	45.0	35.3	41.7	41.6	35.0	41.8
Social Isolation: percentage of adult carers who have as much social contact as they would like (Persons, 18+ yrs)	2021/22	28.0	28.8*	25.5	30.6	30.2	29.6	19.6	31.5	24.4	31.0	34.9
Emergency hospital admissions for intentional self harm, standardised admission ratio (Persons, All ages) ⚠	2016/17 - 20/21	100.0	-	117.6	113.2	184.3	184.1	129.8	154.0	229.7	163.3	147.9
Percentage of physically active adults (Persons, 19+ yrs)	2020/21	65.9	-	70.6	73.4	65.5	54.2	60.5	66.0	66.3	68.0	66.1
Admission episodes for alcohol-specific conditions (Persons, All ages) New data	2021/22	626	-	668	640	908	990	1139	956	1024	662	1089

Office for Health Improvement & Disparities. Public Health Profiles. https://fingertips.phe.org.uk © Crown copyright 2023 (Accessed 8 March 2023).

Comparison of outcome indicators with other local authorities similar to Cheshire East in terms of socio-demographic distribution (CIPFA neighbours)

Indicator	Period	England	Cheshire East nearest neighbours	Cheshire East	1 - Cheshire West and Chester	2 - Shropshire	3 - Wiltshire	4 - North Somerset	5 - Solihull	6 - South Gloucestershire	7 - Stockport	8 - Cornwall	9 - Central Bedfordshire	10 - Dorset	11 - East Riding of Yorkshire	12 - Warrington	13 - Bedford	14 - Calderdale	15 - Bury
Life expectancy at birth, (upper age band 90 and over) (Female, All ages)	2016 - 20	83.2	-	83.8	83.1	83.6	84.4	84.3	84.1	84.5	83.2	83.6	84.2	84.8	83.6	82.4	83.3	82.3	81.7
Life expectancy at birth, (upper age band 90 and over) (Male, All ages)	2016 - 20	79.5	-	80.3	79.7	80.3	81.0	80.3	80.2	81.4	79.7	79.8	80.9	81.0	80.0	79.0	79.6	78.5	78.5
Healthy life expectancy at birth (Female, All ages)	2018 - 20	63.9	-	67.4	67.9	67.1	65.2	68.1	65.7	67.1	62.2	66.0	66.3	65.2	67.9	64.8	59.3	63.4	62.2
Healthy life expectancy at birth (Male, All ages)	2018 - 20	63.1	-	67.4	63.1	62.8	66.5	61.9	67.4	65.3	65.1	63.8	67.9	62.6	65.3	64.6	62.3	59.0	63.4
Long-Term Unemployment- rate per 1,000 working age population (Persons, 16-64 yrs)	2021/22	1.9*	-	0.8*	0.9*	1.4*	0.5*	0.5*	1.2*	0.6*	2.0*	1.0*	1.1*	0.5*	1.9*	0.7*	2.4*	1.0*	1.5*
Modelled estimates of the proportion of households in fuel poverty (%)	2020	13.2	-	10.8	11.9	16.5	10.0	9.3	12.5	8.4	11.9	12.6	11.3	10.2	14.7	11.3	13.8	17.3	13.2
Smoking status at time of delivery (Female, All ages)	2021/22	9.1	-	11.7	11.7	12.0	8.1	8.7	8.3	8.6	6.9	12.4*	7.0	10.0	10.9	8.9	7.0	9.6	8.8
Child development: percentage of children achieving a good level of development at 2 to 2½ years (Persons, 2-2.5 yrs) ⚠	2021/22	81.2	-	81.2	84.4	57.5	84.6	78.1	84.3	84.0	71.2	88.4*	43.5	90.1	87.7	87.2	47.5	89.4	*
Year 6: Prevalence of overweight (including obesity), 3-years data combined (Persons, 10-11 yrs)	2019/20 - 21/22	35.8	-	33.0*	34.6*	31.3*	30.9	30.4	32.3	30.0	33.4	32.2*	30.7	30.2	33.9	33.8	36.6	34.3	36.1*
Social Isolation: percentage of adult social care users who have as much social contact as they would like (Persons, 18+ yrs)	2021/22	40.6	-	47.2	45.8	39.9	37.8	47.1	37.7	42.4	39.3	42.0	34.8	35.3	35.6	35.0	42.3	40.8	44.8
Social Isolation: percentage of adult carers who have as much social contact as they would like (Persons, 18+ yrs)	2021/22	28.0	25.5*	25.5	30.6	24.9	16.0	26.0	25.7	23.6	22.4	20.7	24.2	29.1	31.9	31.0	26.2	23.8	27.9
Emergency hospital admissions for intentional self harm, standardised admission ratio (Persons, All ages) ⚠	2016/17 - 20/21	100.0	-	117.6	113.2	82.6	137.0	139.0	102.8	137.9	112.8	119.8	83.8	133.1	83.7	163.3	100.8	100.5	108.1
Percentage of physically active adults (Persons, 19+ yrs)	2020/21	65.9	-	70.6	73.4	72.9	72.9	71.2	68.8	66.9	66.3	71.7	68.9	68.1	64.4	68.0	68.1	65.6	65.0
Admission episodes for alcohol-specific conditions (Persons, All ages) New data	2021/22	626	-	668	640	412	523	693	517	701	809	518*	474	584	460	662	464	707	530

Office for Health Improvement & Disparities. Public Health Profiles. https://fingertips.phe.org.uk © Crown copyright 2023 (Accessed 8 March 2023).

About the development of Cheshire East Joint Outcomes Framework:

The development of the Cheshire East Joint Outcomes Framework is being led by the Business Intelligence Enabler Workstream Group which reports to both

- **The Cheshire East Strategic Planning and Transformation Group**
- **The Cheshire East Joint Strategic Needs Assessment Steering Group**

About Phase One of the Joint Outcomes Framework

Phase One agreed on 14 key outcome indicators for Cheshire East across the four outcomes outlined within the Health and Wellbeing Strategy that:

- Require system-level solutions across multiple partners/organisations
- If improved, might help to relieve system pressures and the extent to which Cheshire East thrives
- Are in line with Cheshire and Merseyside Integrated Care System-level priorities, where possible

Phase 1 focused on indicators within the Office for Health Improvement and Disparities Public health profiles - OHID (phe.org.uk) **.** This tool was chosen to simplify the process of developing the first phase of the tool by utilising a single data source.

The indicators were agreed through a multi-stage, multi-partner consensus building approach.

About Phase Two of the Joint Outcomes Framework

Phase Two has begun. It will take place over 2023/24 and intends to:

- Develop a Microsoft Power BI Dashboard to present the Joint Outcomes Framework indicators
- Improve the ability to understand variation in the indicators by ward or care community level
- Consider including further indicators to the Phase One set
- Develop a further second set of indicators to monitor against the Cheshire East Health and Wellbeing Board Five Year Delivery Plan 2023 – 2028 that will sit along slide the Joint Health and Wellbeing Strategy/ Place Plan.

Phase Two will aim to include more regularly updated indicators than in Phase One. It will also involve further engagement and consensus building across Cheshire East.

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Appendix C- Joint Outcomes Framework methodology document proposed to be published as an appendix for information alongside the interim Outcomes Framework

The Cheshire East Joint Outcomes Framework:

Consensus Building Methodology

Background

The Cheshire East Joint Outcomes Framework is being developed to inform and monitor health and care transformation towards closer integration, and to summarise progress in relation to the Joint Health and Wellbeing Strategy/ Place Plan and Place-level Delivery Plan.

The Cheshire East Health and Wellbeing Strategy 2018-2021 has recently been refreshed. This strategy will also act as the Place Plan and will run from 2023-2028.

A Place-level Delivery Plan is also being developed in parallel. This will run from 2023-2028 and focus on implementation of the Strategy and health and care transformation.

The Joint Outcomes Framework is being developed alongside these two documents and through two initial phases.

The work is being led by the Business Intelligence (BI) Enabler Workstream Group which reports to both

- The Cheshire East Strategic Planning and Transformation Group
- The Cheshire East Joint Strategic Needs Assessment Steering Group

The aim of Phase One was to agree up to ten key outcome indicators for Cheshire East across the four outcomes outlined within the Health and Wellbeing Strategy that:

- Require system-level solutions across multiple partners
- Positively impact on system pressures and the extent to which the Place thrives
- Align with Cheshire and Merseyside Integrated Care System-level priorities, where feasible and appropriate.

Approach to Phase One

Phase One focused on indicators within the Office for Health Improvement and Disparities Public Health Fingertips tool.

- This tool was chosen to simplify the process of developing the first phase of the tool by utilising a single data source.

This process was a pragmatic approach that recognised the time frame requirements. Further iterations of the framework will follow in Phase Two.

At the time of the consensus building process, the four outcomes within the draft Health and Wellbeing Strategy were:

The wording of these outcomes has been further refined in the finalised version of the Health and Wellbeing Strategy, however the outcomes are broadly the same.

Consensus building methodology

Consensus building took place at an event on 30 November 2022 via Microsoft Teams and included representatives from:

- Cheshire East Place BI enabler workstream
- Cheshire East Joint Strategic Needs Assessment (JSNA) Steering Group
- Cheshire East Health and Wellbeing Board (HWB)
- Cheshire East Strategic Planning and Transformation Group (SPTG)

17 attended the event including 11 from Cheshire East Council, 5 from the NHS and one from the VCFSE sector:

	Admin	BI**	Commissioning	Communities	Other	Public Health	**Grand Total**
Cheshire East Council	1	1	3	1		5	**11**
NHS		2			3		**5**
VCFSE*					1		**1**

*VCFSE-Voluntary, Community, Faith and Social Enterprises

**BI-business intelligence

In advance of this event, we invited representatives from the above groups to contribute to an online pre-event poll (between 24 November and 29 November 2022) on what they felt were the most important indicators to include (Appendix 1). We asked contributors to select up to 10 key indicators, ideally with an even spread of indicators across each of the four Health and Wellbeing Strategy outcomes. People who were unable to attend the event itself could still contribute to the poll.

All contributors were encouraged to review a series of overviews of health and wellbeing indicators and Cheshire East's performance against these, prior to polling (Appendix 1).

Healthy life expectancy and life expectancy were not included as part of the consensus building as we proposed that they should be included as key overarching indicators.

At the event on 30 November 2022, the pre-event poll results were reviewed (Appendix 2) and considered. Three small group discussions then considered the results of the pre-event poll, particularly the indicators that were frequently selected. The three small groups then each contributed to a second poll, as a group after which, the indicators were agreed through a final discussion.

The agreed indicators were circulated back to the SPTG, HWB and JSNA steering group, and after feedback from the SPTG, an additional indicator was included:

- Smoking at time of delivery

After allowing until 3 January 2023 to feedback, the indicators for Phase One were confirmed.

Indicators selected and reasons for their selection

Indicator	Reason for selection
Life expectancy at birth (upper age band 90 and over) (female)	This indicator was pre-selected by the Place Business Intelligence lead as being a marker of overall health and wellbeing. It is also one of the Marmot Beacon indicators, which the Cheshire and Merseyside Integrated Care System is using to monitor inequalities across the Cheshire and Merseyside area.
Life expectancy at birth (upper age band 90 and over) (male)	This indicator was pre-selected by the Place Business Intelligence lead as being a marker of overall health and wellbeing. It is also one of the Marmot Beacon indicators, which the Cheshire and Merseyside Integrated Care System is using to monitor inequalities across the Cheshire and Merseyside area.
Healthy life expectancy at birth (female)	This indicator was pre-selected by the Place Business Intelligence lead as being a marker of overall health and wellbeing. It is also one of the Marmot Beacon indicators, which the Cheshire and Merseyside Integrated Care System is using to monitor inequalities across the Cheshire and Merseyside area.
Healthy life expectancy at birth (male)	This indicator was pre-selected by the Place Business Intelligence lead as being a marker of overall health and wellbeing. It is also one of the Marmot Beacon indicators, which the Cheshire and Merseysid Integrated Care System is using to monitor inequalities across the Cheshire and Merseyside area.
Long-term unemployment rate/1000 working age population (persons aged 16-64 years)	Employment was the most commonly selected indicator for the “healthy places” outcome in the pre-event poll, and joint top indicator for the post-small group discussion poll. Long-term unemployment was selected due to being highlighted as a key area of challenge by the Poverty deep dive JSNA review. This indicator is also available at ward level, which facilitates the ability to understand inequalities within Care Communities.
Modelled estimates of the proportion of households in fuel poverty (%)	Fuel poverty was in the top three indicators for the “healthy places” outcomes in the pre-event poll and joint top indicator for the post-small group discussion poll. Fuel poverty has been highlighted as a key challenge within the Poverty deep dive JSNA review. This indicator is also available at ward level, which facilitates the ability to understand inequalities within Care Communities. Exercise was also commonly selected within the “healthy places” outcome, nevertheless, this was also selected in relation to the “ageing well” outcome. Fuel poverty was considered to be a helpful metric as it encompassed income and also energy efficiency in housing. It is also one of the Marmot Beacon indicators, which the Cheshire and Merseyside Integrated Care

	System is using to monitor inequalities across the Cheshire and Merseyside area.
Smoking status at time of delivery (female, all ages)	Smoking status at time of delivery was highlighted as one of the leading outcomes in relation to “promoting physical and mental wellbeing in children and young people” outcome. Cheshire East is also significantly worse than the national average in relation to this outcome. Smoking prevalence was highlighted as a key indicator for inclusion in relation to the “ageing well outcome”
Child development: percentage of children achieving a good level of development at 2-2.5 years (Persons, 2-2.5 years)	Child development in our 2-2.5 year olds was considered to be an important early marker of future physical and mental wellbeing in our children and young people. In addition, it is a metric that is collected for the vast majority of children. It is also one of the Marmot Beacon indicators, which the Cheshire and Merseyside Integrated Care System is using to monitor inequalities across the Cheshire and Merseyside area. Social, emotional and mental health was a commonly selected indicator in the polls, nevertheless, there was concern from the consensus building group that this indicator focused on too few children (those with social, emotional and mental health concerns requiring education, health and care plans) and selecting a marker earlier in the life course that covered more children would be more beneficial. Child poverty was also considered, nevertheless, in view of the limited number of indicators to be covered by the framework, the group felt that long term employment and fuel poverty, would need to be sufficient without including an additional marker.
Year 6 prevalence of overweight (including obesity) (Persons, 10-11 years)	Excess weight in children and young people was the leading indicator selected for the “promoting physical and mental wellbeing in children and young people” outcome in the pre-event poll and the top indicator for the post-small group discussion poll. Year 6 prevalence (rather than Reception age) was selected to be able to monitor the impact of early interventions and to complement the earlier marker of development (development at 2-2.5 years).
Social isolation: percentage of adult social care users who have as much social contact as they would like (Persons, 18+years)	Social isolation was frequently selected as a risk factor for poor mental wellbeing through the pre-event poll and joint top indicator for the post-small group discussion poll (with self harm/suicide and self-reported wellbeing). Isolation in adult social care users and adult carers were selected as particularly vulnerable cohorts. Self-reported wellbeing scores were also frequently considered, however, the consensus was that it was important to understand wellbeing in relation to the particularly vulnerable social care cohorts.

Social isolation: percentage of adult carers who have as much social contact as they would like.	Social isolation was frequently selected as a risk factor for poor mental wellbeing through the pre-event poll and joint top indicator for the post-small group discussion poll (with self harm/suicide and self-reported wellbeing). Isolation in adult care users and adult carers were selected as particularly vulnerable cohorts. Self-reported wellbeing scores were also frequently considered, nevertheless, the consensus was that it was important to understand wellbeing in relation to carers.
Emergency hospital admissions for intentional self harm: standardised admission ratio (Persons, all ages)	Suicide and self harm were frequently selected indicators in the pre-event poll and were joint top indicator for the post-small group discussion poll (with social isolation and self-reported wellbeing). Self harm was selected as Cheshire East is significantly worse than the England average in terms of many indicators that relate to this issue. Standardised admission ratios were selected as they encompass all ages and are also available at ward level, allowing for understanding of inequalities within Care Communities. GP diagnosed depression was also considered however, ultimately, the group reflected that it would be difficult to interpret changes in this metric, for example, whether an increase would signify more people were attending with previously unmet need (a positive change), or whether there was more need when there previously was not any (a negative change).
Percentage of physically active adults (Persons, 19 years+)	Physical activity was the second most frequently selected indicator in the pre-event poll and joint top indicator for the post-small group discussion poll. It is also one of the Marmot Beacon indicators, which the Cheshire and Merseyside Integrated Care System is using to monitor inequalities across the Cheshire and Merseyside area.
Admission episodes for alcohol-specific admissions (Persons, All ages)	Alcohol was the fourth most frequently selected indicator in the pre-event poll and “alcohol-related harm” was highlighted as joint top indicator for the post-small group discussion poll. Adult excess weight was the third most frequently selected indicator, however, ultimately, physical activity was felt to be a key contributor to excess weight and there was a recognition that childhood excess weight was already included in the framework.

Appendix 1-

Consensus building: pre-event briefing

Cheshire East Joint Outcomes Framework
Consensus Building Event on:
Key focus areas and outcome measures for the Joint Outcomes Framework

Pre-event briefing 23 November 2022

Prepared by:

Dr Susan Roberts, Consultant in Public Health and Place Lead for the Business Intelligence (BI) Enabler Workstream

Audience

Representatives from:

- Cheshire East Place BI enabler workstream
- Cheshire East Joint Strategic Needs Assessment Steering Group
- Cheshire East Health and Wellbeing Board
- Cheshire East Strategic Planning and Transformation Group

Purpose of the briefing:

- To provide an update regarding the proposed purpose and plans for the Cheshire East Outcomes Framework Consensus Building Event. This event has been provisionally booked for 30 November 2022, pending approval from the Cheshire East Health and Wellbeing Board on 29 November 2022.
- To enable representatives of the above groups to contribute to consensus building in advance of the event, even if they are unable to attend the event itself. Should the consensus building event not be approved by the Health and Wellbeing Board, the information gathered through the initial pre-event polling will still be beneficial in shaping the further development of the Framework.

Background

The Cheshire East Health and Wellbeing Strategy 2018-2021 is currently being refreshed. This strategy will also act as the Place Plan and will run from 2023-2028. There is a requirement from the Cheshire and Merseyside Integrated Care System to have this strategy/plan in place by the end of March 2023. Due to the short time-frame, the Strategy / Place Plan is being updated pragmatically through presentation in a variety of forums, rather than completely rewritten. However, it is recognised that in the longer term, there will be a need for a rewrite of the Strategy / Place Plan over a longer time period. The following overarching outcomes, that were agreed in the existing Place Plan (2019-2024), have been agreed to still appropriate for the Health and Wellbeing Strategy 2023-2028/ Place Plan. These are:

- Outcome 1: **Create a place that supports health and wellbeing for everyone living in Cheshire East**
- Outcome 2: **Ensure that children and young people are happy and experience good physical and mental health and wellbeing**
- Outcome 3: **Improve the mental health and wellbeing of people living and working in Cheshire East**
- Outcome 4: **Enable more people to Live Well for Longer in Cheshire East.**

A Place-level Delivery Plan is also being developed in parallel. This will run from 2023-28 and focus on implementation of the Strategy and health and care transformation.

Alongside these plans, a Joint Outcomes Framework is being developed in two phases. Phase 1 will identify readily available metrics to monitor progress against the Health and Wellbeing Strategy / Place Plan. The intention is that this phase will be completed rapidly through the proposed consensus building process.

Phase 2 of the Joint Outcomes Framework development will incorporate indicators to monitor against the Place-level Delivery Plan and build upon the indicators selected in Phase 1.

Aims of the consensus building process

The aims of the proposed consensus building process is to agree up to ten key indicators for Cheshire East across the four outcomes outlined within the Health and Wellbeing Strategy that:

- Require system-level solutions across multiple partners
- Positively impact on
    - System pressures in the short to medium term (0-5 years)
    - System pressures and extent to which the Place thrives, in the longer-term (5 years +)
    - Align with Cheshire and Merseyside Integrated Care System-level priorities, where feasible and appropriate

This process will inform the development of Phase 1 of the Joint Outcomes Framework, which will incorporate the agreed indicators and will focus on readily available validated indicators available within the Office for Health Improvement and Disparities Public Health Fingertips tool[1]. This tool was chosen to simplify the process of developing the first phase of the Framework by utilising a single data source.

The process is a pragmatic approach that recognises the time frame requirements. Further refinement and iterations of the framework will follow in Phase 2.

[1] Office for Health Improvement & Disparities. Public Health Profiles. [21 November 2022] https://fingertips.phe.org.uk © Crown copyright 2022.

Approach to consensus building

The consensus building event is planned to take place on 30 November 2022 via Microsoft Teams and including representatives from:

- Cheshire East Place BI enabler workstream
- Cheshire East Joint Strategic Needs Assessment (JSNA) Steering Group
- Cheshire East Health and Wellbeing Board
- Cheshire East Strategic Planning and Transformation Group

In advance of this event, we are inviting representatives from the above groups to contribute to a **pre-event poll** (between 24 November and 29 November 2022) on what they feel are the most important indicators to include. We are asking contributors to select up to 10 key indicators, with ideally an even spread of indicators across each of the four Health and Wellbeing Strategy outcomes. People who are unable to attend the event itself can still contribute to the poll. **All contributors are encouraged to review Appendices A-D of this document and consider these in relation to their own insights prior to making their selection- a process which should take approximately 15 minutes in total.** Appendices A-C consider health and wellbeing across a wide range of indicators, whilst Appendix D is a proposal based on the conversations that have taken place so far, which can be considered in conjunction with the wider range of indicators in Appendices A-C.

The pre-event questionnaire can be found at: xxxx **select three indicators per outcome.**

Healthy life expectancy and life expectancy have not been included as part of the consensus building as we propose that they should be included as key overarching indicators.

At the event on 30 November 2022, we propose to follow the agenda below:

1. Introduction and review of pre-event poll results (10 minutes)
2. Small group discussion based on pre-event poll and review of information in the Appendix, concluding in a second polling with a small group selection of 10 indicators (30 minutes)
3. Break (10 minutes)
4. Review of the second poll and final discussion (20 minutes)

Following the event, the agreed indicators will be circulated to the BI Enabler Workstream Group, JSNA Steering Group, Strategic Planning and Transformation Group, and Health and Wellbeing Board prior to finalising the Phase 1 framework as an interim tool. The BI Enabler Workstream Group will then turn their attention to Phase 2, which will consider additional key delivery metrics and refinement of the Phase 1.

Appendix A (of the pre-event briefing):

Health and wellbeing across Cheshire East

This summary considers health and wellbeing indicators presented within the Cheshire East Life Course Statistics (Appendix B), the Tartan Rug (Appendix C), the Public Health Outcomes Framework[2], and in relation to indicators agreed within the Joint Health and Wellbeing Strategy 2018-2021.

Outcome 1: Create a place that supports health and wellbeing for everyone living in Cheshire East

Areas of focus highlighted within the draft Health and Wellbeing Strategy 2023-2028 include:

- Neighbourliness
- Developing life skills and getting the education that will help children to thrive
- Helping people to live independently for as long as possible
- Access to good cultural, leisure and recreational facilities
- Active travel initiatives
- Ensuring people have housing that is not detrimental to their health and wellbeing
- Supporting key employment sectors and local supply chains
- A focus on deprived and rural communities

According to the indicators identified within the Health and Wellbeing Strategy 2018-2021, Cheshire East is statistically similar to or better than the national average for:

- Percentage of people in employment (16-64 yrs)
- Killed and seriously injured (KSI) casualties on England's roads
- Utilisation of outdoor space for exercise/health
- Modelled estimates for the proportion of households experiencing fuel poverty.

Cheshire East has one of the lower rates of utilisation of outdoor space for exercise/health (it is important to note this based on 2015/16 data).

Indicator	Period	Chesh East			Region England	England			
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Percentage of people in employment (Persons, 16-64 yrs)	2020/21	➡	162,400	72.3%	73.2%	75.1%	63.2%		100%
Killed and seriously injured (KSI) casualties on England's roads (Persons, All ages)	2020	–	146	59.4*	79.5*	86.1*	456.1		24.1
Utilisation of outdoor space for exercise/health reasons (Persons, 16+ yrs)	Mar 2015 - Feb 2016	–	-	12.4%	17.5%	17.9%	5.1%		36.9%
Modelled estimates of the proportion of households in fuel poverty (%)	2020	–	18,457	10.8%	-	13.2%	22.4%		4.4%

[2] Office for Health Improvement & Disparities. Public Health Profiles. 21 November 2022 https://fingertips.phe.org.uk © Crown copyright 2022

Other relevant indicators (which are also Marmot Beacon Indicators[3]) that could be considered include:

- Households in temporary accommodation
- Percentage unemployed (aged 16-64 years) (Unemployed and claiming benefits, and long term unemployment metrics are available on fingertips)
- Cycling or walking for travel (3-5 times per week)(Two separate metrics available on Public Health fingertips, one for cycling and one for walking).

Outcome 2: Ensure that our children and young people are happy and experience good physical and mental health and wellbeing

Areas of focus within the draft Health and Wellbeing Strategy 2023-2028 include:

- Supporting expectant mothers to have a healthy pregnancy
- Supporting new mothers with breastfeeding
- Prioritising school readiness
- Focusing on childhood obesity and building emotional wellbeing
- Caring for children with a learning disability and reduce waiting times for autism assessments
- Treatments for children with cancer
- Focusing on vulnerable children and young people, looked after children and care leavers

According to the indicators identified within the Health and Wellbeing Strategy 2018-2021, Cheshire East is statistically similar to, or better than the national average for:

- Prevalence of overweight (including obesity) in reception aged and year 6 children (2017/18-19/20)
- % of 15 year olds eating 5 portions of fruit and vegetables a day (2014/15)
- % of children with social, emotional and mental health needs (2021), but this is increasing
- Child poverty (2019)
- 16 or 17 year olds not in education, employment or training (2020).

[3] Marmot Beacon Indicators monitor progress in relation to the Cheshire and Merseyside Marmot Community programme: All Together Fairer.

Indicator	Period	Chesh East			Region England	England		England	
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Children with one or more decayed, missing or filled teeth (Persons, 5 yrs)	2016/17	–	-	*	33.9%	23.3%	47.1%		12.9%
Reception: Prevalence of overweight (including obesity) (Persons, 4-5 yrs)	2019/20	–	-	*	25.2%	23.0%	31.8%		14.9%
Year 6: Prevalence of overweight (including obesity) (Persons, 10-11 yrs)	2019/20	–	-	*	37.4%	35.2%	44.7%		22.0%
Reception: Prevalence of overweight (including obesity), 3-years data combined (Persons, 4-5 yrs)	2017/18 - 19/20	–	1,665	22.2%*	24.4%	22.6%	30.0%		15.3%
Year 6: Prevalence of overweight (including obesity), 3-years data combined (Persons, 10-11 yrs)	2017/18 - 19/20	–	2,325	31.3%*	36.2%	34.6%	44.7%		22.1%
Percentage who eat 5 portions or more of fruit and veg per day at age 15 (Persons, 15 yrs)	2014/15	–	-	57.3%	48.7%	52.4%	39.9%		67.6%
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Persons, School age)	2021	↑	1,211	2.2%	2.9%	2.8%	4.9%		1.4%
16-17 year olds not in education, employment or training (NEET) or whose activity is not known (Persons, 16-17 yrs)	2020	→	160	2.2%	5.3%	5.5%	13.8%		0.6%
Child Poverty, Income deprivation affecting children index (IDACI) (Persons, <16 yrs)	2019	–	7,070	10.7%	-	17.1%	32.7%		3.2%

Source: Office for Health Improvement & Disparities. Public Health Profiles. [21 November 2022] https://fingertips.phe.org.uk © Crown copyright 2022.

Conversely, according to the Cheshire East Life Course Statistics (Appendix B), Public Health Outcomes Framework and Tartan Rug, Cheshire East is worse than the national average for:

- **Smoking status at time of delivery**
- **Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)**
- **Population vaccination coverage - DTaP/IPV booster (5 years);-Flu (primary school aged children); HPV vaccination coverage for one dose (12-13 year old) (Male); HPV vaccination coverage for two doses (13-14 years old) (Female); Meningococcal ACWY conjugate vaccine (MenACWY) (14-15 years)**
- **Newborn Hearing Screening: Coverage**
- **School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception (2018/19)**
- **Emergency admissions in 0-4 year old and admissions for injury (0-4) (**this could reflect need or practice **)**
- **Admissions for self harm in people aged 10-24 years**
- **Alcohol-specific admissions under 18.**

Other relevant indicators (which are also Marmot Beacon Indicators[4]) that could be considered include:

- Percentage achieving a good level of development at 2-2.5 years or at end of reception (**development at end of reception is only available for 2018/19 as the most recent year**)
- Average Attainment 8 score
- Hospital admissions as a result of self harm (15-19 years).

[4] Marmot Beacon Indicators monitor progress in relation to the Cheshire and Merseyside Marmot Community programme: All Together Fairer.

Outcome 3: Improving the mental health and wellbeing of people living and working in Cheshire East

Areas of focus within the draft Health and Wellbeing Strategy 2023-2028 include:

- Improved emotional wellbeing and mental health through a focus upon prevention and early support
- Access to mental health services
- Reducing isolation and loneliness
- Feeling a part of their 'place'

According to the indicators identified within the Health and Wellbeing Strategy 2018-2021, Cheshire East is statistically similar to, or better than the national average for:

- Self reported wellbeing- low happiness scores in 16+ (2020/21)
- Self reported wellbeing- high anxiety score in 16+ (2020/21)
- Depression prevalence (2020/21)
- Social isolation in adult social care users (2019/20)
- Gap in the employment rate for those who are in contact with mental health services and on the Care Plan Approach
- Suicide rate, age 10+ years (2019-21).

Conversely, Cheshire East is worse than the national average for:

- **Social isolation in adult carers (2018/19)**

Indicator	Period	Chesh East			Region England	England			
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Self-reported wellbeing - people with a low happiness score (Persons, 16+ yrs)	2020/21	–	-	8.6%	10.3%	9.2%	-	*Insufficient number of values for a spine chart*	-
Self-reported wellbeing - people with a high anxiety score (Persons, 16+ yrs)	2020/21	–	-	25.3%	25.7%	24.2%	32.4%		15.9%
Depression: Recorded prevalence (aged 18+) (Persons, 18+ yrs)	2020/21		46,984	14.1%	15.0%*	12.3%	3.1%		19.8%
Social Isolation: percentage of adult social care users who have as much social contact as they would like (Persons, 18+ yrs)	2019/20	–	2,250	54.4%	46.7%	45.9%	34.3%		56.6%
Social Isolation: percentage of adult carers who have as much social contact as they would like (Persons, 18+ yrs)	2018/19	–	80	25.4%	32.4%	32.5%	11.7%		45.7%
Gap in the employment rate for those who are in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate (Persons, 18-69 yrs)	2020/21	–	-	59.3	66.2	66.1	76.0		47.7
Suicide rate (Persons, 10+ yrs)	2019 - 21	–	-	10.1	11.4	10.4	19.8		4.8

Source: Office for Health Improvement & Disparities. Public Health Profiles. [21 November 2022] https://fingertips.phe.org.uk © Crown copyright 2022.

From the Public Health Outcomes Framework and Tartan Rug, Cheshire East is also worse than the national average for:

- **Emergency Hospital Admissions for Intentional Self-Harm (2020/21)**
- **Excess under 75 mortality rate in adults with severe mental illness (SMI) (2018-202)**

Other relevant indicators (which are also Marmot Beacon Indicators[5]) that could be considered include:

- Hospital admissions as a result of self harm (15-19 years)
- %loneliness

Outcome 4: Enable more people to live well for longer

Focus areas within the draft Health and Wellbeing Strategy, 2023-2028 include:

Taking action across the life-course, from childhood to older age focusing upon prevention and early intervention to address

- Alcohol and substance misuse
- Smoking
- Physical activity
- Healthy eating

According to the indicators identified within the Health and Wellbeing Strategy 2018-2021, Cheshire East is statistically similar to, or better than the national average for:

- Adult smoking prevalence
- Percentage of physically active adults
- Admissions for alcohol related conditions
- Successful treatment for non-opiate and opiate users
- Percentage of the population eating five portions of fruit and vegetable a day
- Health related quality of life in older people.

Cheshire East is worse than the national average for:

- **Prevalence of adults who are overweight or obese (2020/21)**
- **Admissions for alcohol specific conditions (2020/21)**
- **Cumulative percentage of those offered an NHS health check who received a health check (2017/18-20/21)**
- **Emergency admissions due to falls in people 65 years old and older (2020/21).**

[5] Marmot Beacon Indicators monitor progress in relation to the Cheshire and Merseyside Marmot Community programme: All Together Fairer.

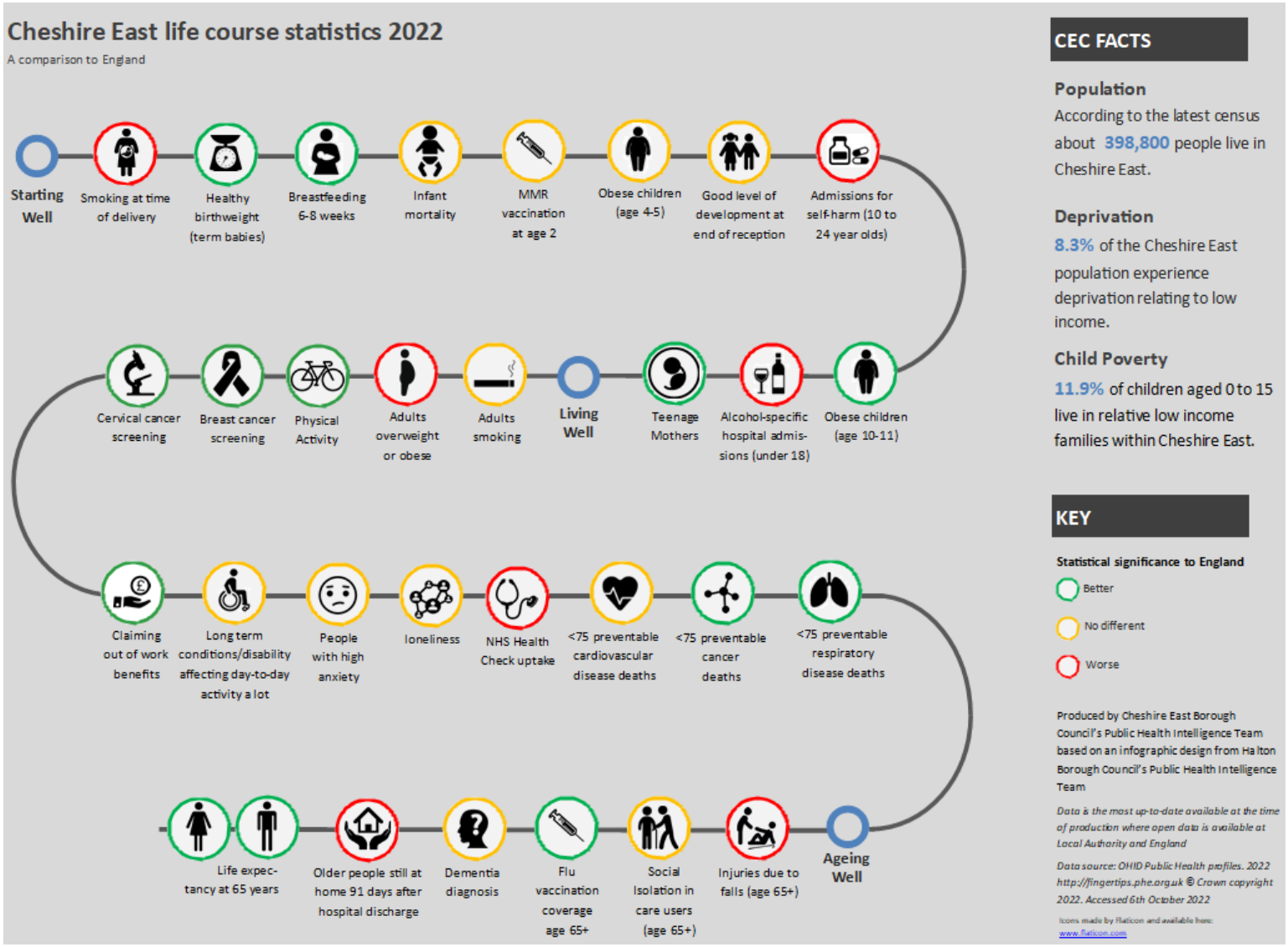
Indicator	Period	Chesh East			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Breastfeeding prevalence at 6-8 weeks after birth - current method (Persons, 6-8 weeks) New data	2021/22	→	1,925	51.4%	*	49.3%	-	*Insufficient number of values for a spine chart*	-
Smoking Prevalence in adults (18+) - current smokers (APS) (2020 definition) (Persons, 18+ yrs)	2020	–	-	10.5%	13.4%	12.1%	20.8%		5.5%
Percentage of adults (aged 18+) classified as overweight or obese (Persons, 18+ yrs)	2020/21	–	-	68.3%	65.9%	63.5%	76.3%		44.0%
Percentage of physically active adults (Persons, 19+ yrs)	2020/21	–	-	70.6%	64.5%	65.9%	48.8%		83.6%
Admission episodes for alcohol-specific conditions (Persons, All ages)	2020/21	→	2,540	650	795	587	2,276		298
Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons, All ages)	2020/21	→	1,825	463	500	456	805		251
Successful completion of drug treatment - non-opiate users (Persons, 18+ yrs)	2020	→	92	34.3%	36.5%	33.0%	10.7%		61.9%
Successful completion of drug treatment - opiate users (Persons, 18+ yrs)	2020	→	48	6.3%	4.7%	4.7%	0.9%		11.2%
Successful completion of alcohol treatment, treatment ratio (Current method) (Persons, 18+ yrs)	2020	–	179	0.78	-	-	-	-	-
Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults) (Persons, 16+ yrs)	2019/20	–	-	53.5%	51.2%	55.4%	41.4%		66.9%
Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check (Persons, 40-74 yrs)	2017/18 - 21/22	–	35,995	41.4%	41.8%	44.8%	15.6%		100.0%
Health related quality of life for older people (Persons, 65+ yrs)	2016/17	–	-	0.764	0.716	0.735	0.634		0.797
Emergency hospital admissions due to falls in people aged 65 and over (Persons, 65+ yrs)	2020/21	→	2,255	2,438	2,273	2,023	3,234		1,319

Source: Office for Health Improvement & Disparities. Public Health Profiles. [21 November 2022] https://fingertips.phe.org.uk © Crown copyright 2022.

From the Cheshire East Life Course Statistics (Appendix B) Tartan Rug (Appendix C) and Public Health Outcomes Framework, Cheshire East is also worse than the national average for:

- **Binge drinking (**however, this metric is very out of date**)**
- **New cases of bowel and breast cancer (**these are challenging metric in terms of optimising detection and early diagnosis and reducing mortality**)**
- **Emergency admissions all causes**
- **Abdominal Aortic Aneurysm Screening Coverage**
- **Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check**
- **Preventable sight loss-age-related macular degeneration**
- **Preventable sight loss-sight loss certifications**
- **Older people still at home 91 days after discharge.**

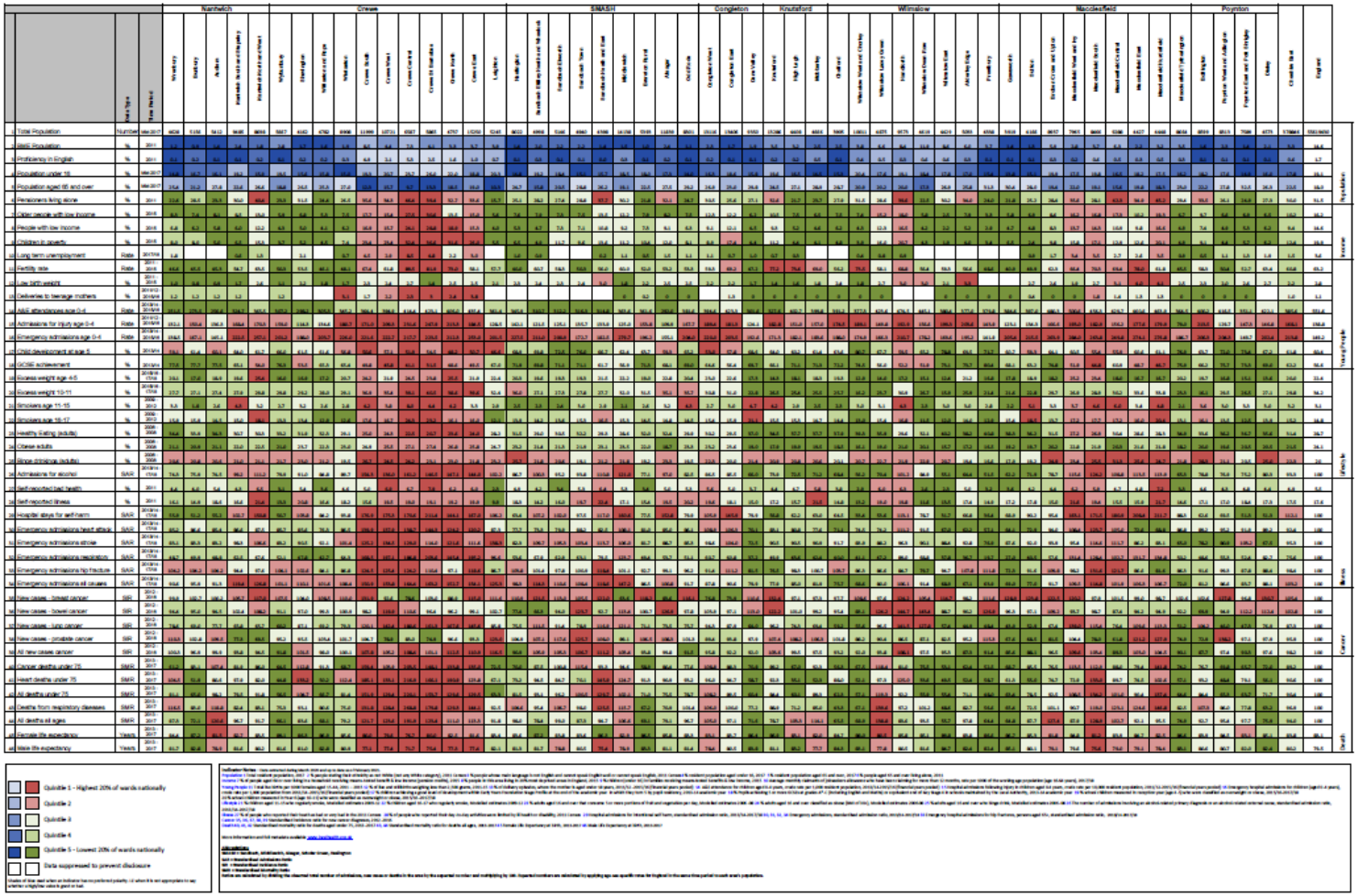
Appendix B (of the pre-event briefing)



Appendix C (of the pre-event briefing):

The Tartan Rug

Health Profiles for Electoral Wards plus Primary Health and Social Care Areas February 2021



Appendix D (of the pre-event briefing)

Place Business Intelligence Enabler Workstream Lead proposal

The proposal below has been developed by the Place lead for the Business Intelligence Workstream. It is based on feedback from the Business Intelligence Enabler Workstream Group, emergent findings from the Joint Strategic Needs Assessment work programme 2022/23, and feedback from representatives within the Strategic Planning and Transformation Group.

This proposal aims to highlight one example of a balanced range of relevant indicators, which aligns with the draft Health and Wellbeing Strategy, where improvement would be beneficial and where partnership working across Cheshire East Place is vital in achieving progress. However, contributors to the consensus building process are encouraged to review the wider range of indicators outlined in Appendix A when considering the appropriateness of this proposal, and when completing the pre-event online questionnaire.

Create a place that supports health and wellbeing for everyone living in Cheshire East

% Households in fuel poverty
% unemployed and claiming benefits

Ensure that our children and young people are happy and experience good physical and mental health and wellbeing

Smoking at time of delivery
Child development at 2.5 years
Overweight and obesity prevalence year 6

Improving the mental health and wellbeing of people living and working in Cheshire East

Self-reported wellbeing- Low happiness score
Emergency admissions for self harm

Enable more people to live well for longer

Alcohol-specific admissions
Falls in over 65s

Healthy life expectancy
Life expectancy

Appendix 2

Consensus building: pre-event poll results

Pre-event poll results

Based on 21 responses

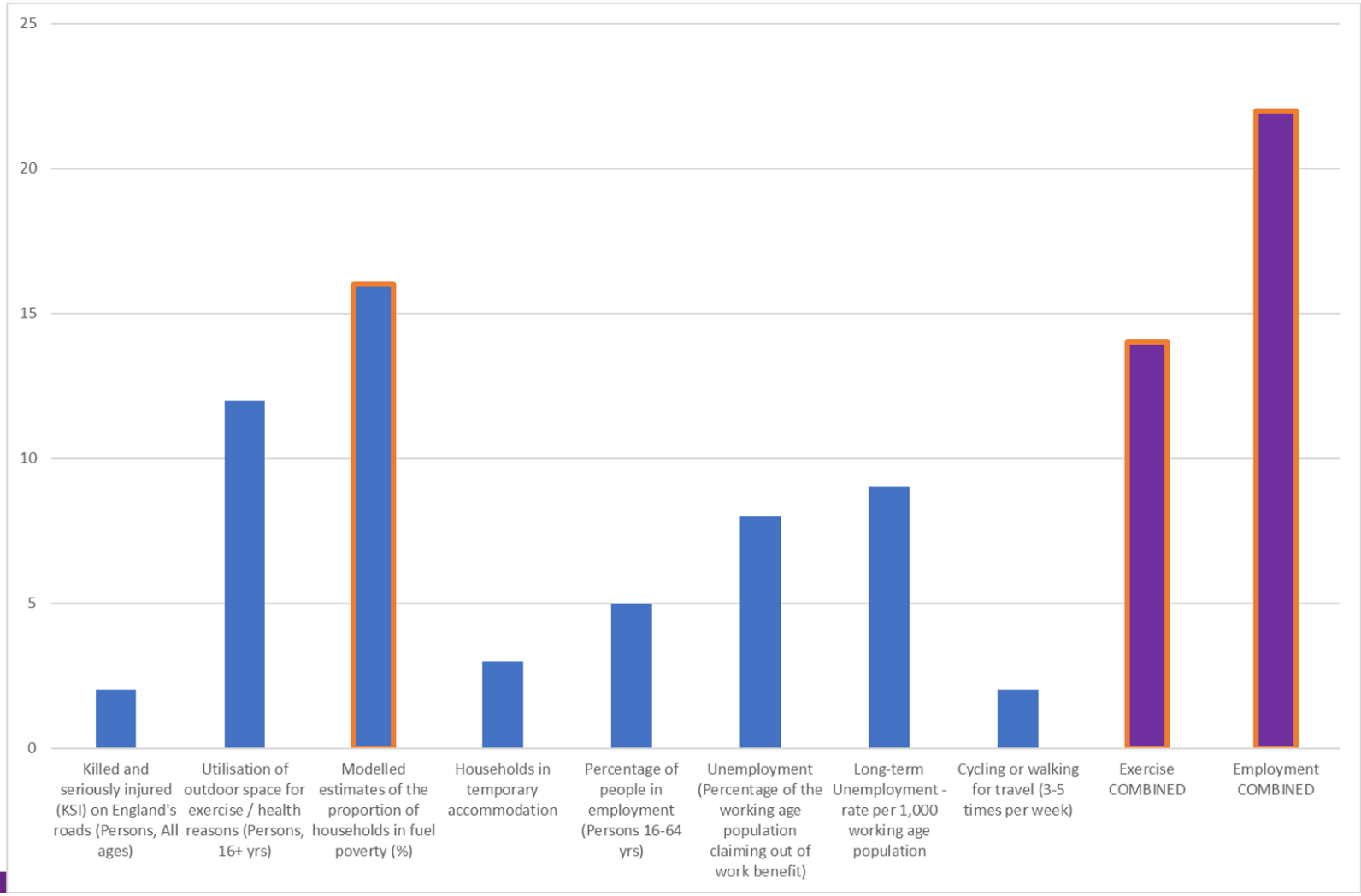
Open Fair Green

Cheshire East Council

UNCLASSIFIED

Outcome 1

Create a place that supports health and wellbeing for everyone living in Cheshire East


25
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15
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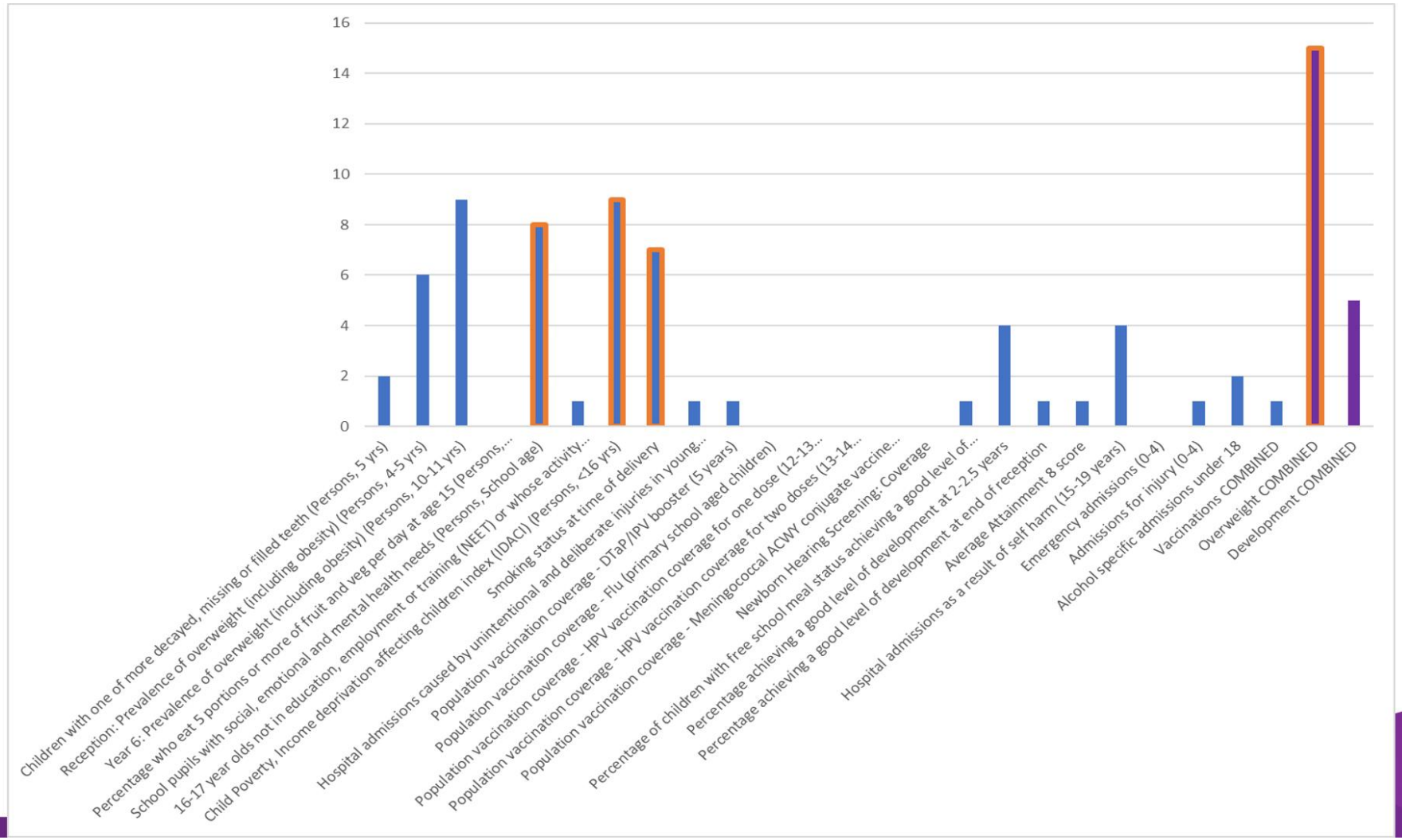
Killed and seriously injured (KSI) on England's roads (Persons, All ages)
Utilisation of outdoor space for exercise / health reasons (Persons, 16+ yrs)
Modelled estimates of the proportion of households in fuel poverty (%)
Households in temporary accommodation
Percentage of people in employment (Persons 16-64 yrs)
Unemployment (Percentage of the working age population claiming out of work benefit)
Long-term Unemployment - rate per 1,000 working age population
Cycling or walking for travel (3-5 times per week)
Exercise COMBINED
Employment COMBINED

Outcome 2

Ensure that children and young people are happy and experience good physical and mental health and wellbeing

Comments around number of options, difficulty choosing vaccines


16
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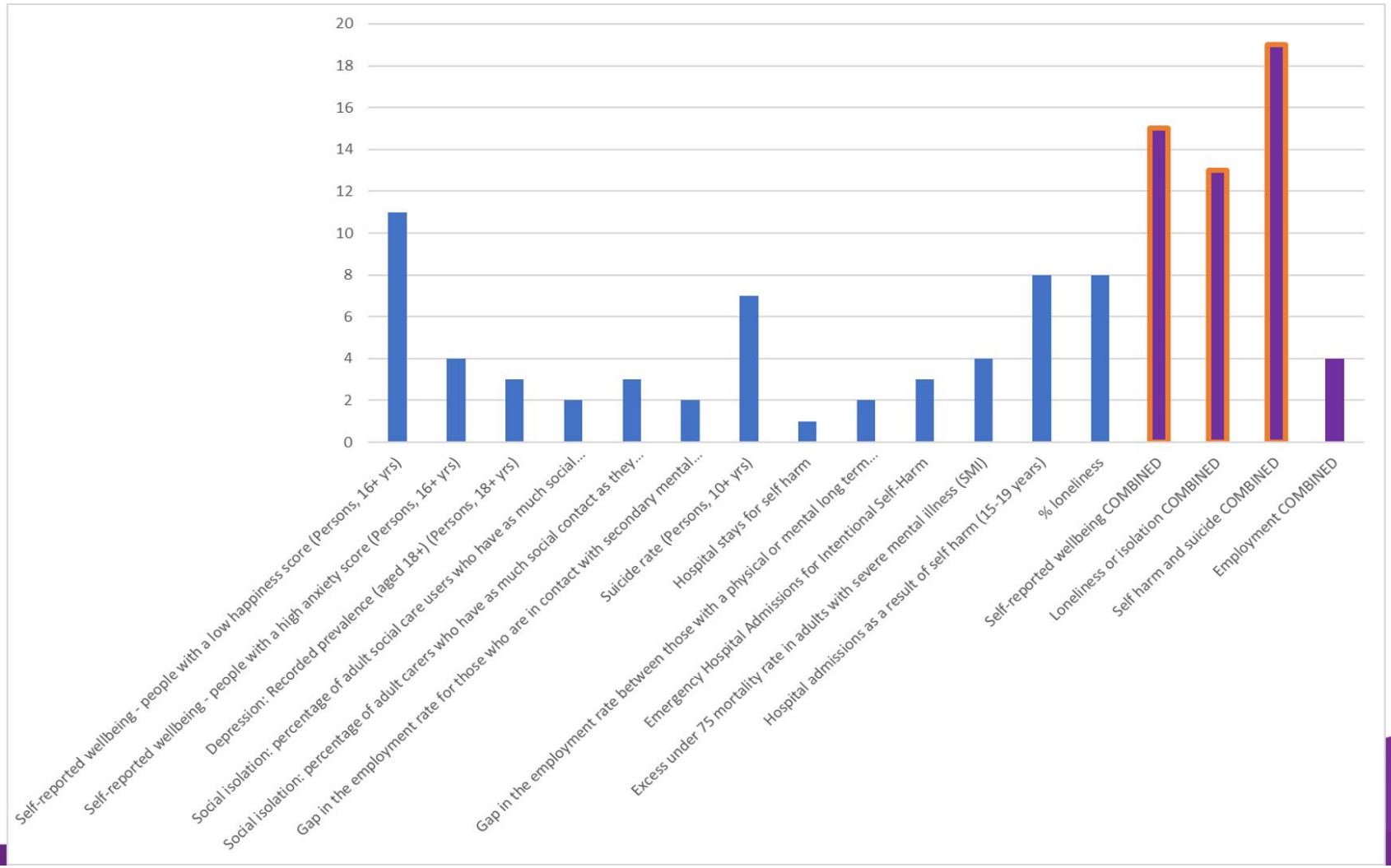
Children with one of more decayed, missing or filled teeth (Persons, 5 yrs)
Reception: Prevalence of overweight (including obesity) (Persons, 4-5 yrs)
Year 6: Prevalence of overweight (including obesity) (Persons, 10-11 yrs)
Percentage who eat 5 portions or more of fruit and veg per day at age 15 (Persons,...
School pupils with social, emotional and mental health needs (Persons, School age)
16-17 year olds not in education, employment or training (NEET) or whose activity...
Child Poverty, Income deprivation affecting children index (IDACI) (Persons, <16 yrs)
Hospital admissions caused by unintentional and deliberate injuries in young...
Smoking status at time of delivery
Population vaccination coverage - DTaP/IPV booster (5 years)
Population vaccination coverage - Flu (primary school aged children)
Population vaccination coverage for one dose (12-13...
Population vaccination coverage for two doses (13-14...
Population vaccination coverage - HPV vaccination coverage - Meningococcal ACWY conjugate vaccine...
Population vaccination coverage - HPV vaccination coverage - Coverage
Newborn Hearing Screening: Coverage
Percentage of children with free school meal status achieving a good level of...
Percentage achieving a good level of development at 2-2.5 years
Percentage achieving a good level of development at end of reception
Average Attainment 8 score
Hospital admissions as a result of self harm (15-19 years)
Emergency admissions (0-4)
Admissions for injury (0-4)
Alcohol specific admissions under 18
Vaccinations COMBINED
Overweight COMBINED
Development COMBINED

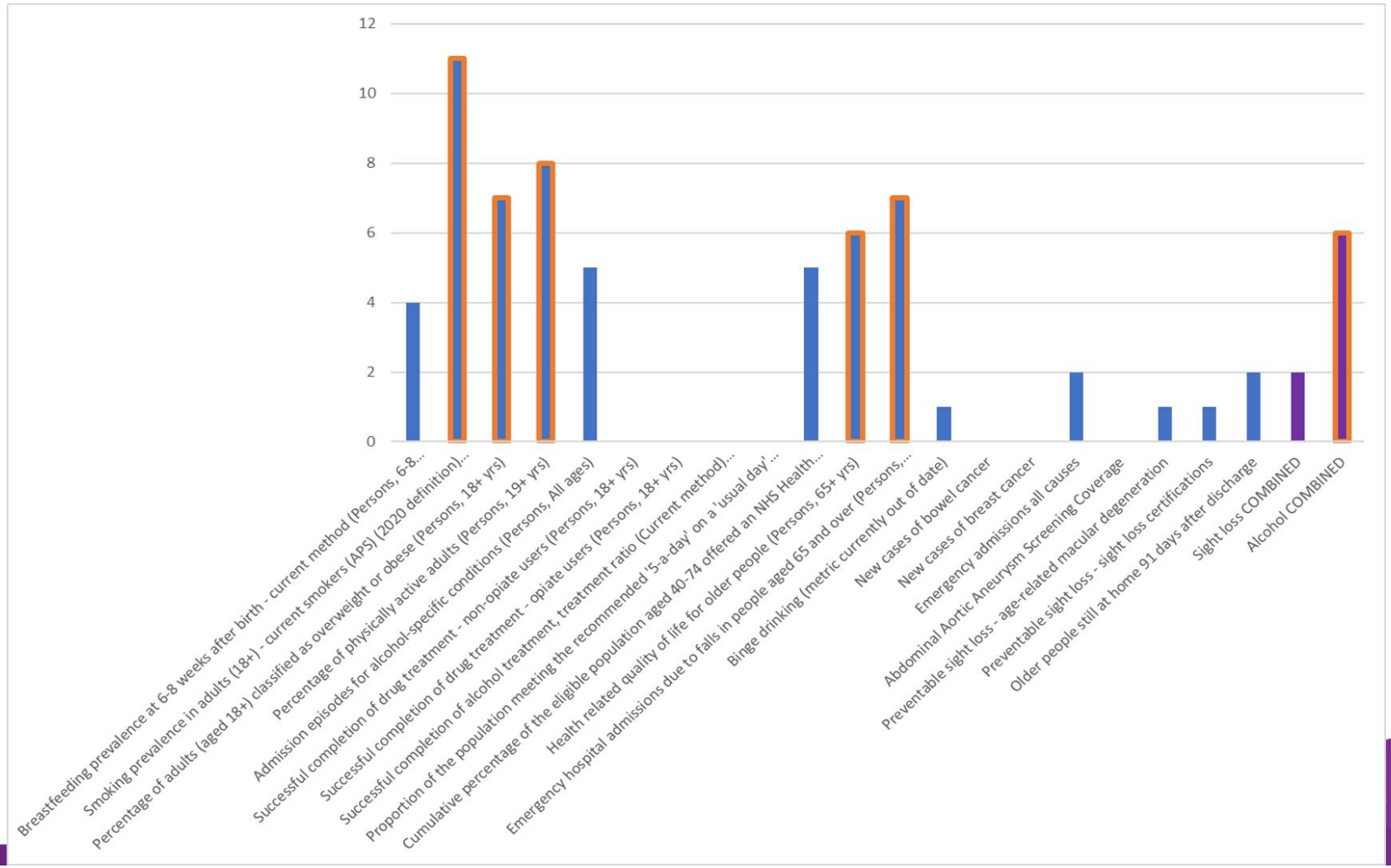
Outcome 3

Improve the mental health and wellbeing of people living and working in Cheshire East


20
18
16
14
12
10
8
6
4
2
0
Self-reported wellbeing - people with a low happiness score (Persons, 16+ yrs)
Self-reported wellbeing - people with a high anxiety score (Persons, 16+ yrs)
Depression: Recorded prevalence (aged 18+) (Persons, 18+ yrs)
Social isolation: percentage of adult social care users who have as much social...
Social isolation: percentage of adult carers who have as much social contact as they...
Gap in the employment rate for those who are in contact with secondary mental...
Suicide rate (Persons, 10+ yrs)
Hospital stays for self harm
Gap in the employment rate between those with a physical or mental long term...
Emergency Hospital Admissions for Intentional Self-Harm
Excess under 75 mortality rate in adults with severe mental illness (SMI)
Hospital admissions as a result of self harm (15-19 years)
% loneliness
Self-reported wellbeing COMBINED
Loneliness or isolation COMBINED
Self harm and suicide COMBINED
Employment COMBINED

Outcome 4

Enable more people to Live Well for Longer in Cheshire East


12
10
8
6
4
2
0
Breastfeeding prevalence at 6-8 weeks after birth - current method (Persons, 6-8...
Smoking prevalence in adults (18+) - current smokers (APS) (2020 definition)...
Percentage of adults (aged 18+) classified as overweight or obese (Persons, 18+ yrs)
Percentage of physically active adults (Persons, 19+ yrs)
Admission episodes for alcohol-specific conditions (Persons, All ages)
Successful completion of drug treatment - non-opiate users (Persons, 18+ yrs)
Successful completion of drug treatment - opiate users (Persons, 18+ yrs)
Successful completion of alcohol treatment, treatment ratio (Current method)...
Proportion of the population meeting the recommended '5-a-day' on a 'usual day' ...
Cumulative percentage of the eligible population aged 40-74 offered an NHS Health...
Health related quality of life for older people (Persons, 65+ yrs)
Emergency hospital admissions due to falls in people aged 65 and over (Persons,...
Binge drinking (metric currently out of date)
New cases of bowel cancer
New cases of breast cancer
Emergency admissions all causes
Abdominal Aortic Aneurysm Screening Coverage
Preventable sight loss - age-related macular degeneration
Preventable sight loss - sight loss certifications
Older people still at home 91 days after discharge
Sight loss COMBINED
Alcohol COMBINED

Summary

1. Healthy place
    1. Employment
    2. Fuel poverty
    3. Exercise*
2. Happy and healthy children
    1. Overweight/obesity
    2. Child poverty
    3. Pupils' mental health
    4. Smoking at delivery
3. Mental health and wellbeing
    1. Self harm / suicide
    2. Self-reported wellbeing
    3. Loneliness and isolation
4. Live well for longer
    1. Smoking prevalence
    2. Physically active adults*
    3. Overweight
3. Admissions due to falls
5. Alcohol
5. Q of L in older people

*similar indicators

Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Joint Strategic Needs Assessment update: the 2023/24 work programme
Date of meeting:	27 June 2023
Written by:	Jack Chedotal and Susan Roberts
Contact details:	Jack.chedotal@cheshireeast.gov.uk Susan.roberts@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Dr Matt Tyrer

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision ☒
Why is the report being brought to the board?	The purpose of this report is to seek approval for the 2023/4 JSNA work programme.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☐ Improving the mental health and wellbeing of people living and working in Cheshire East ☐ Enable more people to live well for longer ☐ All of the above ☒		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☒ Accessibility ☒ Integration ☒ Quality ☐ Sustainability ☒ Safeguarding ☐ All of the above ☐		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The Health and Wellbeing Board is asked to approve the 2023/24 JSNA work programme		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	This report has been considered by the Cheshire East Council Adults, Health and Integration Directorate Management Team, and the Cheshire East Council Corporate Leadership Team.		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	No
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	It is envisaged that adopting the JSNA recommendations will help to reduce inequalities and enhance existing work to improve overall health and wellbeing in Cheshire East.

1 Report Summary

1.1 The purpose of report is to seek approval of the 2023/24 work programme:

- Special educational needs and disabilities (SEND) deep dive review
- Isolation deep dive review
- Care for older people deep dive review
- Macclesfield light touch review
- A lifestyle survey.

1.2 Health and Wellbeing Boards have a duty to produce JSNAs which are an in-depth assessment of the current and future health and social care needs. They are informed from a wide range of sources to produce recommendations for commissioners and partners to use to improve the overall health and wellbeing of residents of Cheshire East whilst looking to reduce inequalities.

2 Recommendations

2.1 The Health and Wellbeing Board is asked to approve the 2023/24 JSNA work programme.

3 Reasons for Recommendations

3.1 The 2023/24 work programme has been developed through a multi-stage, multi-partner consensus building approach.

3.2 Publishing updated JSNAs allow partners and commissioners to use up to date information, evidence and research when designing services in Cheshire East.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The production of the JSNA supports the four outcomes from the Health and Wellbeing Strategy 2023-28:

- Cheshire East is a place that supports good health and wellbeing for everyone.
- Our children and young people experience good physical and emotional health and wellbeing.
- The mental health and wellbeing of people living and working in Cheshire East is improved.
- That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place.

5 Background and Options

5.1 Health and Wellbeing Boards have a duty to produce Joint Strategic Needs Assessments (JSNA) for their area.

5.2 JSNAs are assessments of the current and future health and social care needs of the local community. These are needs that can be met either by the local authority or by the NHS. JSNAs are informed by a wide range of sources including research, evidence, local insight, and intelligence to help to improve outcomes and reduce inequalities. They also consider wider factors that impact on their community's health and wellbeing, produce recommendations, and identify where there is a lack of evidence or research.

5.3 The 2022/23 JSNA work programme is summarised at Appendix A. There has been a new approach to the development of a JSNA chapter over the course of this programme, which is to create three separate products designed for different audiences. They are as follows:

- A resident summary produced to be accessible for all audiences
- An executive summary which contains the key findings
- A full report which contains all the findings, link to the website location. The full report acts as a reference manual for informing strategic developments.

The executive summary and the full report are produced for planning and commissioning purposes.

5.4 The priorities for the 2023/24 JSNA programme were developed by the JSNA Steering Group through extensive consultation with stakeholders, during the 2022/23 year and particularly during January/February 2023. A poll was undertaken with the JSNA steering group and VCFSE partners which then informed a consensus building conversation and led to five priorities being identified.

5.5 They are:

- Special educational needs and disabilities (SEND) deep dive review
- Isolation deep dive review
- Care for older people deep dive review
- Macclesfield light touch review
- A lifestyle survey.

The SEND JSNA was a priority for the 2022/23 JSNA programme but due to system pressures, it has been re-allocated to the 2023/24 work programme.

5.6 There is a plan to evaluate the JSNA programme over the course of 2023/24. This will seek to understand how the new JSNA is received and how partners found the new approach to collaborative working. Evaluation will initially involve a survey. In addition, the JSNA website will be analysed to understand how many people are viewing the JSNA and which chapters are viewed the most. This will be used to inform the future development of the JSNA.

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

Name: Jack Chedotal
Designation: Public Health Information Analyst
Email: jack.chedotal@cheshireeast.gov.uk

Name: Dr Susan Roberts
Designation: Consultant in Public Health
Email: susan.roberts@cheshireeast.gov.uk

Appendix A – JSNA Work Programme 2022/23: Summary

Deep dives
Poverty
Crewe
Emotional and mental wellbeing in children and young people
Special Educational Needs and Disability
Light touch reviews
Smoking
Substance misuse
Falls
Automation of the Tartan Rug to allow for further Tartan Rug updates to be produced more efficiently
Development of Cheshire East Outcomes Framework
Update of the JSNA website to improve usability and accessibility, where feasible

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CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund End of Year report 2022 - 2023
Date of meeting:	27 June 2023
Written by:	Alex Jones and Daniel McCabe
Contact details:	Alex.T.Jones@cheshireeast.gov.uk Daniel.McCabe@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Helen Charlesworth-May, Executive Director – Adults, Health and Integration

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision ☐
Why is the report being brought to the board?	The purpose of this paper is to provide the Health & Wellbeing Board (HWB) with a summary of progress made during 2021-22 of the Better Care Fund.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☐ Improving the mental health and wellbeing of people living and working in Cheshire East ☐ Enable more people to live well for longer x All of the above ☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above x		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The Health and Wellbeing Board (HWB) is asked to note the progress made during 2020/21 of the Better Care Fund.		
Has the report been considered at any other committee meeting of the Council/meeting of the ICB board/stakeholders?	The following report has separately been distributed to the Better Care Fund Governance Group.		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	No
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	N/A

1 Report Summary

1.1 To highlight the performance of the Better Care Fund including the Improved Better Care Fund in Cheshire East in 2022/23.

2 Recommendations

2.1 That the Health and Wellbeing Board notes the Better Care Fund programme performance in 2022/23. Within this, that the Health and Wellbeing Board considers: Better Care Fund scheme overview, metric performance, the financial income and expenditure of the plan and individual scheme performance noted in Appendix one.

3 Reasons for Recommendations

3.1 This end of year report forms part of the monitoring arrangements for the Better Care Fund.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 This report supports the Health and Wellbeing Priority of Ageing Well.

5 Background and Options

5.1 The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant and the iBCF. Since 2015, the Government's aims around integrating health, social care and housing, through the Better Care Fund (BCF), have played a key role in the journey towards person-centred integrated care. This is because these aims have provided a context in which the NHS and local authorities work together, as equal partners, with shared objectives. During 2022, the CCG closed down on the 1st July 2022 and was replaced by the Integrated Care Board (ICB). Since the abolition of CCG's the s75 agreement was novated over to the ICB.

5.2 Local BCF plans are subject to national conditions and guidance. Local plans are monitored through NHS England and there are strict timelines regarding submission of plans for both regional and national assurance of plans to take place.

5.3 There were four National Conditions, in line with the BCF policy framework:

- Plans to be jointly agreed
- NHS contribution to adult social care to be maintained in line with the uplift to ICB Minimum Contribution
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day

services and adult social care
- Managing Transfers of Care: A clear plan for improved integrated services at the interface between health and social care that reduces Delayed Transfers of Care (DToC).

5.4 Beyond this, areas had flexibility in how the Fund was spent over health, care and housing schemes or services. Since June 2018, local health systems have been tasked with reducing the number of extended stays in hospital.

5.5 **Key changes from previous BCF plan**

5.6 The priorities noted for 2021/22 included: market risk management oversight, collaborative commissioning, effective contract management, increasing out of hospital resource, collaborative system planning, reducing length of stay, 7-day services, transfer of care hubs and Age Well. The priorities for 2022/23 reflect the development of the place and closer alignment between partners in respect of the problems and issues facing the system, this in turn has led to a closer focus on a fewer number of problems and issues. This has also been aided by joint appointments at director level and rationalisation of place governance.

5.7 The key priorities noted for the 2022/23 period are:
- Implementing the Home first programme
- Stabilising the care at home market
- Reducing the impact of the Cost-of-living crisis
- Having joined up winter planning

5.8 **Implementing the Home first programme**

Home First is an ‘umbrella’ term used to describe a collection of services commissioned and delivered by Health, Social Care, including Physical and Mental Health and the Voluntary Sector across Cheshire East place. These are evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed.

5.9 **Stabilising the care at home market**

The care at home market has faced a series of unprecedented pressures over the last 12-18 months, these include: recruitment and retention, financial pressures as well as the COVID pandemic. The local system has put in place a number of measures to try to stabilise the market including: an uplift for providers, assistance with recruitment and support through the pandemic through information and advice as well as protective equipment and grant funding.

5.10 **Reducing the impact of the Cost-of-living crisis**

The cost-of-living crisis is impacting upon residents, service users as well as providers by in Cheshire East. It represents an additional burden impacting upon daily life and for providers in continuing to operate. Mitigating actions taken by the local system include a dedicated phone line, winter warm places scheme and people helping people volunteer scheme.

5.11 **Having joined up winter planning**

Each partner develops plans on an annual basis to target increased pressure faced during the winter. Partners have continued to join up efforts through a single plan which identifies all of the schemes and funding to be deployed. This is with the aim of bringing greater efficiency and value and maximising possible outcomes

5.12 **Joint priorities for 2022/23**

Implementing the Home first programme

As noted, Home First is an ‘umbrella’ term used to describe a collection of services commissioned and delivered by Health, Social Care, including Physical and Mental Health and the Voluntary Sector across Cheshire East place

5.13 Objectives We will provide an equitable and fully integrated urgent and emergency care service for patients with physical, mental health or social care needs, via our Care Communities in conjunction with secondary care services. We will harness digital solutions, collaborative working and information sharing so that the population of Cheshire East will be able to access the right advice, care, or support in the right place, first time.We will reduce attendances to Emergency Departments and reduce the length of stay for those admitted to an acute hospital bed by enabling patients to self-care and recover through our Care Communities, underpinned by a philosophy of ‘home first’ wherever safe and appropriate.We will develop and deliver on system wide approaches to "growing" our workforce, developing skills and innovative/creative solutions as system providers, underpinned by the philosophy that working closely together will lead to sustainable future services.

5.14 **Programme aims**

5.15 Develop a care and support model that responds at the point of crisis, Offer more care at home and ensure we have the right amount of capacity and the right type to provide timely access to advice, treatment, and support to prevent a hospital admission and support people to remain at home. Develop an integrated workforce.Transform a sustainable model for step up and step-down beds.

5.16
- Share relevant data for patients who are currently delayed within the Mental Health wards and feed into place-based governance
- Provide a breakdown of individual needs of those waiting for discharge (triangulation of out puts from MADE, LA intelligence, CWP)
- Understand the care and support needs and whether these needs can be met by existing provision – also need to understand longer term needs based on population
- Increase bed base capacity and community support options for people living with Autism and Mental Health needs
- Develop service specifications that can be shared with care providers to test the market, such as specialist local bed-based provision and community capacity to support people with Physical and Mental Health needs.
- Some recent examples of progression within the Homefirst programme are around the rollout of the Transfer of Care (ToC) Hub.
- ToC hub currently operates Monday 8am– 5pm. Weekends are covered on a voluntary basis only. Community Crisis Response respond 7 days, 8am – 8pm.
- The Hub have a range of staff skill mix from Health and Social teams such as Social Workers, Therapy Staff, Nurses, Brokerage Officers and Care Providers
- A health professional/team leader acts as the single senior coordinator and ensures consistent procedures are in place and implements good practice and learning across all areas.
- IDT attend daily board rounds promoting and supporting ward staff with the Home First ethos.
- Patient Flow Support Workers carry out safety and wellbeing checks on all planned discharges, pathways 1, 2 and 3. They escalate any poor discharge, and a date is completed by either the ward or the ToC hub.
- Operate as a team without bureaucratic hand-offs and referral processes.
- A generic email address and a dedicated telephone number are in place, this has been shared inside the hospital and outside particularly amongst the care sectors.
- A case manager is allocated to every person coming through the hub on pathways 1-3 and a daily review of these patients takes place.
- Assessments are sent to providers prior to discharge to ensure they can meet the needs of the patient prior to transfer. Regular meetings are held with providers to ensure quality assurance. Family and friends are encouraged to complete the questionnaire on their discharge from the service.
- ECT uses Criteria to Reside as a daily reporting mechanism which escalates the number of patients who don’t meet the CtR what they are waiting for and how long they have been waiting.

- • We have a developed a discharge tracker which is used by all professionals, it tracks the journey of all people requiring supported discharge.

5.17 **Stabilising the care at home market**

5.18 The local context of the care at home marketplace is that providers were facing increasing cost pressures, the main area of cost was associated with staff and increases to wages to stay competitive within in the local employment market. From April 2022 national minimum wage and national insurance rises took effect. Whilst most care at home employers already paid the national minimum wage it was noted that they would still have to increase pay rates to remain competitive as well as increasing front line staff providers also increased pay rates for back-office staff to maintain wage differentials within their staff groups.

5.19 Other pressures faced by providers were recruitment and retention, across the sector there is a shortage of staff with increasing competition from other sectors which meant retention was also made more difficult. Care at home providers also noted pressure faced by the geographical variation in Cheshire East with an extensive mix of rural areas and urban hubs. Geographical variation created an increased cost between providing services in rural areas in comparison to urban hubs as a result of increased travel times. In order to bring about greater stability to the care at home market additional funding of £1,987,420 was provided to the market. Of this money £1,134,000 was provided by the Better Care Fund from monies carried forward from 2021/22. The funding has brought about sustained increased care being available in the marketplace

5.20 **Reducing the impact of the Cost-of-living crisis**

5.21 Recent winter scenario planning has included the impact that the crisis is having on residents/service users as well as providers. Care providers are being profiled to ascertain the level of market failure risk over the winter period. Scenario planning from 2021 is being re-visited to consider heightened risks around COVID, winter demand and the cost of living.

5.22 There will be the Winter Wellbeing campaign which has the aim of reducing excess winter deaths in Cheshire East, reduce the number of people who become so ill that they require admission to hospital and to provide information and advice to people on how to stay safe, well and warm during the colder weather. This will run from September/October 2022 – February 2023.

5.23 **Having joined up winter planning**

5.24 The local system has developed a joined-up approach - Warm Up for the Winter Plan – The planning group is to track the progress and fully understand each system partner plans on the approach to winter and what will be in place covering all areas of urgent care across Acute, Mental Health, Primary Care and Social Care services. The purposes of the planning meetings is to focus on operational concerns and emerging risks recognised as a system challenge and to identify any practical solutions that could be implemented ahead of winter.

5.25 This is an established forum made up of system leaders from Health & Social Care who will then be responsible for briefing their own organisations on the progress of the system Winter plan. In readiness for winter planning the ICB recently completed a winter readiness self-assessment. The council as part of the local system has developed a plan to focus on a number of priorities across adult social care in readiness for winter. The schemes cross the following areas: Care homes, voluntary sector, Mental health, Substance misuse, poverty and the cost of living, Direct payments, Domiciliary care, fire service and carers.

5.26 A Good Winter will be delivered by supporting people to remain well and as healthy as possible at home, having responsive effective services that offer choice, and a system that is resilient, resolution focused and has a shared vision to deliver meaningful positive Health and Wellbeing outcomes for the population of Cheshire East. System partners will support this through the

following methods:

5.27
- High uptake in the flu and covid vaccinations boosters with the 65+ year.
- Effective wellbeing & support for staff.
- Ability to access community provision unhampered by covid or other viral infections & Infection - Prevention Control restrictions.
- Utilisation of winter capacity provision to be 85% or above with high level throughput/flow..
- Patients deemed to no longer meet the criteria to reside in hospital have clear exit and support routes out.
- ED attendances reduced and no ambulance delays.
- Increased use of Voluntary Community Faith Sector
- Robust governance and system oversight

5.28 Winter Wellbeing campaign which has the aim of reducing excess winter deaths in Cheshire East, reduce the number of people who become so ill that they require admission to hospital and to provide information and advice to people on how to stay safe, well and warm during the colder weather. This will run from September/October 2022 – February 2023. Areas of focus will be;

5.29
- The cost-of-living crisis – food and fuel poverty and accessing benefits (September/October)
- Warm banks (September/October)
- Flu (November)
- Avoid being scammed on Black Friday (November)
- Preparing your home for winter (late November weather dependent)
- Ensuring you are accessing appropriate winter-related benefits to help pay for heating bills etc (November)
- Being a good winter neighbour including social isolation (November)
- 12 scams of Christmas (Early December)
- Using services appropriately (December)
- Staying Warm, including energy efficiency (January)
- Staying active (January)
- Nominated neighbour scheme

5.30 In addition to the annual Winter Wellbeing Campaign, the council's Stay Well Squad (formally Swab Squad) will be undertaking a tour of Cheshire East offering a range of information, advice and guidance with a focus on 'Winter Wellbeing' during the 2022-23 autumn/winter period. The tour will take place between October 2022 – February 2023. This will involve working with a range of partners with expertise in certain areas. The areas of focus will be:

5.31
- Winter ailments: Covid/Flu/Pneumonia
- Physical and mental health during winter
- Fuel poverty
- Food poverty
- Warm banks
- Accessing benefits
- Job hunting and CV writing advice
- Walking stick repairs/winter proofing

5.32 Cheshire Fire & Rescue Service - Safe and well visits, Cheshire Fire and Rescue Service offer a free 'Safe and Well Visit' for people who are aged over 65 and for people who are referred to us by partner agencies because they are considered to be a particular risk. Safe and Well Visits incorporate the traditional fire safety information (and smoke alarm fitting) but also offer additional advice on slips, trips, fall prevention, a heart check, bowel cancer screening as well as offering additional support to those who wish to stop smoking, taking drugs or reduce their alcohol consumption. During winter, winter warmth advice will also be discussed.

5.33 **Cheshire East Council**

5.34 Each year the council implements a winter plan in coordination with partners, the adult social care winter plan comprises of a number of schemes which will provide support through the following areas:

5.35
- Care homes
- Voluntary sector
- Mental health
- Substance misuse
- 0-19
- Poverty/ cost of living
- Public health campaigns
- Carers
- Direct payments
- Dome care
- Fire service support
- Winter scenario planning

5.36 The local authority is undertaking winter scenario planning, this process includes reviewing possible scenario's which could take place over winter: provider failure, increased demand, staff shortages, cost of living crisis and identifying action plans/mitigations which could take place in the event of them happening. Through this process a number of actions are underway which also include things such as: exploring how voluntary services could support the domiciliary care sector to provide low level support to clients, how and if students could be recruited and opportunities around additional dedicated care settings.

5.37 **Adult social care discharge fund**

5.38 Purpose of the funding - The Fund can be used flexibly on the interventions that best enable the discharge of patients from hospital to the most appropriate location for their ongoing care. It was noted that funding should prioritise those approaches that are most effective in freeing up the maximum number of hospital beds and reducing bed days lost within the funding available, including from mental health inpatient settings.

5.39 In total 30 schemes were developed. The list of schemes included as part of the fund are noted in appendix one. The list of schemes were endorsed by the Operational Delivery Group on 25/11/2022 as well the Place executive leaders group on 01/12/2022. National reporting is every couple of weeks. The list of schemes is found in Appendix three.

5.40 Project group meets weekly to discuss:
- Discharge scheme performance update including person centred outcomes
- Spend review and schemes highlight reports
- Recommendations for financial repurposing of any schemes underspent
- Reporting returns locally and nationally
- Risk review
- Items for escalation
- AOB.

5.41 We are tracking the following system performance measures:

- UEC metrics – Average daily type 1 A&E attendances – East and Mid trusts
- UEC metrics - Average daily non-elective admissions* - East and Mid Trusts
- UEC metrics – Average daily discharges – East and Mid trusts
- UEC metrics – Average daily number not meeting criteria to reside excluding discharges –
- East and Mid trusts
- UEC metrics – Average daily number of patients with 21+ day LoS – East and Mid trusts
- It should be noted that as of 16/01/2023 we are seeing positive performance against all of these system measures.

5.42 A separate paper will be coming to the health and wellbeing board to provide an update on the

schemes implemented.

5.43 **Current schemes**

5.44 There were 20 Schemes funded through Winter pressures, iBCF and BCF during 2022-23. The expenditure in the table results in a BCF carry forward for 2022/23 of £132,244 resulting in total headroom brought forward to 2023/24 of £184,790.

5.45

ID	Scheme Name	Source of Funding	Expenditure (£)
1	iBCF Block booked beds	iBCF	£1,450,638
2	iBCF Care at home hospital retainer	iBCF	£45,000
3	iBCF Rapid response	iBCF	£613,000
4	iBCF Social work support	iBCF	£456,000
5	iBCF 'Winter Schemes	iBCF	£500,000
6	iBCF Enhanced Care Sourcing Team (8am-8pm)	iBCF	£976,754
7	iBCF General Nursing Assistant	iBCF	£300,000
8	iBCF Improved access to and sustainability of the local Care Market	iBCF	£4,364,479
9	BCF Disabled Facilities Grant	DFG	£2,342,241
10	BCF Assistive technology	Minimum ICB Contribution	£757,000
11	BCF British Red Cross / Early Discharge	Minimum ICB Contribution	£724,364
12	BCF Combined Reablement service	Minimum ICB Contribution	£4,842,724
13	BCF Safeguarding Adults Board (SAB)	Minimum ICB Contribution	£447,723
14	BCF Carers hub	Minimum ICB Contribution	£307,415
15	BCF Programme management and infrastructure £227,368 plus Elmhurst £268,000 and MH SW's of £43,556	Minimum ICB Contribution	£538,924
16	BCF Winter schemes ICB	Minimum ICB Contribution	£557,673
17	BCF Homefirst schemes ICB	Minimum ICB Contribution	£20,091,176
18	BCF Trusted assessor service	Minimum ICB Contribution	£99,146
19	BCF Carers hub	Minimum ICB Contribution	£250,258
20	BCF Community Equipment service	Minimum ICB Contribution	£610,225

5.46 **Metric performance**

5.47 The following narrative on the performance on the BCF metrics is based on the latest available data which is up to the end of November 2022. Year end forecasts are purely based on performance to date and historic trends and do not take account of any operational or policy interventions that have been put in place since November 2022 or that may take effect in the future.

5.48 **Unplanned hospitalisation for chronic ambulatory care sensitive conditions**

Data for this metric is only available on a quarterly basis. Cumulatively to quarter 2, the rate stands at 337.0. This is extremely close to the planned cumulative rate of 338.0. This is also 48.5 lower than the average rate for all local authorities and is in line with the average rate for Cheshire East's comparator authorities (Cheshire East is 4.6 higher). When comparing the cumulative position at Quarter 2 in 22/23 with the same cumulative position in 21/22, Cheshire East is 14.9 lower in 22/23. The current forecast year end performance is 675 against a full year plan figure of 689 (-2.0%).

5.49 **Discharge to usual place of residence**

In quarter 1, Cheshire East performance was at 88.5% against a quarter 1 plan of 88.3%. In quarter 2, performance was at 89.1% against a quarter 2 plan of 89.7%. In quarter 3 (to November), performance was at 88.2% against a quarter 3 plan of 90.0%. Cumulatively, to November 2022, performance was at 88.7%. This is broadly in line with performance over the same period in 21/22 (88.9%) which, given the challenges in the home care sector in 2022, should be viewed positively.

Cheshire East performance is lower than both national performance and the average for Cheshire East comparator authorities – an average gap of about 3-4 percentage points - which is the same gap seen in 21/22. The current forecast quarter 4 performance is 88.3% against a quarter 4 planned figure of 89.1%.

5.50 **Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population**

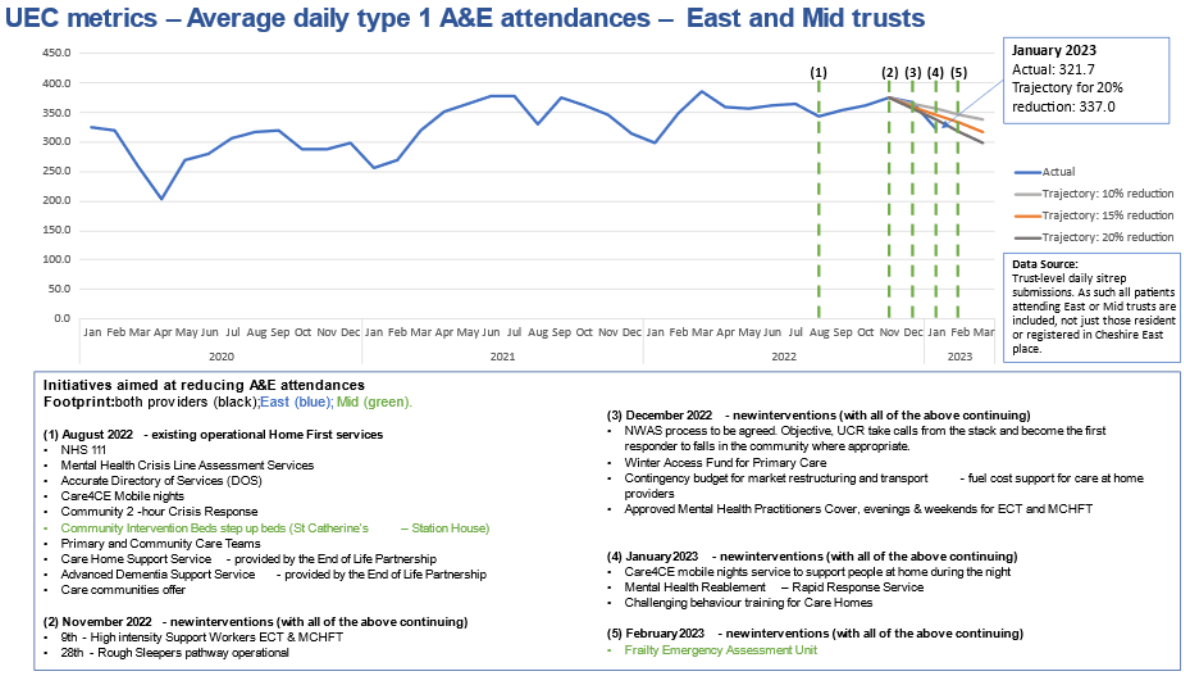
Please note that the latest actuals are estimated to take into account data lags.
The latest cumulative rate is at 453.7, which is 15.1 above the planned rate (+3.4%). This equates to 14 admissions above the planned number at this stage. This is currently in line with the rate seen in 21/22 at this point (455.8).

The current forecast year end performance is 626.5 against a full year plan figure of 657.4 (-4.7%). This is however, based on historic performance from 21/22 where a drop in admissions was seen in the final quarter. It is not clear whether this drop will be replicated in 22/23. A forecast, based solely on the trajectory of admissions in 22/23, however, would see a forecast end year rate as high as 684.4 (+4.1%).

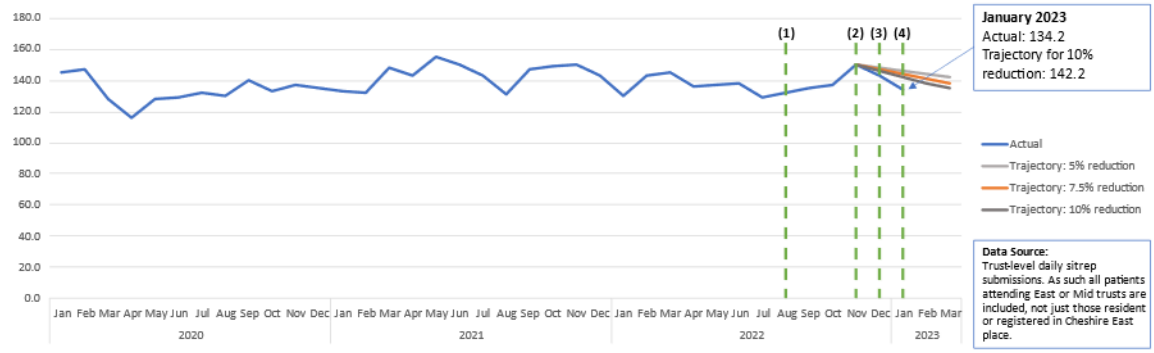
5.51 **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**

Please note that the figures below are estimates based on partial data.
In quarter 1, Cheshire East performance was at 82.2%. In quarter 2, performance was at 80.2%. In quarter 3 (to November), performance was at 85.6%. The current end year forecast performance is 83.7% against a planned figure of 82.2%.

5.52 The table below includes the BCF metrics and the performance for the for 2022/23 period.



UEC metrics - Average daily non- elective admissions* - East and Mid Trusts



*this specific data feed did not commence till January 2020 and from comparison to other sources we expect historic activity presented here to be lower than activity seen in 2018 -2019 due to COVID.

Initiatives aimed at reducing non-elective admissions
Footprint: both providers (black); East (blue); Mid (green).

(1) August 2022 - existing operational Home First services
- Frailty Service ECT
- React Service MCHFT
- Mental Health Crisis Response bed base
- Acute Visiting Service, GPOOH

(2) November 2022 - new interventions (with all of the above continuing)
- 21st - Co-locate Care4Ce Mobile Night & ECT Out of Hours District Nursing
- 21st - 200 Hours additional community capacity to positioned into ECT, ED Department linked to Frailty service and Urgent Community Response

(3) December 2022 - new interventions (with all of the above continuing)
- Hot Hub escalation expansion for non -elective and Paediatrics

(4) January 2023 – new interventions (with all of the above continuing)
- East Cheshire Hospice and St. Luke's Hospice bed capacity
- Co-locate Care4Ce Mobile Night & Mid Out of Hours District Nursing

UEC metrics – Average daily discharges – East and Mid trusts

Initiatives aimed at reducing total discharge volumes
Footprint: both providers (black); East (blue); Mid (green).

(1) August 2022 - existing operational Home First services
- Mental Health Reablement
- Community Equipment
- Community Reablement
- Raid Response Care Via Routes and Evolving Care Support Hospital Discharge
- General Nursing Assistants Hospital Discharge
- D2A Community beds
- Resilience Beds to support P1 discharges
- Virtual Wards Home Oximetry
- British Red Cross discharge to home service
- Personal Health Budgets to support discharges
- Carers Payments to facilitate rapid discharge
- St Pauls Hospital Discharge Support delivered via Community Voluntary Sector

(2) September 2022 - new interventions (with all of the above continuing)
- 1st - 4-week assistive technology offer at the point of discharge
- 5th - Community Connectors deployed into Transfer of Care Hub
- 5th - Reablement Workers deployed into Transfer of Placements
- 5th - Bridging Placements of Care packages GNA & Reablement
- 12th - Home First OT Therapist & Reablement 72 discharges
- 14th - Community Voluntary Services St Michaels & St Pauls support
- ISL in reach support for MH patients contract extended

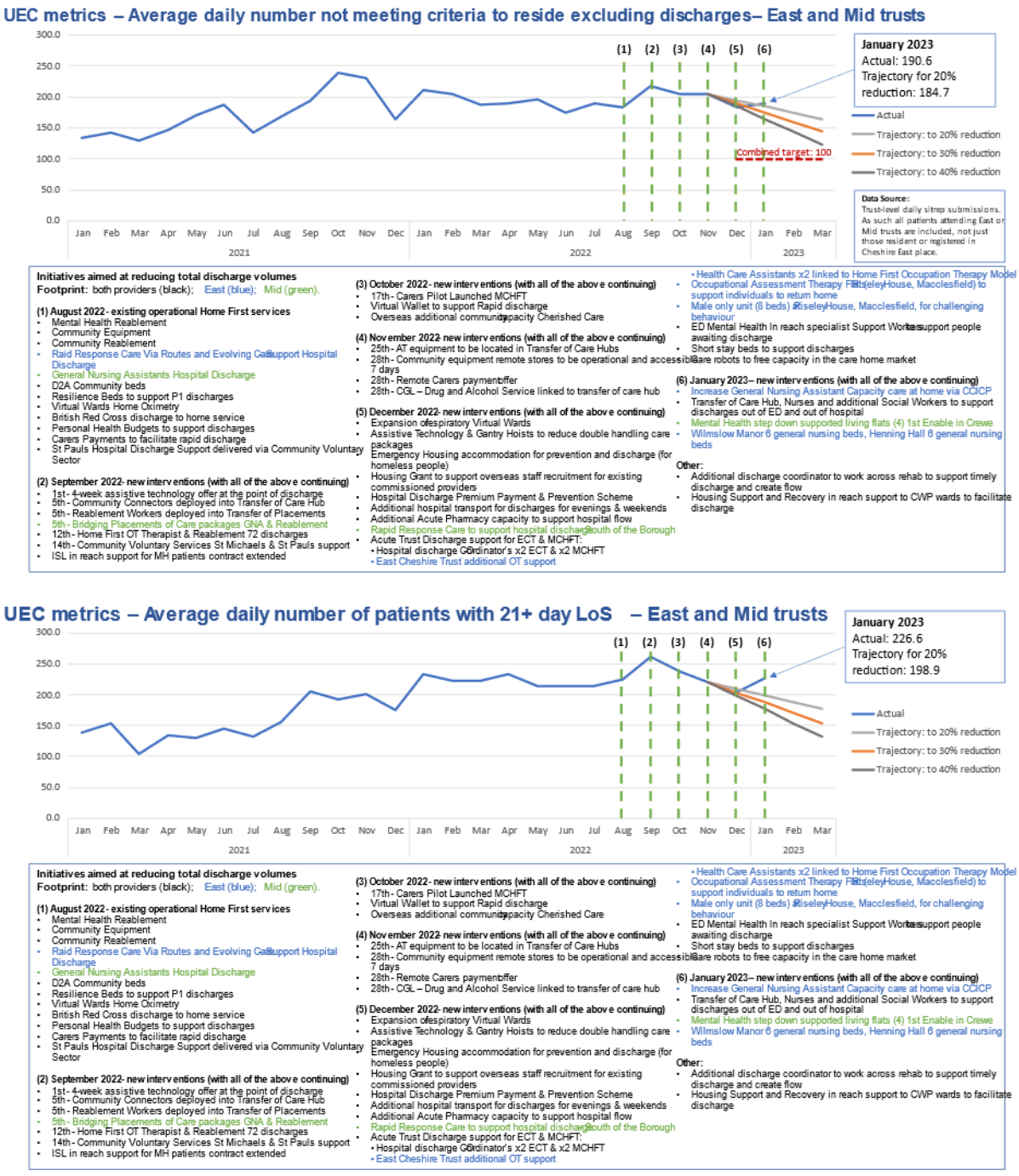
(3) October 2022 - new interventions (with all of the above continuing)
- 17th - Carers Pilot Launched MCHFT
- Virtual Wallet to support Rapid discharge
- Overseas additional community capacity Cherished Care

(4) November 2022 - new interventions (with all of the above continuing)
- 25th - AT equipment to be located in Transfer of Care Hubs
- 28th - Community equipment remote stores to be operational and accessible 7 days
- 28th - Remote Carers payment offer
- 28th - CGL – Drug and Alcohol Service linked to transfer of care hub

(5) December 2022 - new interventions (with all of the above continuing)
- Expansion of respiratory Virtual Wards
- Assistive Technology & Gantry Hoists to reduce double handling care packages
- Emergency Housing accommodation for prevention and discharge (for homeless people)
- Housing Grant to support overseas staff recruitment for existing commissioned providers
- Hospital Discharge Premium Payment & Prevention Scheme
- Additional hospital transport for discharges for evenings & weekends
- Additional Acute Pharmacy capacity to support hospital flow
- Rapid Response Care to support hospital discharge South of the Borough
- Acute Trust Discharge support for ECT & MCHFT:
  - Hospital discharge Co-ordinator's x2 ECT & x2 MCHFT
  - East Cheshire Trust additional OT support
  - Health Care Assistants x2 linked to Home First Occupation Therapy Model
- Occupational Assessment Therapy Flat Risley House, Macclesfield) to support individuals to return home
- Male only unit (8 beds) @ Risley House, Macclesfield, for challenging behaviour
- ED Mental Health In reach specialist Support Worker to support people awaiting discharge
- Short stay beds to support discharges
- Care robots to free capacity in the care home market

(6) January 2023 – new interventions (with all of the above continuing)
- Increase General Nursing Assistant Capacity care at home via CCICP
- Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital
- Mental Health step down supported living flats (4) 1st Enable in Crewe
- Wilmslow Manor 6 general nursing beds, Henning Hall 6 general nursing beds

Other:
- Additional discharge coordinator to work across rehab to support timely discharge and create flow
- Housing Support and Recovery in reach support to CWP wards to facilitate discharge



5.53 Income and Expenditure

The following table describes the budget for the Better Care Fund the actual spend, the variance between the budget and the actual spend.

Running Balances	Income	Expenditure	Balance
DFG	£2,342,241	£2,342,241	£0
Minimum ICB Contribution	£28,748,176	£28,748,176	£0
iBCF	£8,705,870	£8,705,870	£0
Additional LA Contribution	£610,225	£610,225	£0
Additional ICB Contribution	£0	£0	£0
Total	£40,406,512	£40,406,512	**£0**

5.54 Access to Information

5.55 The background papers relating to this report can be inspected by contacting the report writer:

Name: Alex Jones
Designation: Better Care Fund Programme Manager
Tel No: 07803846231
Email: Alex.t.jones@cheshireeast.gov.uk

Appendix one – Aim of schemes

Scheme ID	Scheme Name	Expenditure (£)
1	iBCF Block booked beds Direct award of short-term contracts for 8 winter pressure beds to support Covid-19 pressures, winter pressures, supporting hospital discharges or preventing admission. The rationale for completing a direct award was as follows: an anticipated second wave of Covid-19, non Covid-19 related elective surgery and procedures which were cancelled/postponed are currently being reinstated in hospitals which will increase demand, residents have avoided accessing primary care services and we anticipate a surge in demand on these beds due to people's conditions deteriorating due to lack of treatment, we are now seeing the demand on A & E services in our hospitals rapidly increasing, Covid-19 is likely to be with us for the foreseeable future, we will need to access these beds to prevent hospital admissions as well as support hospital discharges and Care home providers do not have available capacity and would not be inclined to complete a standard tendering process due to the short term nature of these contracts during normal circumstances. We know the enormous pressures that care homes are under at present due to Covid-19, therefore, there is an even great need to award these contracts via a direct award.	£1,450,638
2	iBCF Care at home hospital retainer Since the implementation of the new Care at Home contract in November 2018 the Council does not pay a retainer fee for the first 7 days for hospital admission or respite; however, the provider is contractually obligated to hold open the care packages for this time. In order to assist with service continuity there may be instances upon agreement from the Contracts Manager where a retainer fee will be paid for up to the following 7 days. (i.e. day 8 to 14). In certain circumstances there may be cases where a Service User is only a few days from being discharged from hospital and so to support a smooth transition a retainer fee may be paid for a nominal number of days. This is only in exceptional cases and needs authorising in partnership with Contracts and Operational Locality Managers.	£45,000
3	iBCF Rapid response The Rapid Response Service will facilitate the safe and effective discharge of service users from hospital who have been declared as medically fit for discharge but who may have still have care needs that can be met in the service users own home. The service will seek to prevent readmission to hospital by ensuring wrap around services are in place in the first 48 hours following hospital discharge. The Service will also provide support to Service Users with complex health needs and end of life support at a level. Through the provision of 7 day working, the service will ensure a timely response to hospital discharge to reduce delayed transfers of care and create capacity and throughput for non-elective admissions.	£613,000
4	iBCF Social work support Social Worker (x1) dedicated to the Discharge to assess beds at Station House, Crewe. Social Care Assistants (x2) additional assessment and care management capacity to support the revised processes around hospital discharge using reablement exclusively for this purpose (East locality). Funding of additional staff to support a 'Discharge to assess' model. Funding is continuing to provide a team manager, social worker and occupational therapist. Increased capacity in the Social Work Team over Bank Holidays and weekends. This is to ensure patient flow and assisting in reducing the pressure on the NHS can be maintained over a seven-day period. Cheshire East will provide 2 social workers and 2 care arrangers (split between the 2 hospitals) that cover the weekends and bank holidays. This support would be 124 days for the weekends and another 8 days for bank holidays giving 132 days each per year.	£456,000
5	iBCF 'Winter Schemes	£500,000

	Additional capacity to support the local health and social care system to manage increased demand over the winter period. Evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed.	
6	iBCF Enhanced Care Sourcing Team (8am-8pm) The scheme sees the continuation of funding for the Care Sourcing Team following on from a successful pilot; the service provides a consistent approach to applying the brokerage cycle and in turn, makes best use of social worker time. The Care sourcing team undertake all aspects of the Brokerage cycle: enquiry, contact assessment, support planning, creation of support plan, brokering, putting the plan into action as well as monitor and review of the support. The service operates Monday to Sunday. The Care Sourcing Team comprises of a range of employees including team and deputy manager, admin, care sourcing officers as well as a social care assessor. This funding is to enable an 8 till 8 operation. The model is fully compliant with the Care Act 2014 as it provides information and advice, prevention, assessment, review, safeguarding, carers, market management and shaping, charging, support planning, personalisation and arranging care and support.	£976,754
7	iBCF General Nursing Assistant Provide an additional 7 GNA staff within the CCICP IPOCH team for a period of 12 months. An evaluation of effectiveness will be undertaken during this period subsequent to discussion and agreement regarding permanent funding. These additional staff would be utilised across South Cheshire and the Congleton area of East Cheshire to support patients requiring domiciliary care that would normally be delivered by Local authority. It is expected that whilst this proposal will reduce the current pressure it is not expected to eliminate the pressure and further work would be required in order to ensure sufficient and timely access to pathway 1 care.	£300,000
8	iBCF Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care) Cheshire East Council has a duty under Section 5 of the Care Act to promote the efficient and effective operation and sustainability of a market in services for meeting the care and support needs of individuals. There are increasing financial pressures on the social care market, for example National Living Wage, recruitment and retention issues, which is resulting in a rise in care costs. This scheme contributes towards the cost of care home and home care fees as well as supporting the delivery of additional care packages within the marketplace.	£4,364,479
9	BCF Disabled Facilities Grant The Disabled Facilities Grant provides financial contributions, either in full or in part, to enable disabled people to make modifications to their home in order to eliminate disabling environments and continue living independently and/or receive care in the home of their choice. Disabled Facilities Grants are mandatory grants under the Housing Grants, Construction and Regeneration Act 1996 (as amended). The scheme is administered by Cheshire East Council and is delivered across the whole of Cheshire East.	£2,342,241
10	BCF Assistive technology Assistive technologies are considered as part of the assessment for all adults who are eligible for social care under the Care Act where it provides greater independence, choice and control and is cost-effective for individuals. The provision of assistive technology is personalised to each individual and is integrated within the overall support plan. The scheme will continue to support the existing assistive technology services. The scheme also involves piloting assistive technology support for adults with a learning disability (both living in supported	£757,000

	tenancies and living in their own homes).	
11	BCF British Red Cross 'Support at Home' service Cheshire East 'Support At Home' Service is a 2-week intensive support service with up to 6 Interventions delivered within a 2-week period for each individual. The aim is to support people who are assessed as 'vulnerable' or 'isolated' and who are at risk of admission to hospital or becoming a delay in hospital. Service users have been identified as requiring additional support that will enable them to remain independent at home, or to return home more rapidly following a hospital admission. The interventions may include: A 'safe and well' phone call. A 'follow-up visit' within 1 working day. Help with shopping. Signposting and referring to other agencies for specialist support. The main focus of the service is on supporting people to remain at home (preventing unnecessary hospital admissions by increasing intensive support at home). The commissioning responsibility for the British Red Cross services has transferred from the ICB to the local authority.	£724,364
12	BCF Combined Reablement service The current service has three specialist elements delivered across two teams (North and South): 1. Community Support Reablement (CQC-registered) - provides a time-limited intervention supporting adults with physical, mental health, learning disabilities, dementia and frailty, from the age of 18 to end of life, offering personal care and daily living skills to achieve maximum independence, or to complete an assessment of ongoing needs. 2. Dementia Reablement - provides up to 12-weeks of personalised, post-diagnostic support for people living with dementia and their carers. The service is focused on prevention and early intervention following a diagnosis of dementia. 3. Mental Health Reablement - supports adults age 18 and over with a range of mental health issues and associated physical health and social care needs, focusing on coping strategies, self-help, promoting social inclusion and goal-orientated plans.	£4,842,724
13	BCF Safeguarding Adults Board (SAB) The overarching objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who: have needs for care and support (whether or not the local authority is meeting any of those needs) and; are experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect.	£447,723
14	BCF Carers hub The Cheshire East Carers Hub provides a single point of access for carers, families and professionals. The Hub ensures that carers have access to information, advice and a wide range of support services to help them continue in their caring role and to reduce the impact of caring on their own health and wellbeing. Carers can registered directly with the Hub or referrals can be made by professionals, any agency or organisation, relatives or friends. The Hub offers groups and activities which carers will be familiar with along with introducing new support opportunities co-produced with local carers. Through the period of 2022/23 the carers service is being recommissioned as part of the developments a carers apprentice has been recruited to support the work being carried out.	£307,415
15	BCF Programme management and infrastructure	£538,924

	The delivery of the Better Care Fund relies on joint commissioning plans already developed across the health and social care economy. The scheme covers the following: Programme management, Governance and finance support to develop s75 agreements; cost schemes and cost benefit analysis, Financial support, and amongst other things additional commissioning capacity might be required to support the review of existing contract and schemes and the procurement of alternative services.	
16	BCF Winter schemes ICB The proposed schemes specifically support the achievement and maintenance of the four-hour access standard, admission avoidance, care closer to home and a continued compliance with the DTOC standard. Schemes cover: discharge to assess, British Red Cross transport, non-emergency transport, additional acute escalation ward and additional ED staffing amongst others. Each of the partners will be developing winter plans which will then form part of a place-based plan.	£557,673
17	BCF Homefirst schemes ICB They are evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed. The Home First schemes mainly support older people living with frailty and complex needs to remain independent, or to regain their independence following deterioration in their medical, social, functional or cognitive needs.	£20,091,176
18	BCF Trusted assessor service Delays are caused in the hospital by service users/patients waiting for nursing & residential homes to assess their needs. This scheme deploys a trusted assessor model by commissioning an external organisation to employ Independent Transfer of Care Co-ordinator's (IToCC's) to reduce hospital delays. The trusted assessment model is a key element of the eight High Impact Changes in order to support the timely transfer of patients to the most appropriate care setting and to effect a reduction in the number of delayed transfers of care. The model is being supported nationally by the emergency Care Improvement Programme. Through the period 2022/23 the trusted assessor service is being recommissioned with the aim that the new provider is in place for 1st January 2022.	£99,146
19	BCF Carers hub The Cheshire East Carers Hub provides a single point of access for carers, families and professionals. The Hub ensures that carers have access to information, advice and a wide range of support services to help them continue in their caring role and to reduce the impact of caring on their own health and wellbeing. Carers can registered directly with the Hub or referrals can be made by professionals, any agency or organisation, relatives or friends. The Hub offers groups and activities which carers will be familiar with along with introducing new support opportunities co-produced with local carers. Through the period of 2022/23 the carers service is being recommissioned as part of the developments a carers apprentice has been recruited to support the work being carried out.	£250,258
20	BCF Community Equipment service	£620,225

Appendix two – Individual scheme performance

ID	Scheme Name
1	iBCF Block booked beds

Care Home	No. of Beds	Total Nights Used	Total Commissioned Nights	Cost Per Commissioned Night	Cost Per Night Utilised	%
Bentley Manor	1 (res dem)	105	189	£117.57	£211.63	56
Brookfield House	8 (2 res dem, 6 res)	1196	2443	£105.83	£216.17	49
Corbrook Park	3 (res/nurs)	608	938	£172.86	£266.68	65
Cypress Court	3 (res)	699	938	£103.72	£139.18	75
Elm House	4 (res)	599	1239	£104.55	£216.25	48
Leycester House	5 (res)	1017	1540	£105.06	£159.08	66
Mayfield House	1 (res dem)	207	336	£106.68	£173.17	62
The Elms	3 (res)	610	938	£103.72	£159.48	65
Turnpike Court	4 (2 res, 2 res dem)	774	1239	£104.55	£167.36	62
Twyford House	5 (res/res dem)	859	1540	£168.09	£301.35	56
Total/Average	36	6674	10871	£124.46	£202.73	60

2	iBCF Care at home hospital retainer

Average number of days the retainer was deployed for	**10.02**
Minimum period the retainer was deployed for	2 days
Maximum period the retainer was deployed for	67 days
Total number of days the retainer was deployed for	361
Number of instances where the retainer was deployed	36

Reason For Retainer:	
Best Interest Meeting	2
Care Planning Meeting	1
Covid Positive	2
Discharge Planning	15
Due to medically fit next week	10
House Clean or Building Work ongoing at home	2
Increase in POC and awaiting MFFD.	1
Med fit awaiting transport to be arranged	1
Not Medically Fit- Awaiting Further Assessment	5
Retainer Authorised to facilitate discharge	4
Safeguarding Investigation	1

3	iBCF Rapid response

	Total hours contracted and people supported Month / Block hours / Number of people supported Jan 903.25 20 Feb 1,159 33 Mar 1,292.25 42 Apr 1,227.50 35 May 967.5 33 Jun 1197.75 37 Jul 1,194.50 36 Aug 1,130 36 Sep 1,118.25 36 Oct 905.5 31 Nov 700.25 25 Dec 779.75 34 Total 12575.5 398
4	iBCF social work support Social Work staff supporting approximately 650 cases collectively in addition to duty actions/ safeguarding tasks. This covers a number of settings which includes: Station house, Stepping Hill, Leighton Hospital, Macclesfield Hospital. The scheme also provided additional capacity at Macclesfield and Leighton hospital over the course of the weekend. Combined Short Term Services East and South supported: 1429 new contacts 1090 referrals were progressed 358 support plan reviews took place 91 reablement reviews took place 83 new safeguarding referrals were received 70 S.42 inquiries were completed Agency staff directly supported: 720 new allocations 292 assessments completed 308 support plans 106 STP's (Short Term plans)
5	iBCF 'Winter Schemes

Programme	SRO
Hospital support scheme family and friends to enable family and friends to provid informal care and payment for up to 6 weeks	Operational
Community Connectors positioned in the two Transfer of Care Hubs promoting Community Voluntary Sector services	Operational
Personal Health Budgets to support Rapid Hospital Discharge	Operational
Capacity for Pathway 1– 36 System resilience beds	Operational
Capacity for Pathway 2– 39 block beds are funded via the ICB up to 31st March 2023	Operational
November – January 2023	
C/o locate Care4CE Mobile Nights service and East Cheshire Trust Out of Hour District Nursing Teams thus increasing overnight care, support and resilience	November 2022
Help Force volunteer Programme	November 2022
Nursing Dementia beds x 6	November 2022
ED In reach support for Mental Health patients	November 2022
Additional 200 hours per week, Rapid Response Care linked to East Cheshire Frailty team. November to March 2023	Nov / Dec 2022
Complex Dementia 18 Step up/step down beds	Nov / Dec 2022
Supported Living– Mental Health step down self contained apartments x 6	December 2022
Housing pathway agreed for rough sleepers	December 2022
Increase of the General Nursing Assistant service capacity UNCLASSIFIED	Dec / Jan 2022

Winter Schemes	Budget Allocation
Proposed Additional Discharge Capacity	
ED Mental Health In reach Support Workers	£45,000
Approved Mental Health Practitioners Cover, Evenings & Weekends	£60,000
Mental Health Reablement Support Workers x 4	£100,000
Hospital discharge CoOrdinator's x 4	£110,000
Transfer of Care Hub, Nurses and Social Workers to support weekend discharges	£80,000
Increase General Nursing Assistant Capacity via CCICP	£250,000
Health Care Assistances x 2 linked to the Home First Occupation Therapy Model	£48,000
Personal Health Budgets	£15,000
Carers Payments to facilitate rapid discharge	£15,000
Assistive Technology & Gantry Hoists to reduce double handling care packages	£50,000
Hospice at Home Support and bed base capacity	£85,000
8 Care Communities supporting priorities and Winter	£160,000
Extra Care Housing– step down assessment flats	£40,000
Contingency budget for market restructuring and transport fuel cost support for domiciliary care Staff	£80,000
Total Investment	**£1,138,000**

6 iBCF Enhanced Care Sourcing Team (8am-8pm)

Referral type	Number of Referrals	Hours
Care at Home - Hospital	524	8194.75
Care at Home - Community	405	4627
Rapid Response	113	1103.75
Hospital Home First	377	4476.25
Hand Back	125	1263
Care at Home - Total	1544	19664.75
Accommodation with Care - Hospital	633	
Accommodation with Care - Community	1149	
Pathway 3	437	
Carer Respite - Block Booked Beds	358	
Carer Respite - Spot Purchase	80	
Accommodation with Care - Total	2657	
Complex Care - Hospital	42	
Complex Care - Community	235	
Day Opportunities (started 05/08/2022)	21	
Complex Care - Total	298	
Total	4499	19664.75

7 iBCF General Nursing Assistant

April 2022 - Dec 2022

- 96 referrals were received - 89 service users accessed the service
- Source of referrals – Hospital, NWAS, GP, Care Community
- 3339 Visits were made & 1743 clinical hours of care were delivered

Row Labels	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	Grand Total
Double										
Visits	10	23	20	14	38	94	40	7	37	283
Visit Total Hours	5.0	11.5	10.0	7.8	21.0	49.5	20.0	4.0	26.5	155.3
Single										
Visits	100	98	189	353	644	504	384	456	327	3055
Visit Total Hours	50.0	50.5	97.8	188.8	345.3	262.5	199.0	229.5	164.0	1587.2
Triple										
Visits						1				1
Visit Total Hours						0.7				0.7
Total Visits	110	121	209	367	682	599	424	463	364	3339
Total Visit Total Hours	55.0	62.0	107.8	196.5	366.3	312.8	219.0	233.5	190.5	1743.2

8 iBCF Improved access to and sustainability of the local Care Market

What BCF funds

- Contribution to costs of Care at Home and Accommodation with Care services through fee uplifts and rural enhancements

Care at Home 22/23

- 17% more people in CAH
- 76% reduction in number of service users on waiting list (based on snapshots)
- 81% reduction in number of hours on waiting list (based on snapshots)
- Currently 52 people in rural F1 postcodes supported by rural enhancement

Accommodation with Care 22/23

- 21% reduction in number of people in short term beds
- 20% reduction in people waiting for long term beds (based on snapshots)

9 BCF Disabled Facilities Grant

- The number of grants awarded to disabled people has increased in 2022-23, with 374 new grants approved (compared to 313 in 2021-22).
- The number of grants be completed in 2022-23 was 438 (compared to 298 in 2021-22). Last year we reported a major issue with the failure of the level access shower contract; the performance of the new contractor from April 2022 has enabled us to improve performance and complete more grants. There is still considerable work to do, particularly around bedroom and bathroom extensions, as we are experiencing major issues with our Domestic Build Works Framework, where contractors on the framework have insufficient capacity to meet our demand.
- The average grant awarded to date in 2022-23 is £4,888, compared to £5,558 in 2021-22. This contrasts with inflation, but will be a reflection of the smaller, lower cost adaptations that have been recommended by OTs as part of the enhanced scrutiny of referrals.
- 22.2% of referrals have led to cancellation. There has been a sharp increase in grants being declined by the applicant; reasons cited can be summarised as changing their mind about having works done, refusing the financial assessment, or disengaging from the process without giving a reason.

10 BCF Assistive technology

- The Assistive Technology service (also known as Technology Enabled Care) was recommissioned,

and a new provider Millbrook Healthcare commenced delivering this service from 1st July 2022. The previous provider was Careium (formerly known as Welbeing) delivered the service since December 2018.

- Following the transfer of data from the previous provider in June the total number of service users noticeably reduced from approx. 3600 down to 2612 in July based on data provided by Millbrook. We believe this was due to Careium private clients also being included in our activity data.
- At the end of December 2022, the total number of AT users was approx. 2400.
- During the mobilisation of the service a 4-week free period for hospital discharges was introduced where NHS staff could refer into the provider to support urgent discharges.
- Referrals have been received from the following hospitals, where a Lifeline, Pendant and Key Safe (if required) have been provided to the patients:
- Macclesfield District General Hospital & Leighton Hospital – Majority of the referrals.
- Knutsford District and Community Hospital & Congleton War Memorial Hospital – Also referred.
- Total Hospital referrals have increase month on month from 15 to 30 – With 130 referrals July-Dec.
- There are currently approx. 65 difference LA staff that refer into the service each month.
- From July-Dec there has been approx. 670 installations completed
- Most of the equipment issued out by the provider has been Digital Lifeline Units, Pendants, Vibby Falls Detectors and Key Safes. Other equipment includes sensors and smoke/CO2 detectors.
- Future pilot planned in 2023 include the issuing of equipment (Ownfone) through peripheral stores in hospitals to the Urgent Community Response teams in preventing hospital admissions and supporting discharges out of normal hours ie up to 8pm in the evenings and weekends.

11 BCF British Red Cross

Assisted Discharge Service:

Description	Target per quarter	April to June 2022	July to September 2022	October to December 2022
Number of referrals	240	215	226	182
Number of referrals accepted		202	219	176
% of referrals accepted	90%	94%(avg)	96.69% (avg)	96.33% (avg)
Referral source:	%			
Macclesfield Hospital		89.3%	91.15%	98.35%
CEC Adult Social Care		3.26%	0.90%	1.1%
Congleton War Memorial Hospital		0.47%	0.45%	
Lawton House		0.47%		
No data		6.5%	7.5%	0.55%

Support at Home:

Description	Target per quarter	April to June 2022	July to September 2022	October to December 2022
Number of referrals	150	166	165	155
Number of referrals accepted		163	151	147
% of referrals accepted	90%	98% (avg)	91.67% (avg)	95.67% (avg)
Referral source:	%			
BRC charity		33.3%	4,6%	7.1%
Self referral		27.2%	37.7%	30.3%
Hospital Ward		21.1%	32.5%	45.8%
Internal referral		9.4%	6.6%	
Family/friend		2.8%	7.9%	5.8%
CEC Adult Social Care		2.8%	2%	1.9%
Hospital A&E		1.4%	0.8%	1.4%
Other / GP		2%	7.9%	7.7%

12 BCF Combined Reablement service

Community Reablement Summary

Number of packages delivered - *Referrals in the month relates to Liquidlogic Action Plans and Portal Referrals, these may not be accepted therefore the number will be higher than closed Reablement Plans*

	April	May	June	July	August	September	October	November	December	January	February	March	YTD Total
No. Referrals in the month	186	175	142	133	116	127	123	145	119				1266
Completed Reablement Plans	69	79	103	105	105	98	153	171	135				1018

Mental Health Reablement Summary

Number of packages delivered

	April	May	June	July	August	September	October	November	December	January	February	March	YTD Total
No. Referrals in the month	203	252	197	242	265	219	251	270	193				2092
No. Closed in the month	178	240	206	202	198	213	245	246	180				1908

Dementia Reablement Summary

Number of packages delivered

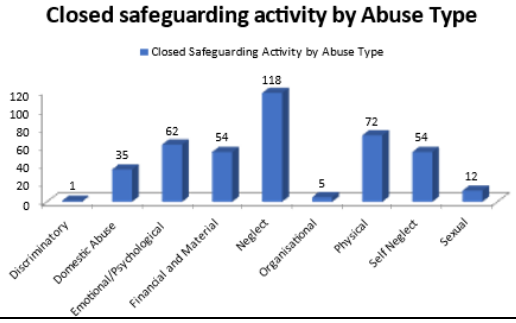
	April	May	June	July	August	September	October	November	December	January	February	March	YTD Total
No. Referrals in the month	111	85	75	74	81	62	75	73	83				719
No. Closed in the month	64	57	53	52	66	56	57	26	82				513

13 BCF Safeguarding Adults Board (SAB)

Closed safeguarding activity by Abuse Type

The chart below shows all safeguarding activity (safeguarding concerns and enquiries) concluding in December 2022.

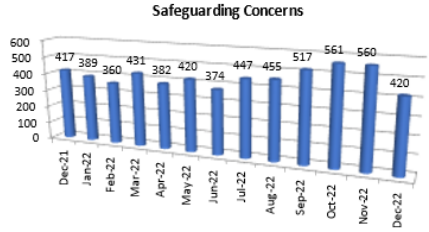
Neglect and Acts of Omission accounts for the greatest proportion with 29%; followed by Physicalabuse with 17% and Emotional abuse with 15%.



Number of new safeguarding concerns

A safeguarding concern is either a contact where safeguarding issues have been identified, or a contact that has been recorded as a safeguarding adults concern. The total number of safeguarding concerns received during December 2022 was 420.

This represents an increase of 3 concerns (1%) compared with December 2021 and 22 concerns less than the average of the last 12 month period (442).



14 BCF Carers hub

- 7183 adult carers & 786 young carers registered with the Hub
- 1039 adult & 141 young carer referrals received
- 693 adult & 101 young carers assessments
- Source of referrals– self referrals are biggest source of referrals, followed by Cheshire East adult social care and then health including GPs.
- Number and type of intervention delivered
  - Low – 3% Moderate – 94% Intensive – 3%
- Outcome following service:
  - 56% of adult carers felt they had improved quality of life, 99% had improved physical health, 100% had improved emotional wellbeing, 100% had increased choice, control & independence.
  - 84% of young carers have an improved positive outlook, 67% had improved relationships, 79% had improved self esteem, 81% had improved resilience
- 2392 adult & 147 young carers provided with a break
- 302 adult carers reporting that service has prevented a carer break down or prevented them / cared from needing residential care

15 BCF Programme management and infrastructure

- Adult Social Care Discharge Fund
  - National submission of plan
  - Implementation, 30 schemes, £3,754,168.
  - Monitoring and tracking of scheme performance
- Better Care fund
  - National submission of plan
  - Implementation and ongoing business as usual for 20 schemes, £39,145,856
- Adult social care winter schemes
  - Submission of plan
  - Implementation, 23 schemes at no cost
  - Monitoring and tracking of scheme performance
- Place development
  - Maturity matrix

- S75 development
- Mapping of governance
- Supporting new enabler workstreams

Reports

- Adult social care winter plan
- BCF end of year 2022/23
- BCF plan 2023/24
- Crewe winter proposals
- Expansion of s75 agreement
- BCF beds paper
- Adult social care discharge evaluation paper

16 BCF Winter schemes CCG

Programme	SRO
Hospital support scheme family and friends to enable family and friends to provid informal care and payment for up to 6 weeks	Operational
Community Connectors positioned in the two Transfer of Care Hubs promoting Community Voluntary Sector services	Operational
Personal Health Budgets to support Rapid Hospital Discharge	Operational
Capacity for Pathway 1– 36 System resilience beds	Operational
Capacity for Pathway 2– 39 block beds are funded via the ICB up to 31st March 2023	Operational
November – January 2023	
C/o locate Care4CE Mobile Nights service and East Cheshire Trust Out of Hour District Nursing Teams thus increasing overnight care, support and resilience	November 2022
Help Force volunteer Programme	November 2022
Nursing Dementia beds x 6	November 2022
ED In reach support for Mental Health patients	November 2022
Additional 200 hours per week, Rapid Response Care linked to East Cheshire Frailty team. November to March 2023	Nov / Dec 2022
Complex Dementia 18 Step up/step down beds	Nov / Dec 2022
Supported Living– Mental Health step down self contained apartments x 6	December 2022
Housing pathway agreed for rough sleepers	December 2022
Increase of the General Nursing Assistant service capacity UNCLASSIFIED	Dec / Jan 2022

Winter Schemes	Budget Allocation
Proposed Additional Discharge Capacity	
ED Mental Health In reach Support Workers	£45,000
Approved Mental Health Practitioners Cover, Evenings & Weekends	£60,000
Mental Health Reablement Support Workers x 4	£100,000
Hospital discharge CoOrdinator's x 4	£110,000
Transfer of Care Hub, Nurses and Social Workers to support weekend discharges	£80,000
Increase General Nursing Assistant Capacity via CCICP	£250,000
Health Care Assistances x 2 linked to the Home First Occupation Therapy Model	£48,000
Personal Health Budgets	£15,000
Carers Payments to facilitate rapid discharge	£15,000
Assistive Technology & Gantry Hoists to reduce double handling care packages	£50,000
Hospice at Home Support and bed base capacity	£85,000
8 Care Communities supporting priorities and Winter	£160,000
Extra Care Housing– step down assessment flats	£40,000
Contingency budget for market restructuring and transport fuel cost support for domiciliary care Staff	£80,000
Total Investment	**£1,138,000**

17 BCF Homefirst schemes CCG

Community Support Connectors – Transfer of Care Hub (TOCH) The Community Support Connectors have been deployed to Macclesfield and Leighton Hospitals to operate and support within the Transfer of Care Hub. The Connectors support has proved to be an essential and integral part of the TOCH.

Primary Care Developments

Access

- Increase access through Enhanced Access and Winter pressures Funding.
- Rollout of APEX – Access, Capacity and Demand reports

- Development of a winter pressures alert system (OPEL) for General Practice (Due April 23)

Acute Respiratory Hubs
- Mobilised in Alsager and Knutsford

GP Confederation
- Development of a GP Confederation to provide coordinated representation & Engagement of General Practice at Place and in the wider system, as well as shaping the future sustainable delivery model of General Practice

Mental Health
- Crewe Winter Pressures Funding (highlight report available upon request)

Everybody Support and Recreation (ESAR) Falls Prevention
- Less NWAS Call outs
- Lower impact to A&E and primary Care

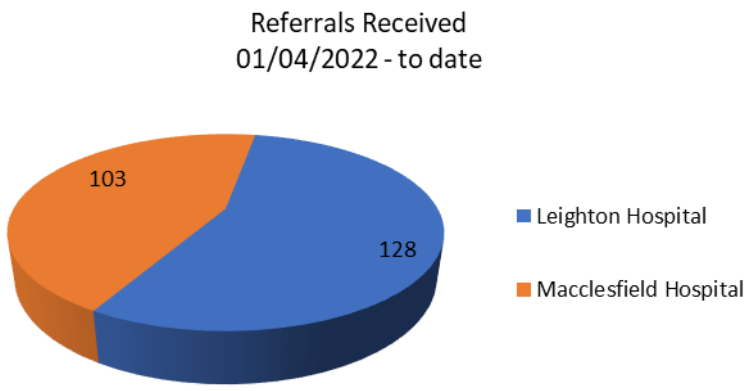
Asylum Seeker Outreach
- Ease pressures at A&E through reduced attendance. Asylum seekers attending practices as opposed to A&E
- Self Care pack translations can be used/adapted to target other non-English speaking patients/other projects

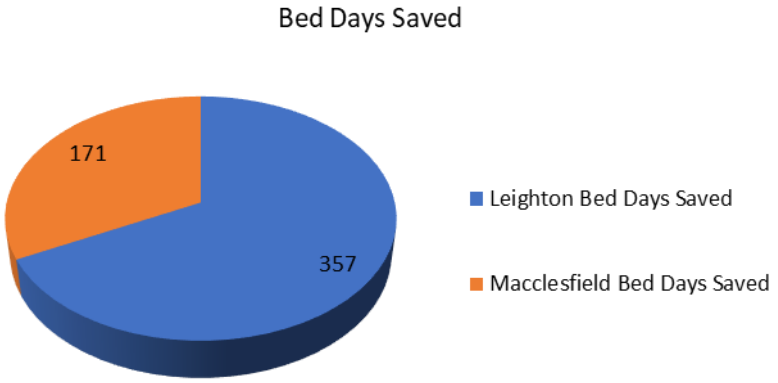
Mental Health Developments – Crisis Cafes: 2 Mental Health Crisis Cafes went live in March 2021 - They are the Crewecial Café in Crewe and Weston Hub in Macclesfield.

Mental Health Developments – Community Crisis Beds: 4 Mental Health Crisis Beds across Cheshire East. Occupancy across the beds is currently high ranging from 67-88% over the last 3 months, with a total of 283 bed days utilised

Care at Home:
- Overseas recruitment has given 1,100 extra hours capacity per week
- Increased care package hospital retainer to 21 days
- Rapid Reablement response service to support Mental Health patients –
- 80 hours per week
- Care at Home financial investment to support hospital discharge
- Carers Payments to facilitate rapid discharge
- Investment of £250,000 into the General Nursing Assistant via Central Cheshire Integrated Care Partnership.
- Increase in Rapid Response care and positioned at the hospital front door – East Cheshire Trust
- Virtual ward domiciliary care growth will be explored in the following way:
    - Combined Cheshire East Council Community Reablement team and General Nursing Assistant service via CCICP
    - Increased external capacity via Routes Healthcare

18 BCF Trusted assessor service





19 BCF Carers hub

A performance update – insight into performance metrics

- 7183 adult carers & 786 young carers registered with the Hub
- 1583 adult & 189 young carer referrals received
- 871 adult & 126 young carers assessments
- Source of referrals– self referrals are biggest source of referrals, followed by Cheshire East adult social care and then health including GPs, including the hospital discharge scheme for carers
- Number and type of intervention delivered
  - Low – 3% Moderate– 94% Intensive- 3%
- Outcome following service:
  - 56% of adult carers felt they had improved quality of life, 99% had improved physical health, 100% had improved emotional wellbeing, 100% had increased choice, control & independence.
  - 84% of young carers have an improved positive outlook, 67% had improved relationships, 79% had improved self esteem, 81% had improved resilience
- 2630 adult & 178 young carers provided with a break. 183 YC supported by Cheshire Young Carers through Living Well Funding.
- 302 adult carers reporting that service has prevented a carer break down or prevented them / cared for from needing residential care

20 BCF Community Equipment service

	Dec-22			Nov-22			Oct-22			Sep-22			Aug-22			Jul-22			Jun-22			May-22			Apr-22		
Description																											
Deliveries within 5 Days (standard), as indicated, on receipt of the Requisition.	381	380	99.7%	432	427	98.8%	415	410	98.8%	440	437	99.3%	414	412	99.5%	399	394	98.7%	413	409	99.0%	394	388	98.5%	390	386	99.0%
Deliveries within 1 Day (urgent), as indicated, on receipt of the Requisition.	232	232	100.0%	212	209	98.6%	196	195	99.5%	216	214	99.1%	221	221	100.0%	186	184	98.9%	161	160	99.4%	201	199	99.0%	172	172	100.0%
Deliveries within Same Day (4 hours) (Critical), as indicated, on receipt of the Requisition.	103	96	93.2%	94	93	98.9%	107	107	100.0%	126	126	100.0%	101	100	99.0%	108	108	100.0%	108	108	100.0%	99	99	100.0%	77	76	98.7%
A minimised number of multiple deliveries - % of service users receiving more than one delivery per order	941	5	0.5%	1015	5	0.5%	992	6	0.6%	1050	9	0.9%	1016	8	0.8%	944	10	1.1%	942	8	0.8%	973	7	0.7%	867	9	1.0%
Special items to be ordered within 5 Days of receipt of Requisition, unless instructed otherwise.	67	67	100.0%	55	55	100.0%	56	56	100.0%	49	49	100.0%	70	70	100.0%	84	84	100.0%	58	58	100.0%	57	57	100.0%	45	45	100.0%
Items collected within 5 Days (standard) of request as indicated, on receipt of the Requisition.	335	335	100.0%	372	372	100.0%	452	449	99.3%	386	380	98.4%	405	402	99.3%	409	402	98.3%	419	415	99.0%	440	435	98.9%	371	365	98.4%
Items collected within 1 Day (urgent), as indicated, on receipt of the Requisition.	25	24	96.0%	15	15	100.0%	33	33	100.0%	29	29	100.0%	34	34	100.0%	20	19	95.0%	25	24	96.0%	24	24	100.0%	24	24	100.0%
Community Equipment recycled (% of total items collected) TO BE DEFINED	795	589	74.1%	1,341	860	64.1%	1,362	942	69.2%	1,355	998	73.7%	1,098	780	71.0%	1,324	958	72.4%	1,325	980	74.0%	1,332	1,021	76.7%	1,040	783	75.3%
All routine repairs shall be completed within 5 Days	67	61	91.0%	90	88	97.8%	70	70	100.0%	69	69	100.0%	89	87	97.8%	95	95	100.0%	79	78	98.7%	82	82	100.0%	84	83	98.8%

Appendix three – Adult Social Care Discharge Fund schemes

	Scheme name	Budget allocation
1	1. Assistive Technology & Gantry Hoists to reduce double handling care packages	50,000
2	2. Emergency Housing accommodation for prevention and discharge (for homeless people)	10,000
3	4. Housing Grant to support overseas staff recruitment for existing commissioned providers	40,000
4	5. Winter Access Fund for Primary Care	250,000
5	6. Contingency budget for market restructuring and transport - fuel cost support for care at home providers	80,000
6	7. Acute Visiting Service & GP out of hours	120,000
7	8. Hot Hub escalation expansion for non-elective and Paediatrics	60,000
8	9. Hospice Beds (East Cheshire Hospice & St Lukes Hospice).	85,000
9	11. Personal Health Budgets to support discharges	15,000
10	12. Carers Payments to facilitate rapid discharge	15,000
11	13. St Pauls Hospital Discharge Support delivered via Community Voluntary Sector	30,000
12	14. Hospital Discharge Premium Payment & Prevention Scheme	180,000
13	15. Additional hospital transport for discharges for evenings & weekends	40,000
14	16. Additional Acute Pharmacy capacity to support hospital flow	70,000
15	18. Acute Trust Discharge support for ECT & MCHFT	300,000
16	19. Increase General Nursing Assistant Capacity care at home via CCICP	250,000
17	20. Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital	80,000
18	21. Approved Mental Health Practitioners Cover, evenings & weekends for ECT and MCHFT	60,000
19	22. Mental Health step down supported living flats (4) 1st Enable in Crewe	115,140
20	23. Mental Health Reablement – Rapid Response Service	12,500
21	24. Challenging behaviour training for Care Homes	5,000
22	27. ED Mental Health In reach specialist Support Workers to support people awaiting discharge	45,000
23	28. Short stay beds to support discharges	1,000,000
24	29. Care robots to free capacity in the care home market	80,000
25	31. £40k to support the Feebris proposal in team CHAW	40,000
26	32. £2k to BDP which will provide transport	2,000
27	33. £70K to provide GP support to Wilmslow Manor	75,000
28	34. PCN Community Pharmacy Link	2,100
29	37. Routes rapid response	476,067
30	38. Carers support in hospital	166,361
	Total spend	3,754,168

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CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund Plan 2023/24
Date of meeting:	27th June 2023
Written by:	Alex Jones
Contact details:	Alex.T.Jones@Cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Helen Charlesworth-May, Executive Director – Adults, Health and Integration

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision ☐
Why is the report being brought to the board?	This report describes the areas of activity and the proposed expenditure for the Better Care Fund covering Cheshire in 2023/24. It identifies a number of schemes and presents the rationale of how they meet the needs and demands of the local care and health economy in Cheshire East.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☐ Improving the mental health and wellbeing of people living and working in Cheshire East ☐ Enable more people to live well for longer x All of the above ☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above x		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The Health and Wellbeing Board (HWB) is asked to endorse the schemes and plan for 2023/24.		
Has the report been considered at any other committee meeting of the Council/meeting of the ICB board/stakeholders?	The following report has separately been distributed to the Better Care Fund Governance Group.		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	No
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	N/A

1 Report Summary

1.1 That Health and Wellbeing Board endorses the BCF schemes and associated expenditure which is outlined in this plan.

2 Recommendations

2.1 That the Health and Wellbeing Board notes and endorses the Better Care Fund plan for 2023/24 which includes: vision for adult social care, priorities for 2023/24, governance changes, schemes for 2023/24, metric performance, income and expenditure.

3 Reasons for Recommendations

3.1 This report forms part of the monitoring arrangements for the Better Care Fund.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 This report supports the Health and Wellbeing Priority of Ageing Well.

5 Background and Options

5.1 The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group allocations, the Disabled Facilities Grant and the iBCF. Since 2015, the Government's aims around integrating health, social care and housing, through the Better Care Fund (BCF), have played a key role in the journey towards person-centred integrated care. This is because these aims have provided a context in which the NHS and local authorities work together, as equal partners, with shared objectives.

5.2 Local BCF plans are subject to national conditions and guidance. Local plans are monitored through NHS England and there are strict timelines regarding submission of plans for both regional and national assurance of plans to take place.

5.3 **Vision for adult social care**

5.4 Recently the government published the policy paper entitled 'People at the Heart of Care: adult social care reform white paper'. The white paper sets out a 10-year vision for adult social care and provides information on funded proposals that we will implement over the next 3 years.

5.5 The white paper has a particular focus on 3 key objectives: 1.How we will support people to have choice, control and independence. 2.How we will provide an outstanding quality of care. 3.How we will ensure that care is provided in a way that is fair and accessible to everyone who needs it.

5.6 Supporting social care reform there was an announcement made at the Spending Review in October 2021 detailing how £5.4 billion over 3 years would be deployed. £3.6 billion to pay for the cap on care costs, the extension to means test, and support progress towards local authorities paying a fair cost of care, which together will remove unpredictable care costs. £1.7 billion to improve social care in England, including at least £500 million investment in the workforce.

5.7 Some of these monies are in areas which are included within the Better Care Fund, with the Better Care Fund therefore growing over the next 3 years. One such area is more money being made available to support the Disabled Facilities Grant which will enable changes to be made to people's property so they can be discharged from hospital in a timely manner and continue to live independently in the community.

5.8 **Priorities for 2023/24**

5.9 A number of priorities have emerged throughout 2021-22 and into 2022-23:

5.10 Ensuring provider market risk management oversight – the council, ICB and hospital trusts have established a number of tools to appropriately manage the care home and domiciliary care market. These include the use of a quality dashboard, capacity tracker, bed vacancy management. Tangible results from this work to-date have included targeting low quality homes for intervention by deploying district nurses. There are strong relationships between partners to highlight and share system risk information and then to deploy appropriate resources. A narrative care market strategic overview is produced on a regular basis, strategic data is produced, and a live strategic risk register is maintained.

5.11 Increase collaborative commissioning – partners have come together to commission and procure services together and develop market strategy, this includes the carers hub, community equipment and assistive technology services. This collaborative commissioning approach also extends to the production of strategy for example jointly producing a Market Position Statement (MPS) and Live Well for longer strategy. The MPS provides key messages for Providers and summarises the supply and demand in a local authority area. The MPS brings together local information and analysis relating to commercial opportunities within the public health, health, and social care market in that area. The MPS also provides details of the Council's strategic commissioning approach, and how Commissioners and Provider can work together to achieve outcomes for local people.

5.12 Effective contract management - partners have also transferred responsibility for contract management and service delivery where appropriate. For example the sourcing and commissioning of Discharge to Assess, Pathways 1,2 and 3 placements has transferred from CHC nurses to the Cheshire East Borough Council Brokerage function. Further examples include the transfer of the responsibility for commissioning and contracting the British Red Cross services and the ICB's plan to consolidate and reconfigure existing pathway 2 bed-based 'step-down' and 'step-up' provision and create clusters across the Borough (with contract management and oversight by the local authority) to release funds to support alternative provision, to ensure people return directly to their homes thus improving outcomes and enhanced performance of service delivery.

5.13 Increasing out of hospital resource - There has been an increased focus on ensuring greater community resource and step down capacity is in place to assist the system. For example a General

Nursing Assistant service has been commissioned. This service provides an additional 7 GNA staff within the CCICP IPOCH team for a period of 12 months. These additional staff would be utilised across South Cheshire and the Congleton area of East Cheshire to support patients requiring domiciliary care that would normally be delivered by Local authority. Other community resources include; British Red Cross hospital avoidance and step-down services, Rapid response, community and mental health reablement.

5.14 Partners have worked more collaboratively on system planning - for example partners have produced the Cheshire East System Flow Plan for second half of the financial year 2021-22 (H2). It was formerly known as the 'winter plan' but as a system we recognised that capacity and demand fluctuations occur across the year and can be planned for to safely and effectively manage the flow of patients throughout the Health & Social Care system. The system flow plan includes a number of schemes; primary care access, GP's aligned to care homes, community pharmacists, mental health crisis line, weekend escalation policy

5.15 A focus on reducing length of stay - A community LOS report is produced and reviewed with each acute Trust on a weekly basis where we review at our joint governance call each person and there identified exit – move on plan. In terms of hospital oversight for patients who are in hospital for over 14- 21 days a review of their length of stay is completed on a weekly basis with IDT, Bed Managers and the ward sisters to identify exit plans and unblock any obstacles that is preventing a discharge. An action plan is produced following on from the review, the most recent review identified the following actions: Clear communication plan to be rolled out over 4week period, Review current process, Ensure early identification of patients with a LOS 21days +, Escalation time frames to be agreed by all stakeholders, Using data to clearly identify themes, Test new processes/pathways using improvement methodology.

5.16 7 day services - The Cheshire East Better Care Fund intends to implement a 7-day working plan to increase 7 day working across health and social care across the Cheshire Health and Wellbeing footprint. The refreshed national high impact change model notes in relation to seven-day working it can deliver improved flow of people through the system. For the seven-day working approach to be successful the model notes that it should consider the systems demand, capacity and bottlenecks, it should be pragmatic.

5.17 Transfer of care hubs – work is underway in the system to develop transfer of care hubs. A 'Transfer of Care Hub' is a single route for arranging all support for people leaving hospital and should facilitate access to long term support arrangements for those that require it. Agreed functions: The Hub would receive information about individual patients (on a Transfer of Care form) which will include a recommendation for the support required. There will be the option for more detailed MDT conversations where required due to complexity of need or risk. There will be pathways from the Hub to a range of short-term services which will allow the Hub to make the appropriate support arrangements for each individual leaving hospital. The care coordinator for each individual will be agreed at the Hub. The Hub will be supported by an IT system that allows for real time information to be accessed by all partners and to which they can all contribute. There will be pathways from the Hub to a range of long-term services for those assessed as requiring support following the period of assessment.

5.18 Age well – The age well programme is underway with an SRO appointed and project support in place. The draft terms of reference has been produced with identified leads to the attend the ageing well programme board with monthly meetings in place. Crucially in Cheshire East the ICB governing body agreed the Age well programme approach in Cheshire East and agreed that funding could be recurrent to support the intended aims of the project. Key components of the age well programme include the 2 hour response, enhanced health in care homes and anticipatory care. Its been noted

that the anticipatory care framework is due to be published. The current pressures within the system have been noted for example those seen in the domiciliary care market. In respect of the enhanced health in care homes work which has taken place to date has focused on what providers need, what the gaps are, priority areas, what is realistic. Its noted that the individual projects in Cheshire East will be in place by the end of March 2022.

5.19 **Governance changes**

5.20 The Health & Care Act 2021 (currently at the bill stage) sets out reforms with the intention of delivering a more integrated provision for health and social care. The current position is that local authorities cannot have committees or arrangements with NHS bodies, other than in a limited way under S75 NHS Act 2006.

5.21 The new Act will provide a statutory framework for collaboration between NHS providers, local authorities and others, to enable them to form joint committees, pool funds and make joint arrangements for the discharge of functions.

5.22 Until we are able to legally set up a Joint Committee (other than our S75 committee) we will operate as a 'Committee in Common'. This is a committee of two or more organisations who meet for a mutual purpose with a consistent agenda, but where each organisation makes its own decision under its own delegated authority, albeit ideally for the benefit of the overall Place.

5.23 Implementation of the Act has been delayed until 1 July 2022, but we are working to have shadow arrangements in place from April 2022 (the original proposed implementation date). This will take the form of a 'Committee in Common' as well as our S75 Joint Committee with the ICB. Any further integration beyond the existing activities included in the BCF would be subject to the normal Cheshire East Council governance procedures for approval, including whether the existing S75 agreement is widened or whether a new separate additional S75 agreement is created. (this is importance given that the S75 outlines key issues such as risk sharing)

5.24 **Schemes for 2023/24**

5.25 There are 22 schemes in total, of which 20 Schemes are funded through Winter pressures, iBCF and BCF for 2023-24. 2 schemes are funded directly by the local authority and the ICB:

BCF/iBCF 2023/24

Scheme ID	Scheme Name	Source of Funding	Expenditure (£)
1	**Adult Social Care Discharge Schemes from 1.1 to 1.13**		
1.1	ibcf - Increase General Nursing Assistant Capacity care at home via CCICP	iBCF	£125,000
1.2	ibcf - Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital	iBCF	£300,000
1.3	ibcf - Mental Health Reablement – Rapid Response Service	iBCF	£25,000
1.4	ibcf - Assistive Technology & Gantry Hoists to reduce double handling care packages	iBCF	£50,000
1.5	Home First Occupational Therapist	iBCF	£63,000
1.6	ibcf - Carers Payments to facilitate rapid discharge	iBCF	£30,000
1.7	ibcf - St Pauls & Silk Life Hospital Discharge Support delivered via	iBCF	£120,000

	Community Voluntary Sector		
1.8	ibcf - Approved Mental Health Practitioners Cover, evenings & weekends for ECT and MCHFT	iBCF	£60,000
1.9	ibcf - Acute Visiting Service & GP out of hours	iBCF	£120,000
1.10	ibcf - Hospital Discharge Premium Payment & Prevention Scheme	iBCF	£125,000
1.11	Hospice Bed Capacity	iBCF	£90,000
1.12	Care Home Fee increase	iBCF	£1,220,549
1.13	Spot purchase beds and Cluster Model	iBCF	£1,200,000
2	iBCF Block booked beds	iBCF	£1,450,638
3	iBCF Care at home hospital retainer	iBCF	£47,250
4	iBCF Rapid response	iBCF	£613,000
5	iBCF Social work support	iBCF	£478,800
6	iBCF 'Winter Schemes	iBCF	£500,000
7	iBCF Enhanced Care Sourcing Team (8am-8pm)	iBCF	£1,025,592
8	iBCF General Nursing Assistant (within BCF Early Discharge scheme (with BRC)	iBCF	£315,000
9	iBCF Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care)	iBCF	£4,275,590
10	BCF Disabled Facilities Grant	DFG	£2,342,241
11	BCF Assistive technology	Minimum ICB Contribution	£757,000
12	BCF British Red Cross 'Support at Home' service / Early Discharge	Minimum ICB Contribution	£460,582
13	BCF Combined Reablement service	Minimum ICB Contribution	£5,084,860
14	BCF Safeguarding Adults Board (SAB)	Minimum ICB Contribution	£470,109
15	BCF Carers hub	Minimum ICB Contribution	£389,000
16	BCF Programme management and infrastructure	Minimum ICB Contribution	£968,429
17	BCF Winter schemes ICB	Minimum ICB Contribution	£588,903
18	BCF Home First schemes ICB	Minimum ICB Contribution	£19,116,250
19	BCF Trusted assessor service	Minimum ICB Contribution	£104,103
20	BCF Carers hub	Minimum ICB Contribution	£324,000
21	BCF Community Equipment service	LA Contribution ICB Contribution	£550,000 £2,112,086
22	VCFSE Grants	ICB Contribution	£182,860
			£45,684,842

5.26 **Metric performance**

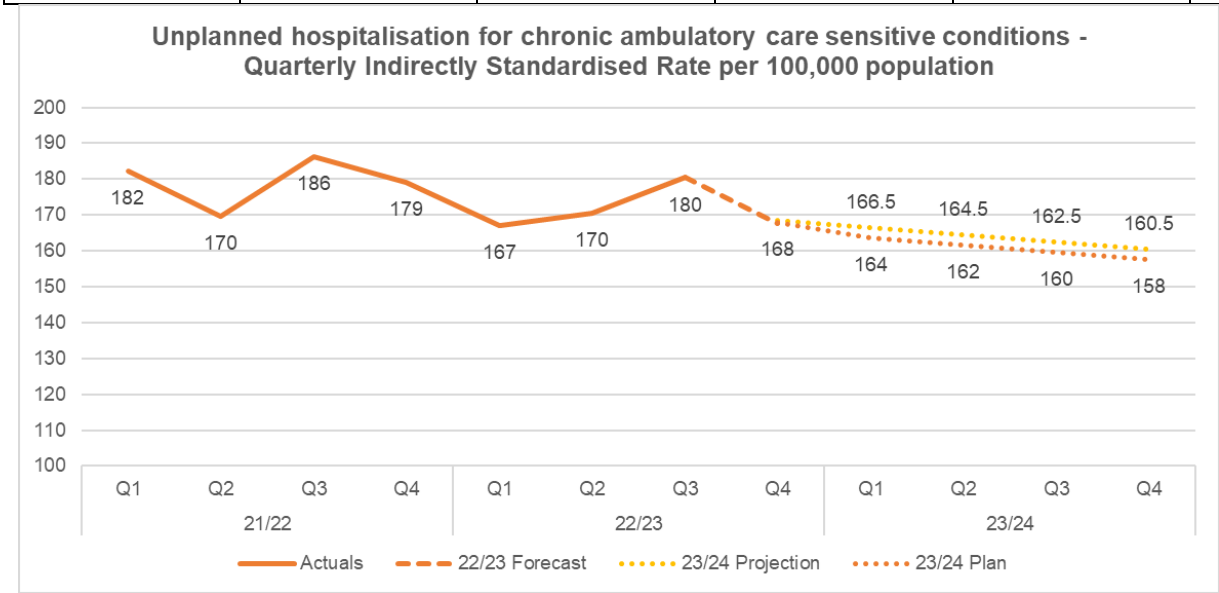
5.27 The table below includes the BCF metrics and expected performance for 2023-24:

Projections are based on historic trend and population projections. Plan figures take into account the projected impact from planned activity in 23/24.

1. Indirectly standardised rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population

	23/24 Qtr 1	23/24 Qtr 2	23/24 Qtr 3	23/24 Qtr 4	Total

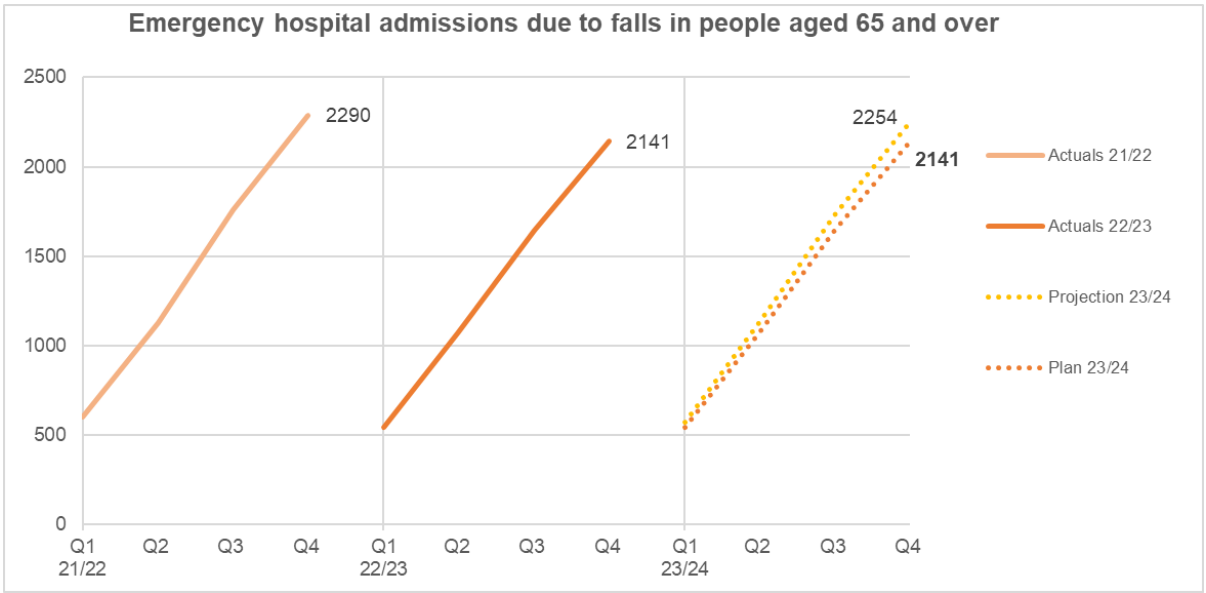
23/24 Projection	166.5	164.5	162.5	160.5	653.9
23/24 Plan	163.6	161.6	159.6	157.6	642.4



2. Emergency hospital admissions due to falls in people aged 65 and over (directly age standardised rate per 100,000 population)

This is a new BCF metric for 23/24.

	23/24 Qtr 1 (cumulative)	23/24 Qtr 2 (cumulative)	23/24 Qtr 3 (cumulative)	23/24 Qtr 4 (cumulative)
23/24 Projection (Falls admissions)	570	1133	1730	2254
23/24 Plan (Falls admissions)	542	1078	1645	2141

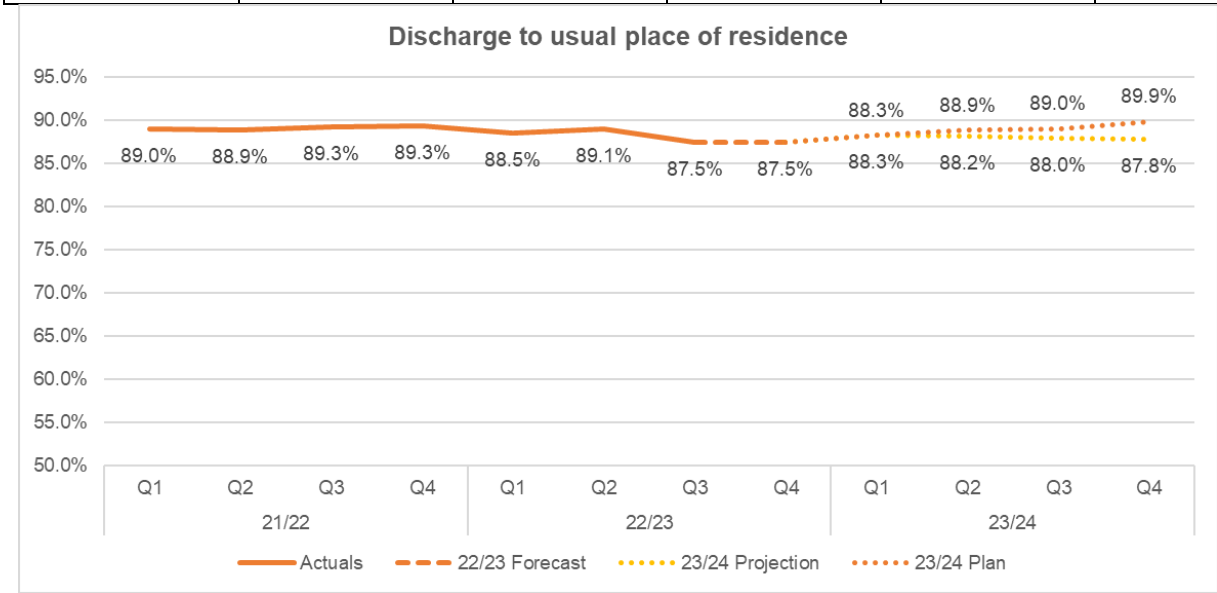


23/24 Projection – Annual directly age standardised rate per 100,000 population: **2,301.6**

23/24 Plan – Annual directly age standardised rate per 100,000 population: **2,188.5**

3. Discharge to usual place of residence

	23/24 Qtr 1	23/24 Qtr 2	23/24 Qtr 3	23/24 Qtr 4	Total
23/24 Projection	88.3%	88.2%	88.0%	87.8%	88.1%
23/24 Plan	88.3%	88.9%	89.0%	89.9%	89.0%

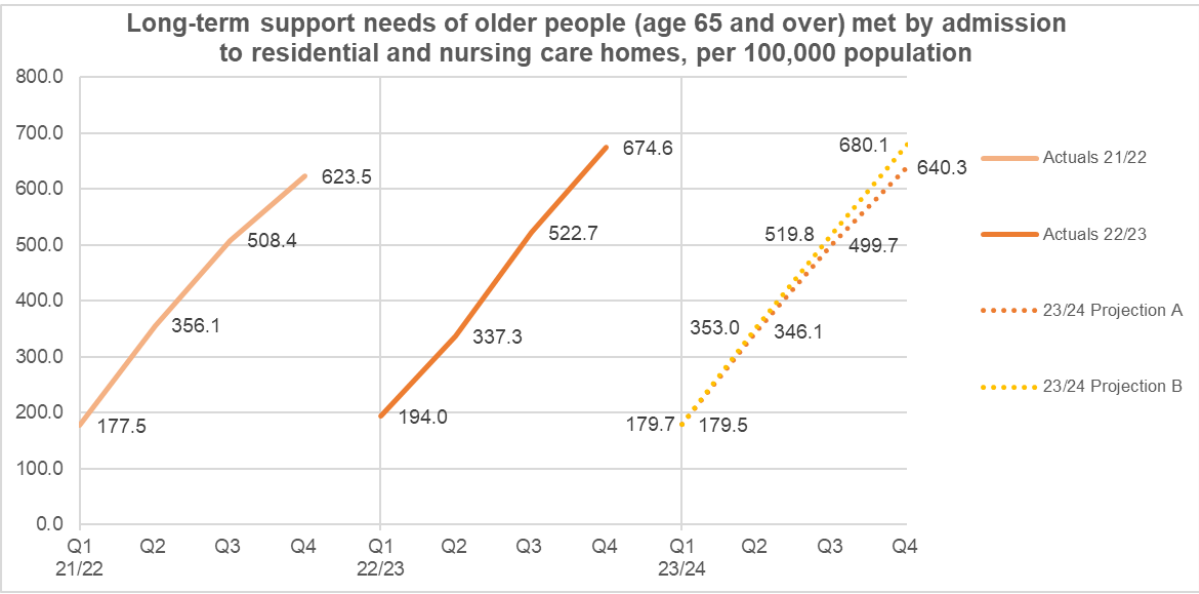


4. Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population

	23/24 Qtr 1	23/24 Qtr 2	23/24 Qtr 3	23/24 Qtr 4
Projection A	179.5	346.1	499.7	640.3
Projection B	179.7	353.0	519.8	680.1

Projection A is based on the trend of both 2021/22 and 2022/23

Projection B is based on the trend of 2022/23



Projection A would equate to 605 permanent admissions in the year

Projection B would equate to 643 permanent admissions in the year

5. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Due to only having complete data for only a small part of 21/22 and 22/23, it is difficult to project forward for 23/24. An equivalent performance to the current estimated year end forecast of 83.9% is suggested. This metric is to be dropped from the Adult Social Care Outcomes Framework (ASCOF) and 2023-24 will be the last year that this data is collected in its current form.

5.28 **Income and Expenditure**

5.29 The following table describes the budget for the Better Care Fund and the anticipated expenditure:

Running Balances	Income	Expenditure
DFG	£2,342,241	£2,342,241
Minimum ICB Contribution	£30,375,322	£30,375,322
iBCF	£8,705,870	£8,705,870
Additional LA Contribution -CES	£550,000	£550,000
Additional LA Contribution – Discharge Funding	£1,220,549	£1,220,549
Additional ICB Contribution – Discharge Funding	£2,308,000	£2,308,000
Additional ICB Contribution – Grants	£182,860	£182,860
Total	**£45,684,842**	**£45,684,842**

	Minimum Required Spend	Planned Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,631,805	£19,758,530
Adult Social Care services spend from the minimum ICB allocations	£8,742,215	£9,141,792

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

Name: Alex Jones
Designation: Better Care Fund Programme Manager
Tel No: 07803846231
Email: Alex.t.jones@cheshireeast.gov.uk

Appendix one – Aim of schemes

Scheme ID	Scheme Name	Brief Description of Scheme	Expenditure (£)
1	Adult Social Care Discharge Fund 1.1 to 1.13	These schemes will support hospital prevention, facilitated discharge and the ongoing implementation of the Home First model of support and transition to the Cluster Model for bed based support A proportion of the funding will provide investment to the Care at Home market to ensure sustainability and ongoing growth.	£2,308,000 plus £1,220,549
2	ibcf Block booked beds	Direct award of short-term contracts for 8 winter pressure beds to support Covid-19 pressures, winter pressures, supporting hospital discharges or preventing admission. The rationale for completing a direct award was as follows: an anticipated second wave of Covid-19, non Covid-19 related elective surgery and procedures which were cancelled/postponed are currently being reinstated in hospitals which will increase demand, residents have avoided accessing primary care services and we anticipate a surge in demand on these beds due to people's conditions deteriorating due to lack of treatment, we are now seeing the demand on A & E services in our hospitals rapidly increasing, Covid-19 is likely to be with us for the foreseeable future, we will need to access these beds to prevent hospital admissions as well as support hospital discharges and Care home providers do not have available capacity and would not be inclined to complete a standard tendering process due to the short term nature of these contracts during normal circumstances. We know the enormous pressures that care homes are under at present due to Covid-19, therefore, there is an even great need to award these contracts via a direct award.	£1,450,638
3	ibcf care at home hospital retainer	Since the implementation of the new Care at Home contract in November 2018 the Council does not pay a retainer fee for the first 7 days for hospital admission or respite; however, the provider is contractually obligated to hold open the care packages for this time. In order to assist with service continuity there may be instances upon agreement from the Contracts Manager where a retainer fee will be paid for up to the following 7 days. (i.e. day 8 to 14). In certain circumstances there may be cases where a Service User is only a few days from being discharged from hospital and so to support a smooth transition a retainer fee may be paid for a nominal number of days. This is only in exceptional cases and needs authorising in partnership with Contracts and Operational Locality Managers.	£47,250
4	ibcf rapid response	The Rapid Response Service will facilitate the safe and effective discharge of service users from hospital who have been declared as medically fit for discharge but who may have still have care needs that can be met in the service users own home. The service will seek to prevent readmission to hospital by ensuring wrap around services are in place in the first 48 hours following hospital discharge. The Service will also provide support to Service Users with complex health needs and end of life support at a level. Through the provision of 7 day working, the service will ensure a timely response to hospital discharge to reduce delayed transfers of care and create capacity and throughput for non-elective admissions.	£613,000
5	ibcf social work support	Social Worker (x1) dedicated to the Discharge to assess beds at Station House, Crewe. Social Care Assistants (x2) additional assessment and	£478,800

		care management capacity to support the revised processes around hospital discharge using reablement exclusively for this purpose (East locality). ibcf Winter Additional Social Care staff to prevent people from being delayed in hospital - Funding of additional staff to support a 'Discharge to assess' model. Funding is continuing to provide a team manager, social worker and occupational therapist. iBCF Social Work Team over Bank Holiday weekends - Increased capacity in the Social Work Team over Bank Holidays and weekends. This is to ensure patient flow and assisting in reducing the pressure on the NHS can be maintained over a seven-day period. Cheshire East will provide 2 social workers and 2 care arrangers (split between the 2 hospitals) that cover the weekends and bank holidays. This support would be 124 days for the weekends and another 8 days for bank holidays giving 132 days each per year.	
6	iBCF 'Winter Schemes	Additional capacity to support the local health and social care system to manage increased demand over the winter period. Evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed.	£500,000
7	iBCF Enhanced Care Sourcing Team (8am-8pm)	The scheme sees the continuation of funding for the Care Sourcing Team following on from a successful pilot; the service provides a consistent approach to applying the brokerage cycle and in turn, makes best use of social worker time. The Care sourcing team undertake all aspects of the Brokerage cycle: enquiry, contact assessment, support planning, creation of support plan, brokering, putting the plan into action as well as monitor and review of the support. The service operates Monday to Sunday. The Care Sourcing Team comprises of a range of employees including team and deputy manager, admin, care sourcing officers as well as a social care assessor. This funding is to enable an 8 till 8 operation. The model is fully compliant with the Care Act 2014 as it provides information and advice, prevention, assessment, review, safeguarding, carers, market management and shaping, charging, support planning, personalisation and arranging care and support.	£1,025,592
8	iBCF General Nursing Assistant	Provide an additional 7 GNA staff within the CCICP IPOCH team for a period of 12 months. An evaluation of effectiveness will be undertaken during this period subsequent to discussion and agreement regarding permanent funding. These additional staff would be utilised across South Cheshire and the Congleton area of East Cheshire to support patients requiring domiciliary care that would normally be delivered by Local authority. It is expected that whilst this proposal will reduce the current pressure it is not expected to eliminate the pressure and further work would be required in order to ensure sufficient and timely access to pathway 1 care.	£315,000
9	iBCF Improved access to and sustainability of the local Care Market (Home Care and	Cheshire East Council has a duty under Section 5 of the Care Act to promote the efficient and effective operation and sustainability of a market in services for meeting the care and support needs of individuals. There are increasing financial pressures on the social care market, for example National Living Wage, recruitment and retention issues, which is resulting in a rise in care costs. This scheme contributes towards the cost of care home and home care fees as well as supporting the delivery of additional care packages within the marketplace.	£4,275,590

	Accommodation with Care)		
10	BCF Disabled Facilities Grant	The Disabled Facilities Grant provides financial contributions, either in full or in part, to enable disabled people to make modifications to their home in order to eliminate disabling environments and continue living independently and/or receive care in the home of their choice. Disabled Facilities Grants are mandatory grants under the Housing Grants, Construction and Regeneration Act 1996 (as amended). The scheme is administered by Cheshire East Council and is delivered across the whole of Cheshire East.	£2,342,241
11	BCF Assistive technology	Assistive technologies are considered as part of the assessment for all adults who are eligible for social care under the Care Act where it provides greater independence, choice and control and is cost-effective for individuals. The provision of assistive technology is personalised to each individual and is integrated within the overall support plan. The scheme will continue to support the existing assistive technology services. The scheme also involves piloting assistive technology support for adults with a learning disability (both living in supported tenancies and living in their own homes).	£757,000
12	BCF British Red Cross 'Support at Home' service	Cheshire East 'Support At Home' Service is a 2-week intensive support service with up to 6 Interventions delivered within a 2-week period for each individual. The aim is to support people who are assessed as 'vulnerable' or 'isolated' and who are at risk of admission to hospital or becoming a delay in hospital. Service users have been identified as requiring additional support that will enable them to remain independent at home, or to return home more rapidly following a hospital admission. The interventions may include: A 'safe and well' phone call. A 'follow-up visit' within 1 working day. Help with shopping. Signposting and referring to other agencies for specialist support. The main focus of the service is on supporting people to remain at home (preventing unnecessary hospital admissions by increasing intensive support at home). The commissioning responsibility for the British Red Cross services has transferred from the ICB to the local authority.	£460,582
13	BCF Combined Reablement service	The current service has three specialist elements delivered across two teams (North and South): 1. Community Support Reablement (CQC-registered) - provides a time-limited intervention supporting adults with physical, mental health, learning disabilities, dementia and frailty, from the age of 18 to end of life, offering personal care and daily living skills to achieve maximum independence, or to complete an assessment of ongoing needs. 2. Dementia Reablement - provides up to 12-weeks of personalised, post-diagnostic support for people living with dementia and their carers. The service is focused on prevention and early intervention following a diagnosis of dementia. 3. Mental Health Reablement - supports adults aged 18 and over with a range of mental health issues and associated physical health and social care needs, focusing on coping strategies, self-help, promoting social inclusion and goal-orientated plans.	£5,084,860
14	BCF Safeguarding Adults Board (SAB)	The overarching objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who: have needs for care and support (whether or not the local authority is meeting any of those needs) and; are experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect.	£470,109

15	BCF Carers hub	The Cheshire East Carers Hub provides a single point of access for carers, families and professionals. The Hub ensures that carers have access to information, advice and a wide range of support services to help them continue in their caring role and to reduce the impact of caring on their own health and wellbeing. Carers can register directly with the Hub or referrals can be made by professionals, any agency or organisation, relatives or friends. The Hub offers groups and activities which carers will be familiar with along with introducing new support opportunities co-produced with local carers. Through the period of 2021/22 the carers service is being recommissioned as part of the developments a carers apprentice has been recruited to support the work being carried out.	£389,000
16	BCF Programme management and infrastructure	The delivery of the Better Care Fund relies on joint commissioning plans already developed across the health and social care economy. The scheme covers the following: Programme management, Governance and finance support to develop s75 agreements; cost schemes and cost benefit analysis, financial support, and amongst other things additional commissioning capacity might be required to support the review of existing contract and schemes and the procurement of alternative services. At this planning stage this project includes any funds yet to be allocated (approx. £500k)	£968,429
17	BCF Winter schemes ICB	The proposed schemes specifically support the achievement and maintenance of the four-hour access standard, admission avoidance, care closer to home and a continued compliance with the DTOC standard. Schemes cover - discharge to assess, British Red Cross transport, non-emergency transport, additional acute escalation ward and additional ED staffing amongst others. Each of the partners will be developing winter plans which will then form part of a place-based plan.	£588,903
18	BCF HomeFirst schemes ICB	They are evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed. The Home First schemes mainly support older people living with frailty and complex needs to remain independent, or to regain their independence following deterioration in their medical, social, functional or cognitive needs.	£19,116,250
19	BCF Trusted assessor service	Delays are caused in the hospital by service users/patients waiting for nursing & residential homes to assess their needs. This scheme deploys a trusted assessor model by commissioning an external organisation to employ Independent Transfer of Care Co-ordinator's (IToCC's) to reduce hospital delays. The trusted assessment model is a key element of the eight High Impact Changes in order to support the timely transfer of patients to the most appropriate care setting and to effect a reduction in the number of delayed transfers of care. The model is being supported nationally by the emergency Care Improvement Programme. Through the period 2021/22 the trusted assessor service is being recommissioned with the aim that the new provider is in place for 1st January 2022.	£104,103
20	BCF Carers hub	The Cheshire East Carers Hub provides a single point of access for carers, families and professionals. The Hub ensures that carers have access to information, advice and a wide range of support services to help them continue in their caring role and to reduce the impact of caring on their own health and wellbeing. Carers can registered directly with the Hub	£324,000

		or referrals can be made by professionals, any agency or organisation, relatives or friends. The Hub offers groups and activities which carers will be familiar with along with introducing new support opportunities co-produced with local carers. Through the period of 2021/22 the carers service is being recommissioned as part of the developments a carers apprentice has been recruited to support the work being carried out.	
21	Community Equipment	The Cheshire Integrated Community Equipment Service (ICES) will provide equipment in discharge of its statutory duties to meet the needs of individuals. This will be delivered by commissioning a single equipment provider. Equipment is provided to adults and children when, by reason of a temporary or permanent disability or health needs, they require the provision of equipment on a temporary or permanent basis for independent living. This includes equipment for rehabilitation, long term care and support for formal and informal carers. It is also vital for hospital discharge, hospital admission avoidance, and nursing need. Equipment is provided to Cheshire East council and Cheshire registered GP population. There are a small proportion of customers who live outside of Cheshire. The population of Cheshire is approximately 727,223 (taken from the mid-2019 ONS Population Estimates)	£2,662,086 (CEC £550,000 and ICB £2,112,086)
22	VCFSE Grants	An integrated Place Based VCFSE Grant process to led by the Council building on exiting good practice and mechanisms within the Council. Aligned to Care Communities in partnership with the VCFSE sector.	£182,860

HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Cheshire East Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

The BCF plan and priorities have been developed in collaboration with system partners and stake holders from Cheshire East Council Adult Social Care, Mental Health services, NHS Trusts, Integrated Care Board , Housing and Third Sector to ensure our plans are aligned across our organisations to support delivering the agreed shared priorities with our stakeholders to shape the way we deliver our agreed prioritise

Discharge performance data has been gathered from the Business Intelligence teams from Cheshire East Council and NHS Trusts who undertake performance reviews and attend the BCF governance group.

Finance colleagues from the Local Authority and Integrated Care Board have been instrumental in the agreed funding allocation for the various schemes

The Cheshire East Health and Wellbeing Board (HWB) retains responsibility for governance and oversight of the Better Care Fund and receives quarterly monitoring reports which is a continuation of the approach adopted in 2021/22.

How have you gone about involving these stakeholders?

BCF plans for this year have been reviewed through local planning processes along with consultation with the Better Care governance group which is made up of all system partners who have actively contributed to the design of the plan along with providing assurance that it supports the Cheshire East Health and Wellbeing strategy and is compliant with the national planning criteria.

Cheshire East BCF plan has been developed with contributions from the following partners,

Cheshire East Council (Adult Social Care, Housing and DFG Leads)

NHS Cheshire and Merseyside Integrated Care Board

East Cheshire NHS Trust

Mid Cheshire Foundation Trust

Business Intelligence Teams

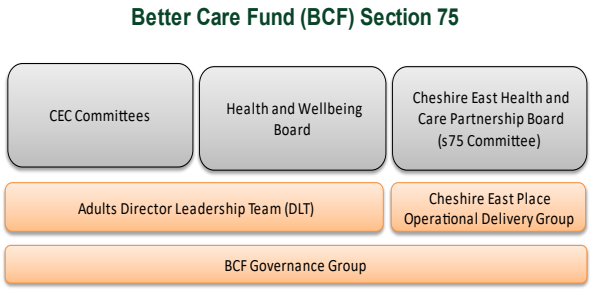
Cheshire and Wirral Partnership NHS Foundation Trust

Community Voluntary Sector

Carers Lead Officers

The BCF plan has been developed as a progression of previous plans but also builds on what worked well during 2022-23 in particular supporting our system partners and a number of the effective discharge schemes that were mobilised during 2022-23

Better Care Governance and Oversight



Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The Cheshire East Health and Wellbeing Board (HWB) retains responsibility for governance and oversight of the Better Care Fund and receives quarterly monitoring reports.

Responsibility for ongoing oversight is delegated to the Cheshire East Health and Care Partnership Board which meets monthly.

The core responsibilities of the Better Care Fund governance group in relation to the Better Care Fund are in the section 75 Agreement.

2023 – 25 Better Care Fund Plan approval timeline:

22nd May 2023 Adult Social Care and Health Department Leadership meeting

9th June 2023, Cheshire East Operational Delivery Group

16th June 2023 Cheshire East Leadership Team, Chaired by Integrated Care Board Place Director

27th June 2023 Health and Wellbeing Board for formal sign of by the HWB Chair

In addition to approval of the plan there is ongoing and regular stakeholder engagement. For example, with our providers in respect of discharge planning and monitoring, system performance, and at individual scheme level with HNS providers, private sector providers, Voluntary Community Sector providers, and housing to ensure these schemes remain effective.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

Over the last twelve months Cheshire East system partners, including members of our operational teams have worked extensively to design, deliver and adopt an ambitious Home First model of support.

The whole Health and Social Care system , voluntary organisations and the faith sector have continued to develop trusted working relationships ,supporting people and building person centred support packages of care in partnership with the person and their support circles.

This Home First programme has continued to develop a care and support model that responds at the point of crisis, to offer more care at home and ensure we have the right amount and right type of resource to provide timely access to advice, treatment and support to help people spend more time in the place they call home, either by preventing an admission to hospital or supporting people to be discharged as soon as possible via the correct pathway.

Key priorities for the BCF plan are:

1. Integrated 'Transfer of Care Hubs' will be the single route for arranging timely discharges for people leaving hospital via Pathway 1 to 3 and will facilitate access to support arrangements for those that require it.

2. To develop a community prevention model of support that supports people to remain at home and prevent a hospital admissions

3. Ensure there is sufficient community reablement provision to maximise the amount of people who are able to remain at home.

4. To ensure there is sufficient capacity across the system that continues to manage the ongoing demand to meet the needs of people.

Partners have collaboratively commissioned a range of services across the system, such as a Rapid Response service to support hospital discharge, and community prevention. In addition to our joint approach to commissioning the Local authority has been the lead commissioner in procuring the D2A bed base provision across the Borough. Going forward the NHS and Local Authority staffing structures have been aligned in a way that provides synergies and opportunities to continue in our joint approach to commissioning across the integrated care system.

The plan will continue building on our journey to date and what has been delivered so far, at a place level on our shared priorities, thus ensuring we continue to support the Health and Social Care system along with delivering positive outcomes for local people

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

In Cheshire East the strategic priority for all stakeholders across Health ,Social Care and Housing is to support people to be discharged home or remain at home or their normal place of residence for as long as possible.

Our vision for person centred integrated care is as follows:

Care and support is planned and organised with people, partners, and communities in ways that ensures continuity in support

Strengths-based assessment approach that support an individual's independence, resilience and ability to make choices

People are supported to manage their own health and well-being, through health, access to self-management programmes and support within the community and have access to appropriate housing.

Ensure integrated care systems make the most of the expertise, capacity and potential of people, families and communities in delivering better outcomes and experiences

Reducing long length of stay remains a system joint priority. This involves community services working closely with hospital discharge teams to ensure that people can be discharged as soon as they are medically optimised.

Increase collaborative commissioning – partners have come together to commission and procure services together and develop market strategy, this includes the carers hub, community equipment and assistive technology services. This collaborative commissioning approach also extends to the production of strategy for example jointly producing a Market Position Statement (MPS) and Live Well for longer strategy. The MPS provides key messages for Providers and summarises the supply and demand in a local authority area. The MPS brings together local information and analysis relating to commercial opportunities within the public health, health, and social care market in that area. The MPS also provides details of the Council's strategic commissioning approach, and how Commissioners and Provider can work together to achieve outcomes for local people.

Increasing out of hospital resource - There has been an increased focus on ensuring greater community resource and step down capacity is in place to assist the system. For example a General Nursing Assistant (GNA)service has been commissioned. This service provides an additional 7 GNA staff within the Central Cheshire Integrated Care Partnership team for a

period of 12 months. These additional staff would be utilised across South Cheshire and the Congleton area of East Cheshire to support patients requiring domiciliary care that would normally be delivered by Local authority. Other community resources include;

British Red Cross hospital avoidance and step-down services, Rapid response, community and mental health reablement.

Age well – The age well programme is underway with an Senior Responsible Officer appointed and project support in place. The draft terms of reference has been produced with identified leads to the attend the ageing well programme board with monthly meetings in place. Crucially in Cheshire East the Cheshire and Merseyside Integrated Care Board governing body agreed the Age well programme approach in Cheshire East and agreed that funding could be recurrent to support the intended aims of the project.

Key components of the age well programme include the 2 hour response, enhanced health in care homes and anticipatory care. It has been noted that the anticipatory care framework is due to be published. The current pressures within the system have been noted for example those seen in the domiciliary care market. In respect of the enhanced health in care homes work which has taken place to date has focused on what providers need, what the gaps are, priority areas, what is realistic. Its noted that the individual projects in Cheshire East will be in place by the end of March 2024.

As part of the system joint prioritise we are progressing an a model of support via Community Reablement which would be, to operate on a hybrid multi-disciplinary model of service delivery. This would require building in other professional roles to facilitate a stream-lined approach in terms of the offer, ensuring each role fully maximises all opportunities both in the hospitals and within the community.

The aim of this investment and additional workforce infrastructure is to design a model of support that effectively responds within the first 72hours of a person experiencing an escalation of their health and social care needs.

The service will provide short-term social care rehabilitation, to support people to become or remain independent at home achieving the right outcome and work closely with the Care Communities.

In summary all partners and stakeholders are working towards developing an admissions avoidance and prevention model of support and early discharge to ensure people live independently at home or in their community for as long as possible.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

The Health and Wellbeing Board and the Cheshire East Health and Care Partnership recognise and acknowledge these challenges. Working together with our residents and other stakeholders is the only way that we can address and overcome them. Our over-arching goal is to improve population health and wellbeing whilst reducing health inequalities. This Strategy sets out our strategic objectives and areas of focus to achieve that over the next five years.

The Joint Local Health and Wellbeing Strategy sets out our high-level vision and aspirations to:

Reduce inequalities, narrowing the gap between those who are enjoying good health and wellbeing and those who are not

Improve the physical and mental health and wellbeing of all of our residents

Help people to have a good quality of life, to be healthy and happy.

There are a number of new processes that are in place to support safe, timely and effective discharge include having appropriate pathways and support in place.

The principles that will underpin our work are to:

Put the voices of people and communities at the centre of decision-making and governance, at every level

Engage with and listen to the seldom heard, for example young carers, cared for children, care leavers, those living in poverty, rural residents and the LGBTQ+ community

Co-design services and tackle Cheshire East priorities in partnership with people and communities, building upon ‘Living Well for Longer’

Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions

Understand community needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect

Build relationships with excluded groups, especially those affected by inequalities

Work with Healthwatch and the voluntary, community, faith, and social enterprise (VCFSE) sector as key partners

Provide clear and accessible public information about vision, plans and progress, to build understanding and trust

Use community development approaches that empower people and communities, making connections to social action

Use co-design and production, insight and engagement to achieve accountable health and care services.

In addition to the Joint Local Health and Wellbeing Strategy the BCF plan for Cheshire East aims to continue to build on the processes that were put in place during 2022/23.

The adopted Occupational Therapy and Reablement Home First Approach supporting people to return home quickly

A new approach to Discharge maximising the use of Community, Voluntary sector and universal services

Carers Payment to support rapid discharge and to remain at home

Mental Health In Reach support into Emergency Departments

The following Prevention / early intervention investment schemes have been commissioned to effectively support people to remain at home and prevent admission.

Community Rapid Response Service, Community Reablement, Mental Health Reablement, Dementia Reablement Services, Acute Visiting Service & GP out of hours, Mobile Night Support, Carers payment incentive, Community Equipment. Falls Coordinators Posts, Falls prevention and response equipment to Care Homes.

Community Connectors positioned within the Transfer of Care Hub promoting Community Voluntary sector services.

Data analysed to ensure that people are discharged from hospital via the correct pathway

Continue to work with the Transfer of Care Hubs and First Point of Contact teams at place which will include NHS Trusts , Care Communities, Primary Care, Social Care, Housing and voluntary are linked in order to coordinate care and support for people who require it during and following discharge and also to prevent a hospital admissions.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified

- where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The Demand and Capacity metrics are populated using a well-established local Cheshire & Merseyside Integrated Care System out of hospital model. It utilises acute provider planning submission for 2023/24 and models predicted out of hospital activity based on the previous years trends and utilisation. A gap analysis has identified that we must collect additional data relating to Pathway 1 Reablement and Pathway 2 NHS commissioned beds. The complete data will be reviewed by commissioners and adjusted to take into account additional schemes and commissioning arrangements for 2023/24

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65

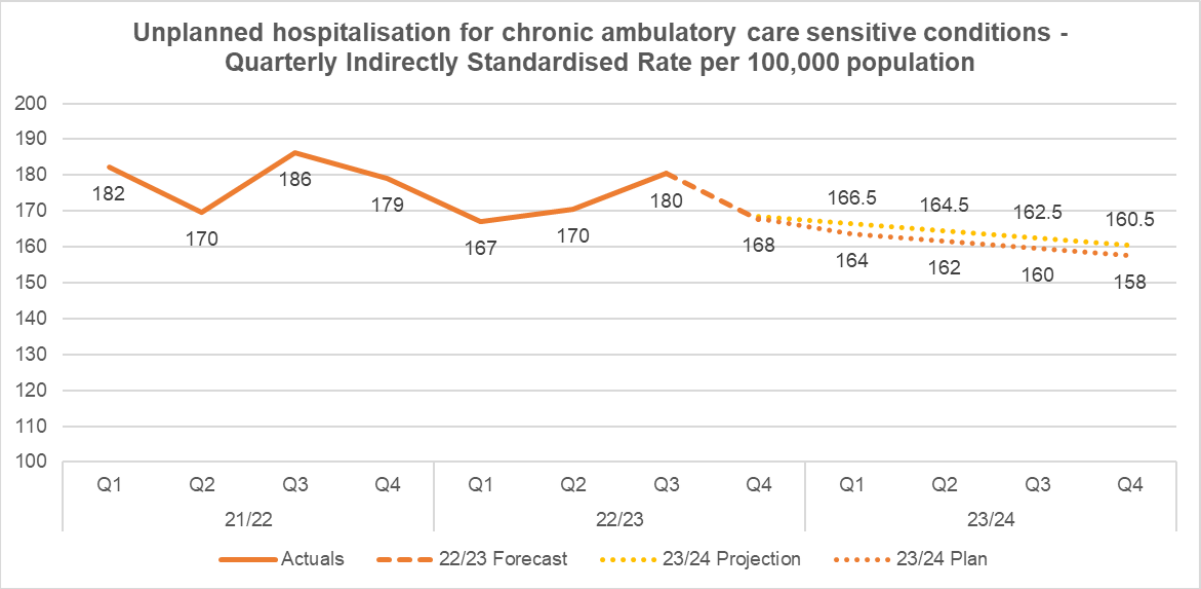
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

The table below includes the BCF metrics and expected performance for 2023-24:

Projections are based on historic trend and population projections. Plan figures take into account the projected impact from planned activity in 23/24.

1. **Indirectly standardised rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population**

	23/24 Qtr 1	23/24 Qtr 2	23/24 Qtr 3	23/24 Qtr 4	Total
23/24 Projection	166.5	164.5	162.5	160.5	653.9
23/24 Plan	163.6	161.6	159.6	157.6	642.4

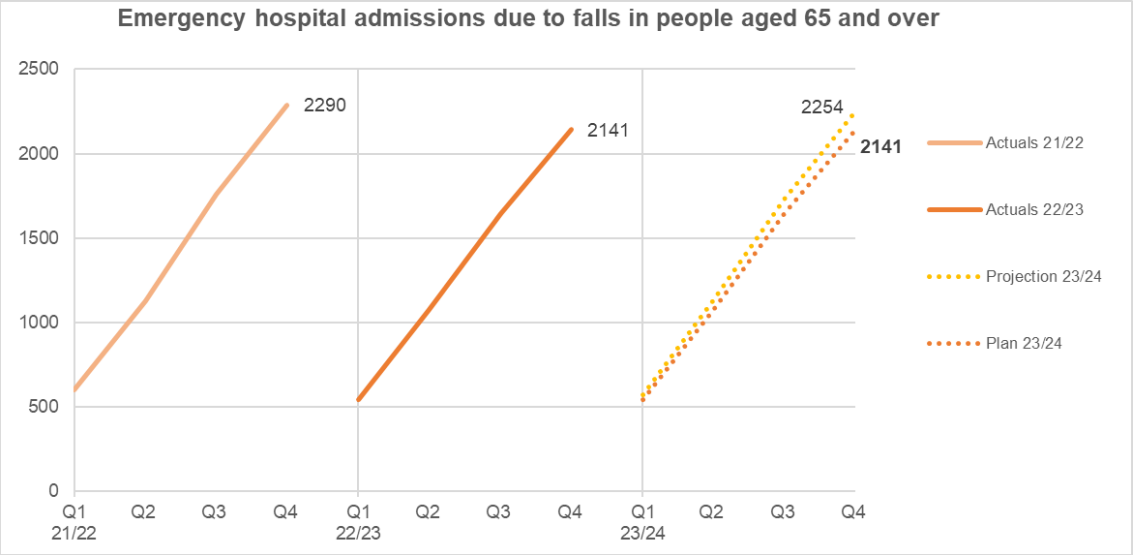


Please see the metrics sheet within the planning template for information on local plans to meet this ambition.

2. **Falls: Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 population**

	23/24 Qtr 1 (cumulative)	23/24 Qtr 2 (cumulative)	23/24 Qtr 3 (cumulative)	23/24 Qtr 4 (cumulative)
23/24 Projection (Falls admissions)	570	1133	1730	2254

23/24 Plan (Falls admissions)	542	1078	1645	2141



This is a new metric, from 2023/24, within BCF Plans. The figures above show a projection based on historic information of admissions due to falls by 5 year age bands combined with population forecasts for those same age bands. This would show an increase of 113 admissions due to falls in 23/24 compared to 22/23. Noting the increased population size for 2023-24, the ambition has been set not to increase the actual number of falls admissions in people aged over 65. This planned ambition reduces the falls rate by 4.8% for 2023/24 compared to 2022/23.

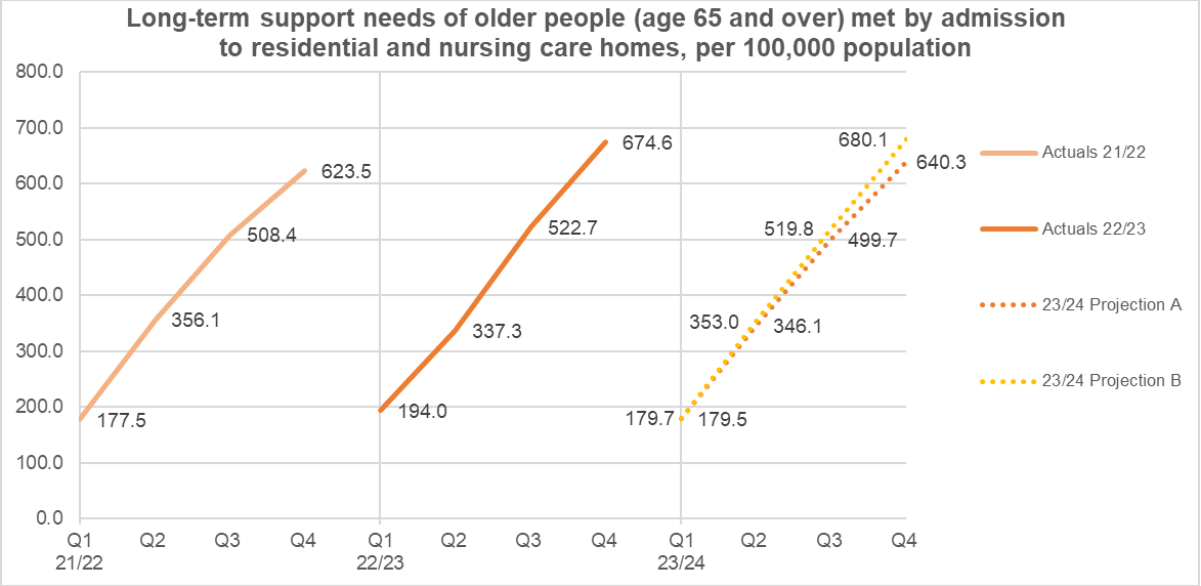
Please see the metrics sheet within the planning template for information on local plans to meet this ambition.

3. Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population

	23/24 Qtr 1	**23/24 Qtr 2**	**23/24 Qtr 3**	**23/24 Qtr 4**
Projection A	179.5	346.1	499.7	640.3
Projection B	179.7	353.0	519.8	680.1

Projection A is based on the trend of both 2021/22 and 2022/23

Projection B is based on the trend of 2022/23



Projection A would equate to 605 permanent admissions in the year
Projection B would equate to 643 permanent admissions in the year

Please see the metrics sheet within the planning template for information on local plans.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

. Priorities for 2023/24: Home First remains a strategic priority across our Integrated Care System in Cheshire East Place and a clear set of associated Home First work programme priorities have been set in line with the NHS Urgent and Emergency Care Operational Planning Guidance for 2023-24 and NHS England delivery plan for recovering Urgent Emergency Care Services January 2023. The key principals of the Home First Model of support are to: Prevent unnecessary or avoidable hospital admissions by working across the community and hospital Facilitate safe discharge from local hospitals in a timely manner to the most appropriate setting to meet people's needs and maintain their independence Design and build a person-centred support package in partnership with the person and there, strengthens and support circles. Ensure people are supported in the community post discharge to reduce readmissions Implement National guidance on discharge requirements As part of our Home First programme of work the system vision is to implement the Home First model of discharge to assess, to maximise the potential for providing more integrated care and support across community-based Health and Social Care. A number of additional schemes have been funded that will create additional Care at Home, Rapid Response Care, support for carers, workforce capacity that will support facilitated discharge, Hospital Prevention and support system flow. The transfer of care hub is works with system partners to ensure that delayed discharges are managed effectively on a daily basis and discharges plans are designed in a way that provides positive outcomes for people.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The demand and capacity analysis has indicated with have a shortage of Care at Home and Bed base across the Borough. Care at Home Capacity, our investment plan shows a

significant financial investment in Care at Home, Rapid Response Care, Community Reablement and General Nursing assistants.

A proportionate of funding will also fund a small number of step down resilience beds that will support step up and down along with carer breakdown.

To support the identified capacity gap an investment proposal is being taken forward that which would enhance the delivery for Community Reablement which would be, to operate on a hybrid multi-disciplinary model of service delivery. This would require building in other professional roles to facilitate a stream-lined approach in terms of the offer, ensuring each role fully maximizes all opportunities both in the hospitals and community.

The aim of this investment and additional workforce infrastructure is to design a model of support that effectively responds within the first 72hours of a person experiencing an escalation of their health and social care needs.

The service will provide short-term social care rehabilitation, to support people to become or remain independent at home achieving the right outcome and work closely with the Care Communities.

National Condition 3 (cont)

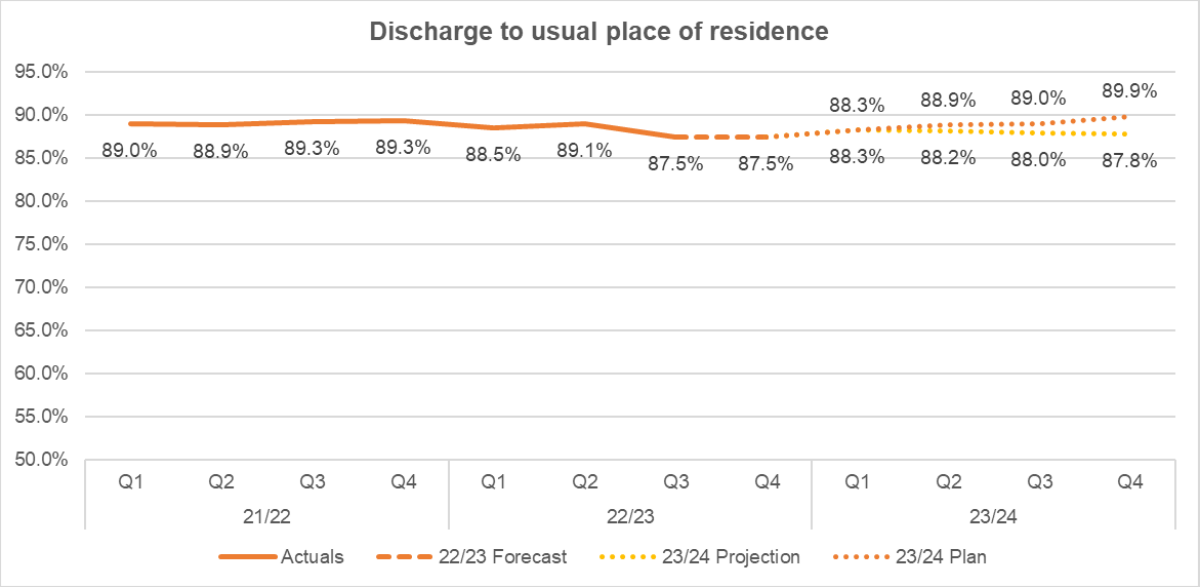
Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Projections are based on historic trend and population projections. Plan figures take into account the projected impact from planned activity in 23/24.

4. Discharge to usual place of residence

	23/24 Qtr 1	23/24 Qtr 2	23/24 Qtr 3	23/24 Qtr 4	Total
23/24 Projection	88.3%	88.2%	88.0%	87.8%	88.1%
23/24 Plan	88.3%	88.9%	89.0%	89.9%	89.0%



Please see the metrics sheet within the planning template for information on local plans to meet this ambition.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

On going work continues to implement the high impact change model on supporting timely and effective discharge through joint working across the Adult Social Care and Health system are continued to be adopted through the transfer of care hub.

As part of our planning for 2023-24 there is a number of work streams that the system is focusing on via the Home First programme of work which is as follows:

Centralised cluster of D2A facilities strategically positioned across Cheshire East Place. The plan is to consolidate and reconfigure existing pathway 2 bed-based ‘step-down’ and ‘step-up’ provision and create clusters across the Borough to ensure people return directly to their homes thus improving outcomes and enhanced performance of service delivery.

The new Model of care will deliver:

An environment for a period of Assessment, Rehabilitation and Reablement for people.

Removal of steps, processes, and delays in the discharge process

A reduction in Length of Stay

Transformation towards a financially sustainable model for step up and step-down beds.

A reduction in the risk associated with people remaining in a hospital environment and deconditioning

A reduction in the number of people who have No Criteria to Reside in Hospitals

Increased discharge rates on the wards and creating acute bed base capacity

Increased patient flow through the hospital

Supporting people out of hospital, to streamline discharge to enable and recovery.

Centralise the wraparound support: Nursing, Therapy, Social Work, and GP clinical resource into key locations, reducing staff travel time and creating staffing capacity to reinvest back into the system

A significant reduction in the spot purchasing of bed base placements

Improved Health & Wellbeing outcomes for people

Home First Admissions Avoidance/ Community Prevention Planning: The objective of this work stream is to design Develop a care and support model that responds at the point of crisis, -Offer more care at home and ensure we have the right amount of capacity and the right type to provide timely access to advice, treatment and support to prevent a hospital admission and support people to remain at home -Develop an integrated workforce - Transform a sustainable model for Discharge to Assess across the Borough via cluster of beds in set localities.

High Intensity Users Programme of Work: To develop a test model to enable local health and social care systems proactively identify and work with high intensity users and empower service users to better manage their own health and social care needs.

Mental Health Services - Develop adequate admission avoidance options including crisis beds, with a focus on earlier intervention and prevention in communities and put in place system wide agreement to combat delays in moving patients from acute to rehab bed provision

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

The Care Act 2014 requires local authorities to ensure the provision or arrangement of services, facilities or resources to help prevent, delay or reduce the development of needs for care and support.

The main principles of the funded investment schemes through BCF, iBCF, ASC discharge fund that have been mobilised are to support people to improve people's independence and wellbeing , support carers and to promote a person-centred approach to the care and support they provide.

The range of schemes and support options demonstrates that our duties and responsibilities are working inline with the Care Act and remaining complaint in the offer of servcies and diverse ramge f services that will be delivered across the people for people

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Cheshire East Carers Hub (All Age Carers Hub) work in partnership with 'Making Space' who are the provider who works with Carers to find solutions and identify support and resources available to you in Cheshire East.The provider provides physical and emotional support and will explore how to support carers in there caring role now and in the future.The support will be personalised and holistic and will consider all the areas of your life and what is important to and for you. This could include:

- Benefits advice and guidance
- A statutory carers assessment
- One to one support
- Peer support and groups
- Activities and carer breaks
- Access to respite
- Training relevant to your caring role
- Volunteering opportunities
- Befriending support
- Referrals and signposting to our partners
- Opportunities to shape the service we provide

The Carers Hospital Discharge to Home Scheme

A newly introduced Carer Hospital Discharge to Home Scheme has been introduced which provides a one off incentive payment that can be paid to an unpaid Carer (family/friend) to support carers in their caring role at the point of discharge. The scheme is aimed at patients who are ready for hospital discharge but need some support to recover or recuperate, which could be met through informal care, either entirely or alongside reduced formal support. The vision of the schemes is to reduce delayed discharges and free up hospital bed capacity.

Help to reduce the need for formal care at home support and short stays.

Support Reablement packages and help to reduce their input.

Support the Transfer of Care Hub in designing holistic packages of care by way of briging support via the carer

Support informal Carers in their role by paying them a one off incentive payment.

Offer another support pathway to enable patients to be discharged from hospital once ready

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

Disabled Facilities Grant - The Disabled Facilities Grant provides financial contributions, either in full or in part, to enable disabled people to make modifications to their home in order to eliminate disabling environments and continue living independently and/or receive care in the home of their choice. Disabled Facilities Grants are mandatory grants under the Housing Grants, Construction and Regeneration Act 1996 (as amended), with a discretionary top-up of £20,000 under the housing renewal policy in accordance with the Regulatory Reform (Housing Assistance) (England & Wales) Order 2002. The scheme will be administered by Cheshire East Council and will be delivered across the whole of Cheshire East.

Assessment and support - Occupational therapists and social care assessors across health and social care are engaged in the delivery of Disabled Facilities Grants, carrying out an holistic assessment of health, care and housing needs including a functional assessment of how people are managing in their homes. Occupational therapists are engaged with continuing healthcare, equipment services and assistive technology, bringing together a range of services to provide a holistic response to meet the needs of disabled people. Occupational therapists are working across health settings to facilitate hospital discharge with the use of home adaptations as appropriate, and utilising the Regulatory Reform Order to facilitate more efficient adaptations for hospital discharge and to support palliative care. In 2022/23 we used a discretionary fast track grant on 59 occasions to support hospital discharge and facilitate care at home for people on palliative care pathways. Occupational therapists' assessments and recommendations take an incremental approach, and where there is need for temporary solutions to facilitate hospital discharge while longer term arrangements can be put in place, they work in collaboration with the service user and the Housing service to implement appropriate solutions.

We have a focus on early intervention for admissions avoidance and preventing inappropriate or unnecessary use of health and social care services. In 2022/23 we delivered adaptations to 123 people as part of this prevention agenda. The predominant support provided was to meet bathing needs and falls prevention. Early intervention officers are employed within the Housing service to identify and support people who do not have eligible care needs but need some form of practical support to be able to maintain independent living. The objective is to provide interventions that support people to maintain their wellbeing at home, such as bathing, access in and out of the home, or being able to move around the home, at an early enough stage that negates or delays the need for them to access health and social care services.

Care and Repair - improving homes, improving lives - We have a care and repair service in Cheshire East which is aimed at helping people to adapt or repair their home. The service is aimed at those over state pension age, or those that have a disability. Care and Repair is a

service for older, disabled and vulnerable people, guiding them through the often complex or daunting process of carrying out repairs and adaptations in their own home. We offer help with many types of work around the home, from replacing a window to building an extension. In 2022-23 the service facilitated 97% of the Disabled Facilities Grants that were completed, and provided advice and guidance to the 3% of service users who arranged adaptations themselves. The service has proved effective at facilitating adaptations in a more timely manner than service users have been able to do for themselves; the average timescale for completion of adaptations by Care & Repair is 4 months, compared to 9 months for adaptations arranged by service users.

The service scope covers those that can afford to pay for work themselves or for those that need help with the cost of repairs and adaptations or finally those people that may just want advice. The following services are offered: technical advice and information about repairs and adaptations, helping the person to find ways to pay for the home repairs and adaptations, and checking your entitlement to benefits, assisting the person with filling in forms for funding applications, providing the person with information about other service to help them live independently within their own home.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Yes

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

£500,000

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

It is an essential priority for Cheshire East to significantly reduce health inequalities. Cheshire East is one of the most polarized boroughs in the country, with some of the most affluent and some of the most deprived local areas, generating significant inequalities among community groups. Our local health and care system is committed to the reduction of inequalities. The Cheshire East Health and Wellbeing Board oversees our BCF activity. The Board has a focus on reducing inequalities and established an Increasing Equalities Commission to review service provision to ensure it is equitable. The Cheshire and Merseyside Health and Care Partnership have placed the reduction of health inequalities as a key aim for our local system. It gave a commitment for the sub-region to become a “Marmot Community” - committed to tackling health inequalities throughout people’s lives through a determined and joint effort to true integration across a number of sectors to achieve common goals. Cheshire East Council has put fairness as one of the three aims at the heart of its Corporate Plan (2021–2025) - “We aim to reduce inequalities, promote fairness and opportunity for all and support our most vulnerable residents”

BCF projects will contribute to our new Joint Local Health and Wellbeing Strategy as part of a comprehensive plan to reduce health inequalities and help people live well for longer.

Inequalities are seen across Cheshire East. Most starkly, these area based, with our most deprived electoral wards in central Crewe (and to a lesser extent Macclesfield) seeing poor health outcomes across the life course. We are ensuring that our BCF projects are active in these areas and will benefit these residents. This includes provision of nursing assistants and the work of our Carer’s Hub. We are funding a third sector organisation to work with residents in central Crewe and Macclesfield.

Cheshire East is becoming increasingly diverse, with significant increases in ethnic minority populations seen in Crewe. Our schemes are accessible in those from ethnic minority groups and we ensure that they are appropriate for those who do not have English as a first language.

In addition to deprivation in our central urban areas, we also have a dispersed rural population, experiencing issues around access to services and social isolation. Our BCF projects are designed to be accessible for our residents in rural and remote areas.

Specific work for those living with disabilities is discussed above.

Further work is needed to explore provision of services to those in the boating community and those who are Gypsy or Roma travellers. We work closely with our Homelessness Team to support those with urgent housing needs.

Our BCF initiatives will Make Every Contact Count and take opportunities to promote prevention and healthy lifestyles to our residents. Smoking cessation is a cross-cutting priority in the reduction of avoidable deaths and health inequalities from cardiovascular diseases, respiratory diseases and cancers, as per the Core20PLUS5 approach.

A consensus building process has been undertaken to identify 12 key outcome indicators to inform action to reduce healthcare inequalities at both national and system level. These indicators will form the first of two parts of a Joint Outcomes Framework. The second part of the Framework will focus on additional indicators to monitor local progress in relation to the Cheshire East Five-Year Health and Care Service Delivery Plan.

The Joint Outcomes Framework as a whole, will continue to evolve over the coming years, influenced by: emergent findings within the Joint Strategic Needs Assessment; community insights; Cheshire and Merseyside intelligence; progress in relation to the Delivery Plan; and developments in what we are readily able to measure. Importantly, the purpose of the Outcomes Framework is not to monitor and evaluate all core activity and transformation across the health and care system. However, there is a recognition across Cheshire East Place, that sustained focus on the above 12 specific outcomes, and inequalities across these, is required in order to demonstrate progress towards achieving the overarching vision outlined in this strategy Our approach to reducing inequalities in Cheshire East will be led through the Increasing Equalities Commission.

Addressing health inequalities and equality in line with the Equality Act for people with protected characteristics through commissioning

A number of schemes are currently in place to support discharge for people with mental health support needs in Cheshire East which range from

Mental Health Step Down – Up Crisis, step down beds to provide a step-down support and overnight accommodation as a planned, safe and sustainable discharge from hospital settings.

Mental Health A&E In Reach at Macclesfield and Leighton Hospitals – this provides a staff member to both A&E departments to support the ward staff in managing and keeping safe those patients who have been assessed as requiring/awaiting an acute bed, and those awaiting discharge.

Rapid Response Reablement Service - support individuals living in Cheshire East with mental health support needs who are fit for discharge and are delayed due to awaiting care package and would benefit from a short-term community intervention. Two2 Mental Health Crisis Cafes Services are open to offer people (18+) a safe space if they are struggling with

emotional and psychological distress and considering themselves to be in a self-defined crisis

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.
5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

HM Government

NHS England

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Complete:
Health and Wellbeing Board:	Cheshire East		Yes
Completed by:	Daniel McCabe		Yes
E-mail:	Daniel.McCabe@cheshireeast.gov.uk		Yes
Contact number:	07702 213420		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no please indicate when the HWB is expected to sign off the plan:	Tue 27/06/2023	<< Please enter using the format, DD/MM/YYYY	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Sam	Corcoran	sam.corcoran@cheshireeast.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Mr	Mark	Wilkinson	mark.wilkinson@cheshireandmerseyside.nhs.uk	Yes
	Additional ICB(s) contacts if relevant	Mr	Dan	McCabe	dan.mccabe@cheshireeast.gov.uk	Yes
	Local Authority Chief Executive	Mrs	Lorraine	O'Donnell	lorraine.odonnall@cheshireeast.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)	Mrs	Helen	Charlesworth-May	helen.charsleworth-may@cheshireeast.gov.uk	Yes
	Better Care Fund Lead Official	Mr	Dan	McCabe	dan.mccabe@cheshireeast.gov.uk	Yes
	LA Section 151 Officer	Mr	Alex	Thompson	alex.thompson@cheshireeast.gov.uk	Yes
Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	Better Care Fund Lead Official	Mrs	Shelley	Brough	shelley.brough@cheshireeast.gov.uk	

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Cheshire East

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,342,241	£2,342,241	£2,342,241	£2,342,241	£0
Minimum NHS Contribution	£30,375,322	£32,094,566	£30,375,322	£32,094,566	£0
iBCF	£8,705,870	£9,193,398	£8,705,870	£9,193,398	£0
Additional LA Contribution	£550,000	£550,000	£550,000	£550,000	£0
Additional ICB Contribution	£182,860	£182,860	£182,860	£182,860	£0
Local Authority Discharge Funding	£1,220,549	£2,026,112	£1,220,549	£2,026,112	£0
ICB Discharge Funding	£2,308,000	£2,308,000	£2,308,000	£2,308,000	£0
Total	**£45,684,843**	**£48,697,177**	**£45,684,842**	**£48,697,177**	**£1**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£8,631,805	£9,120,365
Planned spend	£21,712,551	£22,983,083

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£8,742,215	£9,237,025
Planned spend	£9,146,986	£9,664,706

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	163.6	161.6	159.6	157.6

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,299.7	2,188.5
	Count	2141	2141
	Population	92794	94555

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	88.3%	88.9%	89.0%	89.9%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	641	680

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	83.9%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Cheshire East

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month.
The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabilitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.
The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Methodology: The Demand metrics are populated using a well-established local C&M ICS out of hospital model. It utilises acute provider planning submissions for 2023/24 and models predicted out of hospital activity based on the previous years pathway trends and utilisation. The demand is the modelled caseload/occupancy requirement for 2023/24. A gap analysis has identified that we must collect additional data relating to the QNA service covering Pathway1. Discharges - All Cheshire East Place only

Complete:	
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Demand - Hospital Discharge

Trust Referral Source (Select as many as you need)	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
(Please select Trust/s.....)	Social support (including VCS) (pathway 0)												
(Please select Trust/s.....)	Reablement at home (pathway 1)	44	44	47	48	47	48	49	51	50	43	44	43
(Please select Trust/s.....)	Rehabilitation at home (pathway 1)	10	11	13	13	13	13	13	14	14	11	11	2
(Please select Trust/s.....)	Short term domiciliary care (pathway 1)												
(Please select Trust/s.....)	Reablement in a bedded setting (pathway 2)												
(Please select Trust/s.....)	Rehabilitation in a bedded setting (pathway 2)	126	128	136	140	134	140	142	148	142	124	126	124
(Please select Trust/s.....)	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	19	20	21	22	20	22	22	23	21	19	19	19

3.2 Demand - Community

Demand - Intermediate Care

Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)												
Urgent Community Response	600	600	600	600	600	600	600	600	600	600	600	600
Reablement at home	10	10	11	11	11	11	10	10	10	10	10	10
Rehabilitation at home	1	1	1	1	1	1	1	1	1	1	1	1
Reablement in a bedded setting												
Rehabilitation in a bedded setting	7	8	8	8	9	8	8	8	8	8	8	8
Other short-term social care												

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.												
Reablement at Home	Monthly capacity. Number of new clients.	42	42	42	42	42	42	42	42	42	42	42	42
Rehabilitation at home	Monthly capacity. Number of new clients.	18	18	18	18	18	18	18	18	18	18	18	18
Short term domiciliary care	Monthly capacity. Number of new clients.												
Reablement in a bedded setting	Monthly capacity. Number of new clients.												
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	114	114	114	114	114	114	114	114	114	114	114	114
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	19	20	21	22	20	22	22	23	21	19	19	19

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly

ICB	LA	Joint
	100%	
40%	60%	
	100%	
	100%	
50%	50%	
100%		

3.4 Capacity - Community

Capacity - Community

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.												
Urgent Community Response	Monthly capacity. Number of new clients.	600	600	600	600	600	600	600	600	600	600	600	600
Reablement at Home	Monthly capacity. Number of new clients.	10	10	10	10	10	10	10	10	10	10	10	10
Rehabilitation at home	Monthly capacity. Number of new clients.	2	2	2	2	2	2	2	2	2	2	2	2
Reablement in a bedded setting	Monthly capacity. Number of new clients.												
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	6	6	6	6	6	6	6	6	6	6	6	6
Other short-term social care	Monthly capacity. Number of new clients.												

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly

ICB	LA	Joint
100%		
	100%	
	100%	
100%		

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Cheshire East

Local Authority Contribution			
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	**Complete:**
Cheshire East	£2,342,241	£2,342,241	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£2,342,241**	**£2,342,241**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Cheshire East	£1,220,549	£2,026,112	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS Cheshire and Merseyside ICB	£2,308,000	£2,308,000	Yes
Total ICB Discharge Fund Contribution	£2,308,000	£2,308,000	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Cheshire East	£8,705,870	£9,193,398	Yes
Total iBCF Contribution	**£8,705,870**	**£9,193,398**	

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding	
Cheshire East	£550,000	£550,000	Equipment - see scheme 32	Yes
Total Additional Local Authority Contribution	**£550,000**	**£550,000**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Cheshire and Merseyside ICB	£30,375,322	£32,094,566
Total NHS Minimum Contribution	**£30,375,322**	**£32,094,566**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding	
NHS Cheshire and Merseyside ICB	£182,860	£182,860	VCFSE - see scheme 34	Yes
Total Additional NHS Contribution	**£182,860**	**£182,860**		
Total NHS Contribution	**£30,558,182**	**£32,277,426**		

	2023-24	2024-25
Total BCF Pooled Budget	**£45,684,843**	**£48,697,177**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Cheshire East

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,342,241	£2,342,241	£0	£2,342,241	£2,342,241	£0
Minimum NHS Contribution	£30,375,322	£30,375,322	£0	£32,094,566	£32,094,566	£0
iBCF	£8,705,870	£8,705,870	£0	£9,193,398	£9,193,398	£0
Additional LA Contribution	£550,000	£550,000	£0	£550,000	£550,000	£0
Additional NHS Contribution	£182,860	£182,860	£0	£182,860	£182,860	£0
Local Authority Discharge Funding	£1,220,549	£1,220,549	£0	£2,026,112	£2,026,112	£0
ICB Discharge Funding	£2,308,000	£2,308,000		£2,308,000	£2,308,000	£0
Total	**£45,684,843**	**£45,684,842**	**£1**	**£48,697,177**	**£48,697,177**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,631,805	£21,712,551	£0	£9,120,365	£22,983,083	£0
Adult Social Care services spend from the minimum ICB allocations	£8,742,215	£9,146,986	£0	£9,237,025	£9,664,706	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Planned Expenditure: Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	East Cheshire NHS Trust ED/GP out of hours 7 Days per	These schemes will support facilitated discharge and the ongoing implementation of	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)					Acute		NHS			NHS Acute Provider	ICB Discharge Funding	Existing	£120,000	£120,000	0.3%
2	Approved Mental Health Professionals	These schemes will support facilitated discharge and the ongoing implementation of	Workforce recruitment and retention						Social Care		LA			Local Authority	ICB Discharge Funding	Existing	£60,000	£60,000	0.1%
3	Assistive Technology & Gantry Hoists to	These schemes will support facilitated discharge and the ongoing implementation of	Assistive Technologies and Equipment	Assistive technologies including telecare		2600	2743	Number of beneficiaries	Social Care		LA			Private Sector	ICB Discharge Funding	Existing	£50,000	£50,000	0.1%
4	Care at Home Investment Increase	These schemes will support facilitated discharge and the ongoing implementation of	Home Care or Domiciliary Care	Domiciliary care packages		27600	29118	Hours of care	Social Care		LA			Private Sector	Local Authority Discharge	Existing	£1,220,549	£2,026,112	2.7%
5	Carers Payments to facilitate rapid discharge	These schemes will support facilitated discharge and the ongoing implementation of	Carers Services	Carer advice and support related to Care Act duties		393	415	Beneficiaries	Social Care	Identified Carers	LA			Local Authority	ICB Discharge Funding	Existing	£30,000	£30,000	0.1%
6	Home First Occupational Therapist	These schemes will support facilitated discharge and the ongoing implementation of	Workforce recruitment and retention						Acute		NHS			NHS Acute Provider	ICB Discharge Funding	Existing	£63,000	£63,000	0.1%
7	Hospice Beds (East Cheshire Hospice). (Winter Support -	These schemes will support facilitated discharge and the ongoing implementation of	Residential Placements	Short term residential care (without rehabilitation or reablement input)		2	2	Number of beds/Placements	Community Health		NHS			Charity / Voluntary Sector	ICB Discharge Funding	Existing	£90,000	£90,000	0.2%
8	Hospital Discharge Premium Payment & Prevention	These schemes will support facilitated discharge and the ongoing implementation of	Workforce recruitment and retention						Social Care		LA			Private Sector	ICB Discharge Funding	Existing	£125,000	£125,000	0.3%

9	Increase General Nursing Assistant Capacity care at	These schemes will support facilitated discharge and the ongoing implementation of	Home-based intermediate care services	Rehabilitation at home (to support discharge)		5197	5483	Packages	Community Health		NHS			NHS Community Provider	ICB Discharge Funding	Existing	£125,000	£125,000	0.3%
10	Mental Health Reablement – Rapid Response	These schemes will support facilitated discharge and the ongoing implementation of	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		240	253	Packages	Social Care		LA			Private Sector	ICB Discharge Funding	Existing	£25,000	£25,000	0.1%
11	Integrated Community for the Community	These schemes will support facilitated discharge and the ongoing implementation of	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Social Care		LA			Charity / Voluntary Sector	ICB Discharge Funding	Existing	£120,000	£120,000	0.3%
12	Transfer of Care Hub, Nurses and additional Social	These schemes will support facilitated discharge and the ongoing implementation of	Workforce recruitment and retention						Social Care	Acute and Social Care	Joint	50.0%	50.0%	Local Authority	ICB Discharge Funding	Existing	£300,000	£300,000	0.7%
13	iBCF Block booked beds	Direct award of short-term contracts for 8 winter pressure beds to support	Residential Placements	Short term residential care (without rehabilitation or reablement input)		23	24	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£1,450,638	£520,000	3.2%
14	iBCF Care at home hospital retainer	Retaining packages when service user is admitted to hospital	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		4840	5106	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£47,250	£49,896	0.1%
15	iBCF Rapid response	The Rapid Response Service will facilitate the safe and effective discharge of service	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		400	422	Hours of care	Social Care		NHS			Private Sector	iBCF	Existing	£613,000	£647,328	1.3%
16	iBCF Social work support	Additional Social Care staff to prevent people from being delayed in hospital	Workforce recruitment and retention											NHS Community Provider	iBCF	Existing	£478,800	£505,613	1%
17	iBCF 'Winter Schemes	Additional capacity to supporAdditional capacity to support the local health and	Care Act Implementation Related Duties	Other	Winter System Support									Local Authority	iBCF	Existing	£500,000	£528,000	1.1%
18	iBCF Enhanced Care Sourcing Team (8am-8pm)	The scheme sees the continuation of funding for the Care Sourcing Team	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	iBCF	Existing	£1,025,592	£1,361,768	2.2%
19	iBCF General Nursing Assistant (within BCF Early	These additional staff would These additional staff would be utilised across South	Home-based intermediate care services	Rehabilitation at home (to support discharge)		5197	5483	Packages	Community Health		NHS			NHS Community Provider	iBCF	Existing	£315,000	£332,640	0.7%
20	iBCF Improved access to and sustainability of	Market Management	Care Act Implementation Related Duties	Other	Market Management				Social Care		LA			Private Sector	iBCF	Existing	£4,275,590	£5,248,153	9.4%
21	BCF Disabled Facilities Grant	Provides financial contributions, either in full or in part, to enable disabled	DFG Related Schemes	Adaptations, including statutory DFG grants		440	464	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG	Existing	£2,342,241	£2,342,241	5.1%
22	BCF Assistive technology	The scheme will continue to support the existing assistive technology services.	Assistive Technologies and Equipment	Assistive technologies including telecare		2600	2743	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£757,000	£757,000	1.7%
23	BCF British Red Cross 'Support at Home' service /	A 2-week intensive support service with up to 6 Interventions delivered	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£460,582	£486,651	1%
24	BCF Combined Reablement service	Reablement services	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		346	365	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£5,084,860	£5,372,663	11.1%
25	BCF Safeguarding Adults Board (SAB)	Local safeguarding arrangements	Care Act Implementation Related Duties	Safeguarding					Social Care	Health and Social Care	LA			Local Authority	Minimum NHS Contribution	Existing	£470,109	£496,717	1%
26	BCF Carers hub	The Hub ensures that carers have access to information, advice and a wide range of	Carers Services	Carer advice and support related to Care Act duties		2400	2532	Beneficiaries	Social Care	Identified Carers	LA			Private Sector	Minimum NHS Contribution	Existing	£389,000	£389,000	0.9%
27	BCF Programme management and infrastructure	Programme management, Governance and finance support to develop s75	Enablers for Integration	Programme management					Social Care	System wide colleagues	Joint	50.0%	50.0%	Local Authority	Minimum NHS Contribution	Existing	£968,429	£1,106,445	2.1%
28	BCF Winter schemes ICB	Support the achievement and maintenance of the four-hour access standard, admission	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users		100	106	Number of Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£588,903	£622,235	1.3%
29	BCF Home First schemes ICB	Interventions designed to keep people at home (or in their usual place of	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£19,116,250	£20,198,230	41.8%
30	BCF Trusted assessor service	This scheme deploys a trusted assessor model by commissioning an external	High Impact Change Model for Managing Transfer of Care	Trusted Assessment					Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£104,103	£109,995	0.2%
31	BCF Carers hub	The Hub ensures that carers have access to information, advice and a wide range of	Carers Services	Carer advice and support related to Care Act duties		2400	2532	Beneficiaries	Social Care	Identified Cares	LA			Private Sector	Minimum NHS Contribution	Existing	£324,000	£324,000	0.7%
32	BCF Community Equipment service	Provision of equipment on a temporary or permanent basis for independent living.	Assistive Technologies and Equipment	Community based equipment		2600	2743	Number of beneficiaries	Other	Health and Social Care	LA			Private Sector	Additional LA Contribution	Existing	£550,000	£550,000	1.2%
33	BCF Community Equipment service	Provision of equipment on a temporary or permanent basis for independent living.	Assistive Technologies and Equipment	Community based equipment		2600	2743	Number of beneficiaries	Other	Health and Social Care	NHS			Private Sector	Minimum NHS Contribution	Existing	£2,112,086	£2,231,630	4.6%
34	VCFSE Grants	An integrated Place Based VCFSE Grant process to led by the Council building on	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Other	Voluntary Sector	LA			Charity / Voluntary Sector	Additional NHS Contribution	Existing	£182,860	£182,860	0.4%

35	Spot purchase beds and cluster model	These schemes will support facilitated discharge and the ongoing implementation of	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		165	165	Number of Placements	Community Health		NHS			Private Sector	ICB Discharge Funding	Existing	£1,200,000	£1,200,000	2.6%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Cheshire East

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	165.8	169.0	178.9	172.0	The plan figures are based on a starting position of forecasts based on historic trends and population changes. This projects an annual rate for 23/24 of 653.9. This appears to show that existing strategies are working to reduce this metric. The impact of additional investment activity for 23/24 has then been applied to produce the final plan figure. The planned annual rate is 642.4	• Assistive technology and specialist equipment (e.g. blood pressure monitors, pulse oximetry, thermometers) • GP out of hours 7 Days per week • Night Sitters • ARI Hubs - Alsager & Knutsford • Additional Urgent Community Response capacity	Yes
	Number of Admissions	823	839	888	-			
	Population	386,667	386,667	386,667	386,667			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	163.6	161.6	159.6	157.6			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,436.5	2,299.7	2,188.5	Noting the increased population size for 2023-24 the ambition has been set not to increase the actual number of falls admissions in people aged over 65. This planned ambition reduces the falls rate by 4.8% for 2023/24.	• Falls Coordinator posts recruited across the Cheshire East footprint. • Urgent Community Response teams are reviewing opportunities to take an increased number of referrals from 111 and 999 and agree a robust pathway with the Assistive Technology provider to respond to level 2 falls. • Capital funding for Falls Prevention and	Yes
	Count	2,275	2141	2141			Yes
	Population	89,985	92794	94555			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal	Quarter (%)	88.5%	89.1%	87.5%	89.1%	The plan figures are based on a starting position of forecasts based on historic trends, the average quarterly performance would be 88.1%. There has, historically, been a gap between the percentage seen	• Shift away from bed-based post discharge support through decommissioning of block booked beds and using Home First approach and provision instead.	Yes
	Numerator	7,004	7,359	7,297	6,890			
	Denominator	7,912	8,260	8,337	7,736			

discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	2023-24 Q1 Plan 88.3%	2023-24 Q2 Plan 88.9%	2023-24 Q3 Plan 89.0%	2023-24 Q4 Plan 89.9%	for Cheshire East compared to comparator authority areas. In 2022/23 the average gap was 4.2 percentage points. An ambition has been set to work towards closing this gap by half by Quarter 4.	• Build on the additional domiciliary care capacity seen in the latter part of 2022/23 • Investment in community reablement	Yes
	Numerator	6,986	7,339	7,416	7,153			
	Denominator	7,912	8,255	8,333	7,957			Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	640.5	657.4	674.6	680.0	Based on projections using historic trend and projected population changes. The latest Census figures for Cheshire East show that the oldest age group (those aged 90 and above) increased by a third (32 per cent) compared to 2011. 27% of admissions in 22/23 were people aged 90 or over which was an increase of 2 percentage points compared to 2021/22). This would make decreasing the number of admissions very challenging.	Help people to stay at home longer through: • Supporting Carers so that they are able to continue in a caring role for as long as they want to and thereby decrease the number of admissions to residential care due to carer breakdown • Falls prevention to avoid post-fall deterioration that can lead to residential placements • Assistive technology that enables people to safely stay in their own home • Complementary Third sector offer that supports help at home tasks	Yes
	Numerator	571	610	626	643			Yes
	Denominator	89,148	92,794	92,794	94,555			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.5%	82.2%	83.9%	83.9%	Based on projections from historic trend. About 56% of discharges to reablement/rehabilitation in Cheshire East are aged 85 and over. This is a higher percentage than seen nationally or regionally in previous years. This age group also tends to have a lower percentage that are still at home 91 days after discharge (in 21/22, nationally 79.1% of 85+ age group were still at home 91	• Falls Coordinator posts recruited across the Cheshire East footprint. • Assistive technology that enables people to safely stay in their own home • Investment in community reablement • Complementary Third sector offer that supports help at home tasks	Yes
	Numerator	262	263	230	230			Yes

	Denominator	310	320	274	274	of 85+ age group were still at home 91 days after discharge, compared with 83.6% for the 75-84 age group and 85.1% for the 65-74 age group).		Yes

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Cheshire East

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes				Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUSS. *Paragraph 15*	Narrative plan	Yes				Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes				Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	PR4	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes				Yes
Additional discharge funding	PR5	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes				Yes

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes				Yes
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes				Yes
Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes				Yes
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes				Yes

Agenda Item 14

Cheshire East Council

Cheshire East Health and Wellbeing Board

27th June 2023

Cheshire East Health and Wellbeing Board Terms of Reference update

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Report of: Helen Charlesworth-May, Executive Director of Adults, Health and Integration

Report Reference No: HWB29

Ward(s) Affected: All

Purpose of Report

1 Improving the health and wellbeing of the residents of Cheshire East is a priority for the Council and its partners. The Health and Wellbeing Board was set up because of the requirements of the Health and Social Care Act 2012 and has a key role to play in setting the priorities for Cheshire East and providing system leadership for health and wellbeing.

2 The Health and Care Act 2022 and a Local Government Association facilitated review of the Health and Wellbeing Board have led to the need to update the Board's Terms of Reference. This report and Appendix One highlight those changes and seeks the Board's approval of them. Appendix Two is a clean copy (without tracked changes) for ease of reading.

Executive Summary

3 The Terms of Reference of the Health and Wellbeing Board are reviewed every two years. The current version was agreed in 2021. As a result of the legislative changes last year (in particular the demise of the Cheshire Clinical Commissioning Group), an update was required; in addition, the review of the Health and Wellbeing Board (facilitated by the Local Government Association) has led to some further changes in relation to the membership section.

4 The most significant proposed change is to make all members of the Board, voting members. This was proposed on the basis that if we expect people to

give up their time to join the Board, then their contribution ought to be equally valued to that of the statutory members; giving them a vote was a means of doing that.

RECOMMENDATIONS

That the Cheshire East Health and Wellbeing Board:

1. Recommend that the Corporate Policy Committee and full Council adopt the revised terms of reference for the Cheshire East Health and Wellbeing Board.

Background

5 The current Terms of Reference of the Health and Wellbeing Board were approved by Council in April 2021. Within the Terms of Reference there is a requirement to review them every two years. If any changes are proposed, they are taken to the Corporate Policy Committee and then Council for approval (because they are a part of the Council's Constitution).

6 On 1st July 2022 the Health and Care Act 2022 came into force. This disestablished the Clinical Commissioning Groups (CCG) and replaced them with Integrated Care Systems across wider geographical footprints (ICS) We are now part of the Cheshire and Merseyside Integrated Care System, which comprises nine local authorities, health service providers and the newly established NHS Cheshire and Merseyside Integrated Care Board. A slide illustrating the governance of the ICS is set out at Appendix Three. As can be seen, our Health and Wellbeing Board forms and important part of the overall ICS governance across the Cheshire and Merseyside footprint, and importantly at 'Place' level as well.

7 The CCG is referenced within the existing Terms of Reference for the Health and Wellbeing Board and was represented on the Board. The necessary changes have been made within the revised version to delete references to the CCG and replace with the Integrated Care Board (ICB) and it is now ICB colleagues who attend meetings. Other minor changes have been made to take into account the NHS reorganisation of last year.

8 During 2022 a Local Government Association facilitated review of the Health and Wellbeing Board took place. This was initiated to ensure that the Board was fit for purpose in the light of the ICS. A number of workshops with Board members and a wider group of senior leaders took place. At the conclusion of the review there were recommendations for the Board to take forward and where required these have been incorporated into the revised Terms of Reference.

9 The most significant change is to remove the distinction between the voting Statutory Members and non-voting members. It was felt that having a two-tier voting/non-voting membership could be interpreted as not valuing the time,

knowledge and expertise of the Associate Members. It is therefore proposed that the Statutory Members have a vote and that all additional Members are appointed as voting Members.

Consultation and Engagement

10 The proposed changes have been extensively debated by the Health and Wellbeing Members through three workshops and the informal meetings of the Board. No formal public engagement or consultation has been undertaken.

Reasons for Recommendations

11 To ensure that the Health and Wellbeing Board Terms of Reference facilitate the work of the Board in meeting its statutory duties and responsibilities.

Other Options Considered

12 No other options have been considered.

Option	Impact	Risk
Do nothing	Terms of Reference would not reflect current legislative requirements and organisational arrangements	This would hamper the effectiveness of the Board

Implications and Comments

Monitoring Officer/Legal

13 Health and Wellbeing Boards were established by S194 of the Health and Social Care Act 2012 as committees of local authorities. The legislation provides that the Board must consist of at least one councillor, the Directors of Adults, Childrens and Public Health, a representative of Healthwatch and the CCG (now the ICB), and such others as the local authority thinks appropriate.

14 Full Council has the authority to determine the membership and terms of reference of the Health and Wellbeing Board, following consultation with the Board.

15 Section 194 (8) of the Health and Care Act 2012 also allows the Board to appoint such additional persons to be members of the Board as it thinks appropriate.

Section 151 Officer/Finance

16 No changes are required to the Council's existing Medium Term Financial Strategy (MTFS) as a result of this report. Relevant areas of expenditure are covered by existing resources, for example, those contained within the Better Care Fund (BCF) administered as a Pooled budget between the Council and Local Health partners.

Policy

17 The revisions to the Terms of Reference of the Health and Wellbeing Board will help to ensure that the Board is able to provide the necessary leadership to achieve its role of leading on integration, reducing health inequalities and supporting the delivery of the Joint Local Health and Wellbeing Strategy.

An open and enabling organisation	**A council which empowers and cares about people** Reduce inequalities across the borough	**A thriving and sustainable place** A great place for people to live, work and visit.

Equality, Diversity and Inclusion

18 There are no equality implications in relation to this report and its recommendations/decisions.

Human Resources

19 There are no HR implications of this report.

Risk Management

20 There are no significant risk management implications of this report.

Rural Communities

21 There are no specific implications to rural communities of this report.

Children and Young People including Cared for Children, care leavers and Children with special educational needs and disabilities (SEND)

22 There are no specific implications to children and young people, and cared for children, of this report.

Public Health

23 There are no specific implications in relation to Public Health. However, having Terms of Reference that are fit for purpose will allow the Board to work effectively in leading work to improve Public Health and reduce inequalities. The Board has a strategic leadership role in relation to the implementation of the Joint Local Health and Wellbeing Strategy (approved March 2023), and addressing the wider determinants of health (education, skills, employment status, housing, home environment, access to culture and leisure, green spaces etc); all of which have an impact on health and wellbeing.

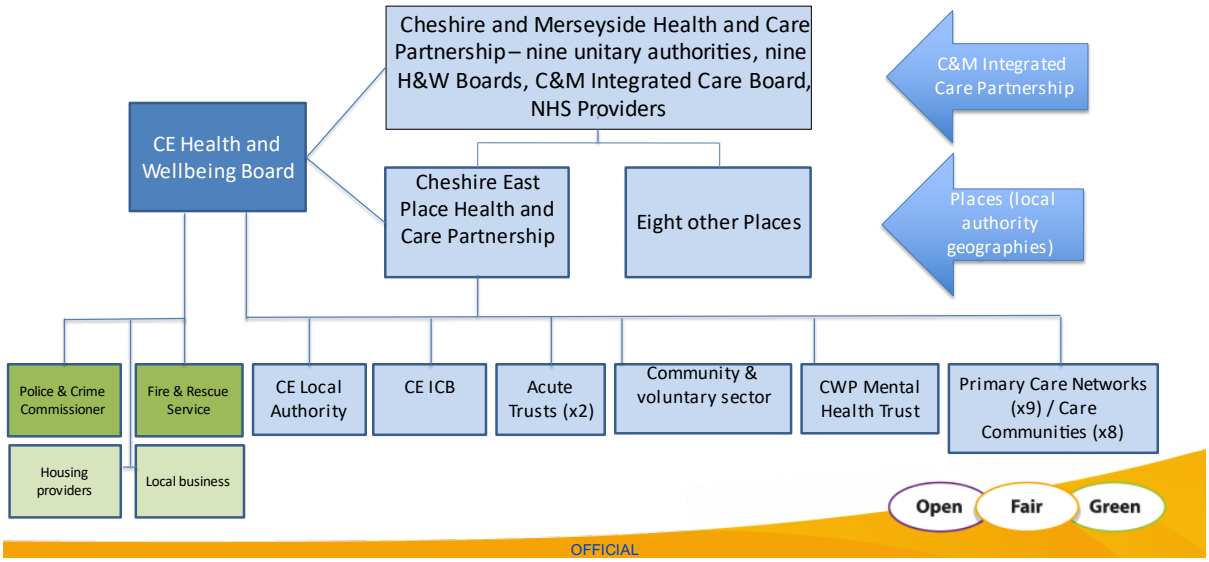
Climate Change

24 There are no impacts upon climate change from this report.

Access to Information	
Contact Officer:	Guy Kilminster, Corporate Manager Health Improvement Guy.kilminster@cheshireeast.gov.uk
Appendices:	Appendix One - Draft revised Terms of Reference for the Cheshire East Health and Wellbeing Board (V4 - showing tracked changes) Appendix Two - Draft revised Terms of Reference for the Cheshire East Health and Wellbeing Board (V4 – clean copy) Appendix Three - Integrated Health and Care System Governance diagram
Background Papers:	N/A

Appendix Three

The Cheshire & Merseyside Integrated Care System



Reviewed May/June 2023 V4

Cheshire East Statutory Health and Wellbeing Board

Terms of Reference June 2023

1. Context

1.1 The full name of the Board shall be the Cheshire East Health and Wellbeing Board. (CEHWB)

1.2 The CEHWB was established in April 2013.

1.3 The Health and Social Care Act 2012 and subsequent regulations provide the statutory framework for Health and Wellbeing Boards (HWB).

1.4 For the avoidance of doubt, except where specifically disapplied by these Terms of Reference, the Council Procedure Rules (as set out in its Constitution) will apply.

2. Purpose

- To work in partnership to make a positive difference to the health and wellbeing of the residents of Cheshire East through an evidence-based focus on improved outcomes and reducing health inequalities.
- To prepare and keep up to date the Joint Strategic Needs Assessments (JSNAs) and Joint Local Health and Wellbeing Strategy ~~ies~~ (JHWS~~s~~), which is a duty of local authorities and integrated care boards. ~~clinical commissioning groups (CCGs).~~
- To lead integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (ie lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.
- To be a forum that enables member organisations of the Board to hold each other to account for their responsibilities for improving the health of the population
- To assist in fostering good working relationships between commissioners of health-related services and the CEHWB itself.
- To assist in fostering good working relationships between commissioners and providers of health-related services (such as housing and many other local government services) and commissioners of health and social care services
- To undertake any other functions that may be delegated to it by the Council under section 196(2) of the Health and Social Care Act 2012.

Such delegated functions need not be confined to public health and social care.

- To provide advice assistance and support for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

3. Roles and Responsibilities

3.1 To work with the Council and NHS Cheshire and Merseyside Integrated Care Board (ICB) ~~CCG~~ effectively to ensure the delivery of the Joint Strategic Needs Assessment and Joint Local Health and Wellbeing Strategy.

3.2 To work within the CEHWB to build a collaborative partnership to key decision making that embeds health and wellbeing challenge, issue resolution and provides strategic system leadership.

3.3 To participate in CEHWB discussions to reflect the views of their partner organisations, being sufficiently briefed to be able to make recommendations about future policy developments and service delivery.

3.4 To champion the work of the CEHWB in their wider work and networks and in all individual community engagement activities.

3.5 To ensure that there are communication mechanisms in place within partner organisations to enable information about the CEHWB's priorities and recommendations to be effectively disseminated.

3.6 To share any changes to strategy, policy, and the system consequences of such on budgets and service delivery within their own partner organisations with the CEHWB to consider the wider system implications.

4. Accountability

4.1 The CEHWB carries no formal delegated authority from any of the individual statutory bodies.

4.2 ~~Core~~ Members of the CEHWB have responsibility and accountability for their individual duties and their role on the CEHWB.

4.3 The CEHWB will discharge its responsibilities by means of recommendations to the relevant partner organisations, which will act in accordance with their respective powers and duties.

4.4 The Council's ~~Core~~ Statutory Members will ensure that they keep Committee Chairs ~~Cabinet~~ and the wider Council advised of the work of the CEHWB.

4.5 The CEHWB may report and be accountable to Full Council and to the ~~relevant Governing Body of the NHS Clinical Commissioning Group~~ Cheshire and Merseyside Integrated Care Partnership by ensuring access to meeting minutes and presenting papers as required.

4.6 The CEHWB will not exercise scrutiny duties around health or adult social care services directly. This will remain the role of the Cheshire East Scrutiny Committee. Decisions taken and work progressed by the CEHWB will be subject to scrutiny by that Scrutiny Committee.

4.7 The CEHWB will provide information to the public through publications, local media, and wider public activities by publishing the minutes of its meetings on the Council's website. The CEHWB is supported by an Engagement and Communications Network across HWB organisations to ensure this function can operate successfully.

5. Membership

5.1 The ~~Core~~ membership of the CEHWB will comprise the following:

~~Voting m~~Members:

- ***Three*** councillors from Cheshire East Council* [1] ~~(~~representing the Administration)
- The Director of Adult Social Services*
- The Director of Children's and Families*
- The Director of Public Health*
- A local Healthwatch representative*
- Two representatives from ~~the~~ NHS Cheshire and Merseyside Integrated Care Board* ~~Clinical Commissioning Group~~
- ~~Two representatives from the Cheshire Integrated Care Partnership~~
- The Chair of the Cheshire East Place Health and Care Partnership
- The Executive Director of Place
- A Police and Crime Commissioner representative
- A Fire and Rescue Service representative
- A representative of CVS Cheshire East
- An additional representative of Children and Families
- A councillor from Cheshire East representating the main opposition group
- A representative of housing providers
- A representative of local businesses

~~Non-voting members:~~

- ~~The Chief Executive of the Council~~
- ~~The Director of Children's and Families~~
- ~~A nominated representative of NHS England / NHS Improvement~~

The councillor membership of the CEHWB ~~(the three core voting members)~~ will be determined by Cheshire East Council.

[1] * Statutory Members of the Board

5.2 The ~~Core~~ Statutory Members will keep under review the Membership of the CEHWB and ~~if appropriate~~ may appoint such additional persons to be members of the Board as it thinks appropriate (as set out in the Health and Social Care Act 2012 194 (8)). ~~will make recommendations to Council on any changes to the Core Membership.~~ All Members of the Board will be voting members.

5.3 ~~The above Statutory Members [2] through a majority vote have the authority to recommend to Council that individuals be appointed as Voting Associate Members of the CEHWB.~~ The length of the~~ir~~ appointment of additional members will be determined by the Health and Wellbeing Board. ~~membership will be for up to one year and will be subject to re-selection at the next Annual General Meeting "AGM" of the CEHWB.Associate Members~~ They will assist the CEHWB in achieving the priorities agreed within the Joint Health and Wellbeing Strategy. ~~and may indeed be chairs of sub structure forums where they are not actual Statutory Members of the CEHWB.~~

~~5.4 The above Statutory Members [3] through a majority vote have the authority to appoint individuals as Non Voting Associate Members of the CEHWB. (Committee Procedure Rule 20.1 refers). The length of their membership will be for up to one year and will be subject to re-selection at the next Annual General Meeting "AGM" of the CEHWB.~~

5.~~4~~5 Each ~~Core~~ Member has the power to nominate a single named substitute. If a Substitute Member be required, advance notice of not less than 2 working days should be given to the Council whenever practicable. The Substitute Members shall have the same powers and responsibilities as the ~~Core~~ Members.

6. Frequency of Meetings

6.1 There will be no fewer than four ~~public~~ meetings per year ~~(including an AGM)~~, usually once every three months. ~~as a formal CEHWB.~~

6.2 Additional meetings of the CEHWB may be convened with the agreement of the ~~CEHWB's~~ Chairman.

7. Agenda and Notice of Meetings

7.1 Any agenda items or reports to be tabled at the meeting should be submitted to the Council's Democratic Services no later than seven working days in advance of the next meeting. Generally, no business will be conducted that is not on the agenda.

~~[2] Regulation 5(1) removes this restriction in relation to health and wellbeing boards by disapplying section 104(1) of the 1972 Act to enable the local authority directors specified in the 2012 Act to become members of health and wellbeing boards~~

~~[3] Regulation 5(1) removes this restriction in relation to health and wellbeing boards by disapplying section 104(1) of the 1972 Act to enable the local authority directors specified in the 2012 Act to become members of health and wellbeing boards~~

7.2 Any ~~voting~~ member of the Board may ~~approach~~ request the Chairman ~~of the Board~~ to deal with an item of business which the ~~voting~~ member believes is urgent and ~~under the circumstances~~ requires a decision of the Board. The Chairman's ruling of whether the requested item is considered / tabled or not at the meeting will be recorded in the minutes of the meeting.

7.3 Meetings of the Board shall be open to the press and public and the agenda, reports and minutes will be available for inspection at the Council's offices and on its website at least five working days in advance of each meeting. ~~In accordance with the Access to Information legislation, Democratic Services will circulate and publish the agenda and reports prior to the next meeting. Exempt or Confidential Information shall only be circulated to Core Members.~~ This excludes items of business containing confidential information or information that is exempt from publication in accordance with Part 5A and schedule 12A Local Government Act 1972 (as amended).

8. ~~Annual General Meeting~~ Election of Chairman

8.1 The CEHWB shall elect the Chairman and Vice Chairman at its first meeting in the Municipal year. ~~each AGM, t~~The appointment will be a simple majority of those present and voting. ~~by majority vote of all Core voting Members present at the meeting.~~

8.2 For the avoidance of doubt, in the event of a tie when a vote is taken, the Chairman will have a casting vote. ~~The CEHWB will approve the representative nominations by the partner organisations as Core Members.~~

9. Quorum

9.1 Any full meeting of the CEHWB shall be quorate if there is representation of any three of the following ~~statutory~~ members: ~~the relevant~~ NHS Cheshire and Merseyside ICB ~~CCG(s)~~, the Cheshire East Health and Care Partnership, Local Health Watch, a Councillor and an Officer of Cheshire East Council.

9.2 Failure to achieve a quorum within fifteen minutes of the scheduled start of the meeting, or should the meeting become inquorate after it has started, shall mean that the meeting will proceed as an informal meeting but that any decisions shall require appropriate ratification at the next quorate meeting.

10. Procedure at Meetings

10.1 ~~General meetings of the CEHWB are open to the public and i~~In accordance with the Council's Committee Procedure Rules, meetings will include a Public Question Time Session. ~~Papers, agendas and minutes will be published on the Cheshire East Health and Wellbeing website.~~

10.2 The Council's Committee Procedure Rules will apply in respect of formal meetings subject to the following:-

10.3 The CEHWB will also hold development/informal sessions throughout the year where all members are expected to attend and partake as the agenda suggests.

~~10.4 Core Members are entitled to speak through the Chairman. Associate Members are entitled to speak at the invitation of the Chairman.~~

10.~~4~~5 With the agreement of the CEHWB, ~~sub~~ working groups (non-decision-making) and/or sub-committees (decision-making) can be set up to consider distinct areas of work. These ~~subgroup~~ will be responsible for arranging the frequency and venue of their meetings. The CEHWB will approve the membership. ~~of the subgroups.~~

10.~~5~~6 Any working group or sub-committee ~~subgroup~~ recommendations will be made to the CEHWB who will consider them in accordance with these terms of reference and their relevance to the priorities within the Joint Local Health and Wellbeing Strategy and its delivery plan.

10.~~6~~7 Whenever possible decisions will be reached by consensus or failing that a simple majority vote by those members entitled to vote.

11. Expenses

11.1 The partnership organisations are responsible for meeting the expenses of their own representatives.

~~11.2 A modest CEHWB budget will be agreed annually to support engagement and communication and the business of the CEHWB.~~

12. Conflict of Interest

12.1 ~~All voting members of the Board are subject to the Cheshire East Council Code of Conduct.~~ All members of the Board are required to uphold the Nolan Principles and all other relevant NHS or Council Code of Conduct requirements which are applicable to them. This includes the requirement to register and dislose pecuniary, registerable and other non-registerable interests at meetings where appropriate. ~~In accordance with the Council's Committee Procedure Rules, at the commencement of all meetings all CEHWB Members shall declare disclosable pecuniary or non-pecuniary interests and any conflicts of interest.~~

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~~12.2 In the case of non-pecuniary matters Members may remain for all or part of the meeting, participate and vote at the meeting on the item in question.~~

~~12.3 In the case of pecuniary matters Members must leave the meeting during consideration of that item.~~

13. Conduct of ~~Core~~ Members at Meetings

13.1 CEHWB members will agree to adhere to ~~the seven~~ principles and behaviours set out in Appendix One when ~~outlined in the CEHWB Code of Conduct~~ when carrying out their duties as a CEHWB member. ~~[Appendix 1].~~

14. Review

Reviewed May/June 2023 V4

14.1 The above terms of reference will be reviewed every two years at the first meeting of the CEHWB in the Municipal year. ~~AGM.~~

14.2 Any amendments to these terms of reference shall only be made ~~included by consensus or a simple majority vote, prior to referral to the Corporate Policy Committee and Council.~~ by the Council, on the recommendation of the Corporate Policty Committee and the CEHWB.

January 2017
Revised July 2019
Revised August 2020
Revised April 2021
Revised June 2023

Definition

Exempt Information
Which is information falling within any of the descriptions set out in Part I of Schedule12A to the Local Government Act 1972 subject to the qualifications set out in Part II and the interpretation provisions set out in Part III of the said Schedule in each case read as if references therein to "the authority" were references to "CEHWB" or any of the partner organisations.

Confidential Information
Information furnished to, partner organisations or the CEHWB by a government department upon terms (however expressed) which forbid the disclosure of the information to the public; and information the disclosure of which to the public is prohibited by or under any enactment or by the order of a court are to be discussed.

Conflict of Interest
You have a Conflict of interest if the issue being discussed in the meeting affects you, your family or your close associates in the following ways;
- *The issue affects their well being more than most other people who live in the area.*
- *The issue affect their finances or any regulatory functions and*
- *A reasonable member of the public with knowledge of the facts would believe it likely to harm or impair your ability to judge the public interest.*

Associate Members
Associate Member status is appropriate for those who are requested to chair sub groups of the CEHWB.

Health Services
Means services that are provided as part of the health service.

Health-Related Services *means services that may have an effect on the health of individuals but are not health services or social care services.*

Social Care Services
Means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970

Appendix 1

Reviewed May/June 2023 V4

~~CEHWB Member Code of Conduct~~

~~1. Selflessness~~

~~Members of the Cheshire East Health and Wellbeing CEHWB should act solely in terms of the interest of and benefit to the public/patients of Cheshire East. They should not do so in order to gain financial or other benefits for themselves, their family or their friends~~

~~2. Integrity~~

~~Members of the Cheshire East Health and Wellbeing CEHWB should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their duties and responsibilities as a CEHWB member~~

~~3. Objectivity~~

~~In carrying out their duties and responsibilities members of the Cheshire East Health and Wellbeing CEHWB should make choices based on merit and informed by a sound evidence base~~

~~4. Accountability~~

~~Members of the Cheshire East Health and Wellbeing CEHWB are accountable for their decisions and actions to the public/patients of Cheshire East and must submit themselves to whatever scrutiny is appropriate~~

~~5. Openness~~

~~Members of the Cheshire East Health and Wellbeing CEHWB should be as transparent as possible about all the decisions and actions that they take as part of or on behalf of the CEHWB. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands~~

~~6. Honesty~~

~~Members of the Cheshire East Health and Wellbeing CEHWB have a duty to declare any private interests relating to their responsibilities and duties as CEHWB members and to take steps to resolve any conflicts arising in a way that protects the public interest and integrity of the Cheshire East Health and Wellbeing CEHWB~~

~~7. Leadership~~

~~Members of the Cheshire East Health and Wellbeing CEHWB should promote and support these principles by leadership and example~~

Health and Wellbeing Board Principles and Behaviours

The Cheshire East Health and Wellbeing Board Partners shall work together to achieve the objectives of the Cheshire East Health and Wellbeing Strategy and The Cheshire East Place Partnership Five Year Plan. The Board shall:

(a) Collaborate and work together on an inclusive and supportive basis, with optimal use of their individual and collective strengths and capabilities;

(b) Engage in discussion, direction setting and, where appropriate, collective agreement, on the basis that all the Partners will participate where agreed proposals affect the strategic direction of the Health and Wellbeing Board and/or of Services, and in establishing the direction, culture and tone of the work and meetings of the Board;

(c) Act in the spirit of partnership in discussion, direction setting and, where appropriate, collective agreement making;

(d) Always focus upon improvement to provide excellent Services and outcomes for the Cheshire east population;

(e) Be accountable to each other through the Board by, where appropriate, taking on, managing and accounting to each other in respect of their financial and operational performance;

(f) Communicate openly about major concerns, issues or opportunities relating to the Board;

(g) Act in a way that is best for the delivery of activity to drive forward the Five Year Plan, and shall do so in a timely manner and respond accordingly to requests for support promptly;

(h) Work with stakeholders effectively, following the principles of co- design and co-production;

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Cheshire East Statutory Health and Wellbeing Board

Terms of Reference June 2023

1. Context

1.1 The full name of the Board shall be the Cheshire East Health and Wellbeing Board. (CEHWB)

1.2 The CEHWB was established in April 2013.

1.3 The Health and Social Care Act 2012 and subsequent regulations provide the statutory framework for Health and Wellbeing Boards (HWB).

1.4 For the avoidance of doubt, except where specifically disapplied by these Terms of Reference, the Council Procedure Rules (as set out in its Constitution) will apply.

2. Purpose

- To work in partnership to make a positive difference to the health and wellbeing of the residents of Cheshire East through an evidence-based focus on improved outcomes and reducing health inequalities.

- To prepare and keep up to date the Joint Strategic Needs Assessments (JSNAs) and Joint Local Health and Wellbeing Strategy (JHWS), which is a duty of local authorities and integrated care boards.

- To lead integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (ie lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.

- To be a forum that enables member organisations of the Board to hold each other to account for their responsibilities for improving the health of the population

- To assist in fostering good working relationships between commissioners of health-related services and the CEHWB itself.

- To assist in fostering good working relationships between commissioners and providers of health-related services (such as housing and many other local government services) and commissioners of health and social care services

- To undertake any other functions that may be delegated to it by the Council under section 196(2) of the Health and Social Care Act 2012.

Such delegated functions need not be confined to public health and social care.

- To provide advice assistance and support for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

3. Roles and Responsibilities

3.1 To work with the Council and NHS Cheshire and Merseyside Integrated Care Board (ICB) effectively to ensure the delivery of the Joint Strategic Needs Assessment and Joint Local Health and Wellbeing Strategy.

3.2 To work within the CEHWB to build a collaborative partnership to key decision making that embeds health and wellbeing challenge, issue resolution and provides strategic system leadership.

3.3 To participate in CEHWB discussions to reflect the views of their partner organisations, being sufficiently briefed to be able to make recommendations about future policy developments and service delivery.

3.4 To champion the work of the CEHWB in their wider work and networks and in all individual community engagement activities.

3.5 To ensure that there are communication mechanisms in place within partner organisations to enable information about the CEHWB's priorities and recommendations to be effectively disseminated.

3.6 To share any changes to strategy, policy, and the system consequences of such on budgets and service delivery within their own partner organisations with the CEHWB to consider the wider system implications.

4. Accountability

4.1 The CEHWB carries no formal delegated authority from any of the individual statutory bodies.

4.2 Members of the CEHWB have responsibility and accountability for their individual duties and their role on the CEHWB.

4.3 The CEHWB will discharge its responsibilities by means of recommendations to the relevant partner organisations, which will act in accordance with their respective powers and duties.

4.4 The Council's Statutory Members will ensure that they keep Committee Chairs and the wider Council advised of the work of the CEHWB.

4.5 The CEHWB may report and be accountable to Full Council and to the Cheshire and Merseyside Integrated Care Partnership by ensuring access to meeting minutes and presenting papers as required.

4.6 The CEHWB will not exercise scrutiny duties around health or adult social care services directly. This will remain the role of the Cheshire East Scrutiny Committee. Decisions taken and work progressed by the CEHWB will be subject to scrutiny by that Scrutiny Committee.

4.7 The CEHWB will provide information to the public through publications, local media, and wider public activities by publishing the minutes of its meetings on the Council's website. The CEHWB is supported by an Engagement and Communications Network across HWB organisations to ensure this function can operate successfully.

5. Membership

5.1 The membership of the CEHWB will comprise the following:

Members:

- ***Three*** councillors from Cheshire East Council* [1] (representing the Administration)
- The Director of Adult Social Services*
- The Director of Children's and Families*
- The Director of Public Health*
- A local Healthwatch representative*
- Two representatives from NHS Cheshire and Merseyside Integrated Care Board*
- The Chair of the Cheshire East Place Health and Care Partnership
- The Executive Director of Place
- A Police and Crime Commissioner representative
- A Fire and Rescue Service representative
- A representative of CVS Cheshire East
- An additional representative of Children and Families
- A councillor from Cheshire East Council representing the main opposition group
- A representative of housing providers
- A representative of local businesses

The councillor membership of the CEHWB will be determined by Cheshire East Council.

5.2 The Statutory Members will keep under review the Membership of the CEHWB and may appoint such additional persons to be members of the Board as it thinks appropriate (as set out in the Health and Social Care Act 2012 194 (8)). All Members of the Board will be voting members.

[1] * Statutory Members of the Board

5.3 The length of the appointment of additional members will be determined by the Health and Wellbeing Board. They will assist the CEHWB in achieving the priorities agreed within the Joint Health and Wellbeing Strategy.

5.4 Each Member has the power to nominate a single named substitute. If a Substitute Member be required, advance notice of not less than 2 working days should be given to the Council whenever practicable. The Substitute Members shall have the same powers and responsibilities as the Members.

6. Frequency of Meetings

6.1 There will be no fewer than four meetings per year, usually once every three months.

6.2 Additional meetings of the CEHWB may be convened with the agreement of the Chairman.

7. Agenda and Notice of Meetings

7.1 Any agenda items or reports to be tabled at the meeting should be submitted to the Council's Democratic Services no later than seven working days in advance of the next meeting. Generally, no business will be conducted that is not on the agenda.

7.2 Any member of the Board may request the Chairman to deal with an item of business which the member believes is urgent and requires a decision of the Board. The Chairman's ruling of whether the requested item is considered / tabled or not at the meeting will be recorded in the minutes of the meeting.

7.3 Meetings of the Board shall be open to the press and public and the agenda, reports and minutes will be available for inspection at the Council's offices and on its website at least five working days in advance of each meeting. This excludes items of business containing confidential information or information that is exempt from publication in accordance with Part 5A and schedule 12A Local Government Act 1972 (as amended).

8. Election of Chairman

8.1 The CEHWB shall elect the Chairman and Vice Chairman at its first meeting in the Municipal year. The appointment will be a simple majority of those present and voting.

8.2 For the avoidance of doubt, in the event of a tie when a vote is taken, the Chairman will have a casting vote.

9. Quorum

9.1 Any full meeting of the CEHWB shall be quorate if there is representation of any three of the following members: – NHS Cheshire and Merseyside ICB , the Cheshire East Health and Care Partnership, Local Health Watch, a Councillor and a Statutory Officer of Cheshire East Council.

9.2 Failure to achieve a quorum within fifteen minutes of the scheduled start of the meeting, or should the meeting become inquorate after it has started, shall mean that the meeting will proceed as an informal meeting but that any decisions shall require appropriate ratification at the next quorate meeting.

10. Procedure at Meetings

10.1 In accordance with the Council's Committee Procedure Rules, meetings will include a Public Question Time Session.

10.2 The Council's Committee Procedure Rules will apply in respect of formal meetings.

10.3 The CEHWB will also hold development/informal sessions throughout the year where all members are expected to attend and partake as the agenda suggests.

10.4 With the agreement of the CEHWB, working groups (non-decision-making) and/or sub-committees (decision-making) can be set up to consider distinct areas of work. These will be responsible for arranging the frequency and venue of their meetings. The CEHWB will approve the membership.

10.5 Any working group or sub-committee recommendations will be made to the CEHWB who will consider them in accordance with these terms of reference and their relevance to the priorities within the Joint Local Health and Wellbeing Strategy and its delivery plan.

10.6 Whenever possible decisions will be reached by consensus or failing that a simple majority vote by those members entitled to vote.

11. Expenses

11.1 The partnership organisations are responsible for meeting the expenses of their own representatives.

12. Conflict of Interest

12.1 All members of the Board are required to uphold the Nolan Principles and all other relevant NHS or Council Code of Conduct requirements which are applicable to them. This includes the requirement to register and disclose pecuniary, registerable and other non-registerable interests at meetings where appropriate.

13. Conduct of Members at Meetings

13.1 CEHWB members will agree to adhere to principles and behaviours set out in Appendix One when carrying out their duties as a CEHWB member.

14. Review

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Revised June 2023

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Appendix 1

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(h) Work with stakeholders effectively, following the principles of co- design and co-production;

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Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Update on development of an Integrated Care System across Cheshire and Merseyside and in Cheshire East
Report Reference Number	
Date of meeting:	27th June 2023
Written by:	Mark Wilkinson, Cheshire East Place Director, NHS Cheshire and Merseyside
Contact details:	Mark.wilkinson@cheshireandmerseyside.nhs.uk
Health & Wellbeing Board Lead:	Mark Wilkinson, Cheshire East Place Director, NHS Cheshire and Merseyside

Executive Summary

Is this report for:	Information X	Discussion X	Decision
Why is the report being brought to the board?	The establishment of the integrated system is a significant change to NHS organisational structures with the explicit aim of further integrating health and care service planning and delivery. This paper provides an update on progress.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☐ Improving the mental health and wellbeing of people living and working in Cheshire East ☐ Enable more people to live well for longer ☐ All of the above X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above X		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	To note the report.		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The report has not received any prior consideration.
Has public, service user, patient feedback/consultation informed the recommendations of this report?	Not applicable.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Not applicable as the recommendation is to the note the report.

Report Summary

The report presents progress with the development of an integrated care system for Cheshire and Merseyside and more specifically Cheshire East. Good progress has been made in delivering improved performance in urgent and emergency care, returning the full range of maternity services to Macclesfield District General Hospital, and with the inclusion of a new hospital for Cheshire East in the NHS new hospitals programme.

Recommendations

To note the report.

Reasons for Recommendations

The report provides update information on the establishment of an integrated care system regionally and locally.

Impact on Health and Wellbeing Strategy Priorities

The closer and more joined up working of health and care services will support the achievement of those health and wellbeing strategy priorities that can be delivered by health and care organisations including in our role as anchor institutions.

System urgent and emergency care demand and capacity modelling

1. Colleagues from Warrington place presented their model for urgent and emergency care system demand and capacity. Some of the value from this approach as they have developed it comes from identifying the root causes rather than the symptoms of system pressure. For example, the most appropriate solution to overcrowding in an emergency department may not lie in spending more on hospital staff, instead spending on GP services might be more advantageous.
2. Developed appropriately a model can also force a level of quantitative rigour. Despite some expectation from system partners their modelling work has not provided 'an answer', however it has helped to focus attention on their 'big-ticket' items. We agreed to review our own modelling work in Cheshire East at a future place leadership group development session.

Inclusion of Leighton Hospital in the national NHS new hospitals programme

3. The Department of Health has recently announced the inclusion of Leighton Hospital in the national new hospitals programme. We agreed that this should be the subject of a future development session for the place leadership group. Meanwhile the Trust is engaging with place partners in the development of a clinical services strategy that will shape an estates strategy that will in turn inform the design of the new hospital.

Return of in-patient maternity services to Macclesfield DGH

4. The full range of maternity services are restored to Macclesfield with return of in patient maternity services on 26th June more than three years after they were suspended at the start of the COVID pandemic.
5. The final assurance visit with representatives from both Greater Manchester and Cheshire and Merseyside maternity networks will take place on 12th June - although the decision to proceed has been confirmed.

Macclesfield urgent and emergency care system pressures and the emergency department capital scheme

6. A capital scheme to significantly improve Macclesfield's emergency department has recently commenced. Urgent and emergency care system pressures mean that we are currently seeing an unacceptably high number of patients sleeping in the emergency

department each night. As the capital scheme progresses some of the physical space to accommodate these patients will be lost, raising the risk of significant ambulance handover delays. With the scheme not due to complete until March 24, this is a system risk not only in the short term but also over next winter. Macclesfield lost Ward 6 beds as part of the return of maternity services at the start of 2023.

Service blueprint for 2030

7. Although our health and wellbeing board and partnership board strategies identify our strategic objectives as a place partnership, a gap has been identified in terms of describing what our health and care services will look like in future. This might be termed a service blueprint. Significant work has been undertaken by our predecessor organisations, and the intention is to use a tightly defined three workshops over the summer to refresh and reconfirm our support for work undertaken previously. When completed, this can be a product to guide both the sustainable hospital services programme for Macclesfield, and also the design of the new hospital in Mid Cheshire.

Joint outcomes framework

8. Dr Susie Roberts, public health consultant, presented the work she has been leading to develop a joint outcomes framework. The framework is being developed to inform and monitor our transformation and integration programmes and crucially to measure progress against the health and well-being strategy.

Tier 1 for urgent and emergency care service delivery

9. The Cheshire and Merseyside ICS has been placed in the highest (least well performing), tier for urgent and emergency care service delivery. This reaffirms our strategic priority around Home First. Locally our performance is relatively strong evidenced by performance information set out in the appendix to this report.

Cheshire and Merseyside Health and Care Partnership stakeholder briefing

10. The Partnership has recently provider a stakeholder briefing which can be accessed by the following link:

View this briefing in your browser

Access to Information

The background papers relating to this report can be inspected by contacting the report writer:

Name:	Mark Wilkinson
Designation:	Cheshire East Place Director, NHS Cheshire and Merseyside
Tel No:	Not applicable
Email:	mark.wilkinson@cheshireandmerseyside.nhs.uk

Appendix

1. This information is taken from a recently produced briefing note on our urgent and emergency care system performance.

2. The period from November 22 to April 23 period has been selected as it is a) fairly recent, b) represents the time of our established collaborative working on Home First, and c) saw place agreed investment in schemes aimed at easing urgent and emergency care pressures.

People going into NHS secondary care

3. Average daily attendances by month at both our emergency departments (Macclesfield and Crewe) have reduced by 4.5% from November to April. From November 21 to April 22 as a point of comparison, they increased by a similar percentage.

4. Average daily non elective admissions have reduced by 8.7% from November to April. In the same period in the previous year though, they fell by 10%.

5. Any local reduction in A&E attendances should be viewed against the UK wide trend of long term increases and is to be welcomed, although the numbers are small. Also worth pointing out that over the last few months the general NHS policy focus has been on reducing the number or people who don't need to be in hospital not stopping them attending in the first place.

People remaining in hospital without a strong medical reason (NCTR – no criteria to reside)

6. From November to April the average daily number of people who didn't need to be in hospital fell by 35%

7. The same period saw a 22% reduction in the average daily number of people with a hospital length of stay over 21 days.

8. One of the contributory factors to this improvement has been our work to reduce waiting for domiciliary care support. As at 7 June, there were only two Cheshire East residents waiting in an NHS hospital bed for domiciliary care to support their discharge.

9. This is where our evidence is strongest. By working together we have got people out of hospital sooner, reduced the deconditioning that inevitably occurs with long hospital stays, and freed up capacity for patients that need to be in hospital.

10. Across Cheshire and Merseyside at the end of April, our local NHS providers were ranked 2nd and 3rd best in terms of the percentages of acute beds occupied by NCTR patients.

11. This percentage measure of our performance has been achieved with fewer beds than previously (in Mid Cheshire due to the building issues; in East Cheshire due to readying a ward for the return of full maternity services). In shorter, our denominator has reduced.