Public Document Pack

Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday, 24th September, 2024**
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 foot 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. **Apologies for Absence**

2. **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.

3. **Minutes of Previous meeting (**Pages 3 - 10)

   To approve the minutes of the meeting held on 2 July 2024

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

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

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.

5. **Lifestyle prescription update (**Pages 11 - 16)

To receive an update relating to the Cheshire East Lifestyle on Prescription resource.

6. **Children and Young People 'Make Your Mark' ballot results (**Pages 17 - 40)

To receive an update from the Youth Council.

7. **All Together Smoke Free/Tobacco Control update**

To receive a presentation on the All Together Smoke Free/Tobacco Control update.

8. **Green Spaces for Wellbeing update (**Pages 41 - 54)

To receive an update on the Greenspaces for Wellbeing project.

9. **Better Care Fund end of year analysis 2023-2024 and plan for 2024-2025 (**Pages 55 - 90)

To receive a report on the end of year overview of the Cheshire East Better Care Fund plan for the period 2023-24 and plan for 2024-2025.

10. **HIV Fast Track Cities (**Pages 91 - 96)

To consider a report on the Cheshire and Merseyside Commitment to HIV Fast Track Cities Approach.

Membership: L Barry, Dr P Bishop, Councillor C Bulman, H Charlesworth-May, Councillor S Corcoran (Chair), M Davis, Councillor J Rhodes, M Wilkinson, Councillor J Clowes, C Jesson, P Skates, K Sullivan, C Williamson, I Wilson and C Wright.

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 2nd July, 2024 in the Council Chamber, Municipal Buildings, Earle Street, Crewe CW1 2BJ

PRESENT

Board Members
Helen Charlesworth-May, Executive Director Adults, Health, and Integration
Councillor Janet Clowes, representing the main opposition group, Cheshire East Council
Councillor Sam Corcoran (Chair), Leader - Cheshire East Council
Councillor Carol Bulman, Chair of Children & Families, Cheshire East Council
Councillor Jill Rhodes, Chair of Adults & Health, Cheshire East Council
Mark Groves, Healthwatch Cheshire (subbing for Louise Barry)
Peter Skates, Acting Executive Director of Place
Deborah Woodcock, Executive Director of Children's Services, Cheshire East Council
Kathryn Sullivan, CVS Cheshire East
Mark Wilkinson, NHS Cheshire, and Merseyside Integrated Care Board
Charlotte Wright, Cheshire Fire and Rescue Service
Chief Inspector Andy Baker (subbing for Superintendent Claire Jesson)

Cheshire East Officers and Others
Russell Favager, Mid Cheshire Hospitals NHS Foundation Trust
Guy Kilminster, Corporate Manager Health Improvement
Jeremy Owens, Development Planning Manager
Dr Susie Roberts, Public Health Consultant
Karen Shuker, Democratic Services Officer
Chief Inspector Daniel Reynolds (Joined remotely via Microsoft Teams)
Inspector Pete Brachaniec (joined remotely via on Microsoft Teams)
Kaylie Locke RCRP Administrator (joined remotely via on Microsoft Teams)

The Chair varied the order of business. Notwithstanding this the minutes are in the order of the agenda.

1 **APPOINTMENT OF CHAIR**

It was moved and seconded that Councillor Sam Corcoran be appointed the Chair.

RESOLVED:

That Councillor Sam Corcoran be appointed as Chair.

2 **APPOINTMENT OF VICE CHAIR**

It was moved and seconded that Louise Barry be appointed as Vice Chair.

RESOLVED:

That Louise Barry be appointed as Vice Chair.

3 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Louise Barry (Health Watch), Dr Paul Bishop (NHS Cheshire and Merseyside Integrated Care Board), Michelle Davis (Guinness Housing), Dr Matt Tyrer (Director of Public Health - CEC), Superintendent Claire Jesson (Police), Claire Williamson (Children's Services - CEC) and Isla Wilson (Cheshire East Health and Care Place Partnership).

Chief Inspector Andy Baker (Police) and Mark Groves (Healthwatch) attended as substitutes.

4 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

5 **MINUTES OF PREVIOUS MEETING**

RESOLVED:

That the minutes of the meeting held on 19 March 2024 be confirmed as a correct record.

6 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no registered public speakers.

7 **MEMBERSHIP REVIEW 2024-2025**

The Cheshire East Health and Wellbeing Board's Terms of Reference require the membership to be reviewed and agreed at the first meeting of the Municipal Year. The Board considered a report which reviewed the membership for 2024-25.

It was noted that the Chamber of Commerce would be contacted in relation to the vacant position for a business representative to sit on the Board.

RESOLVED:

That the statutory Cheshire East Health and Wellbeing Board members agree the following individuals as additional members for 2024-2025

Councillor Janet Clowes – Opposition Group representative
Peter Skates – Acting Executive Director of Place
Isla Wilson – representing the Place Health and Care Partnership Board

Superintendent Claire Jesson – representing the Police and Crime Commissioner
Charlotte Wright - representing the Chief Fire Officer
Kathryn Sullivan - representing the community, voluntary and social enterprise sector.
Claire Williamson – an additional representative for Children and Families
Michelle Davis - representing housing providers.
A Business representative – to be nominated.

8 **RIGHT CARE RIGHT PERSON UPDATE**

The Board received an update on the Right Care Right Person initiative which had been implemented in Cheshire last year. The initiative sought to ensure that the public were getting the right care, by the right person with the right skills, training, and experience to best meet their needs.

Board members asked questions and made comments in relation to

- From a Health and Wellbeing Board perspective it would be useful to have comparative data on a regular basis and over a longer period of time.
- If a call does not meet the Police's threshold for a response is another service offered?
- Is there any extra demand on other agencies as a result of the new approach and if there is how would that be monitored?

In response Chief Inspector Reynolds reported that

- Attendance at a future meeting could be arranged to discuss the long-term data.
- If a decision is made that the threshold had not been met, the information would still be recorded, and a toolkit used to triage it. Alternative services and support would be signposted.
- The Tactical Co-ordination Group (TCG) have asked partners to track their data and they had not seen any displaced demand on other agencies to date.

RESOLVED:

That the update be noted.

9 **JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE AND LIFESTYLE SURVEY FINDINGS**

The Board received an update on the Joint Strategic Needs Assessment (JSNA) work programme.

The update included:

- Following the conclusion of the lifestyle survey headline findings were that the overall picture of the health and wellbeing of residents in the borough was generally good, but with significant pockets of poorer health and wellbeing often aligned to areas of deprivation.
- Work was due to commence on unpicking the findings of the report in relation to whether perceptions of health and wellbeing match the challenges the respondents report in terms of lifestyle and further, to make sure there was cross-checking with other data sources as well.
- Work was progressing on social isolation and care of older people and there continued to be good engagement across the system on all of those aspects of work.
- Topic areas for 2024/25 included health and wellbeing in the early years (0 – 5-year-olds), sexual health needs assessment and a place-based JSNA focusing on Congleton and Holmes Chapel Care Community.

Work would continue to develop in the following areas:

- More resources in easy read and plain English summaries.
- Promotion of the JSNA to inform a wider audience including Members and Parish and Town Councils.

In response to questions asked in relation to taking advantage of Crewe Youth Zone once it had been built and the pilot that had taken place on financial incentives for pregnant women stopping smoking officers report that:

- Contacts were being identified to help progress the recommendations in relation to Crewe and this included the Crewe Youth Zone.
- An evaluation was currently underway in respect of smoking cessation and an academic partner was working with officers on that.

RESOLVED: That the Health and Wellbeing Board

1. Approve the reviews to commence during 2024/25.
2. Note the progress on the JSNA work programme and to adopt the recommendations that have resulted from this work.
3. Agree to utilise the JSNA to inform continued challenging decision making in relation to public sector budgets.

10 **PHARMACEUTICAL NEEDS ASSESSMENT 2025 UPDATE**

The Board considered a report which outlined the approach to be taken to the production of the revised Pharmaceutical Needs Assessment which was due to be published by the 1st October 2025.

RESOLVED: That the Health and Wellbeing Board

1. approves delegation of the day-to-day authority for the development of the revised Pharmaceutical Needs Assessment (PNA) to the Director of Public Health (DPH). This will include the approval of the draft PNA prior to consultation.
2. approves the formation of a working group to steer the production of the revised PNA.
3. agrees contingency arrangements for endorsing the PNA virtually by board members in September 2025 in case the HWB meeting is cancelled, or the timing of the meeting is such that the PNA required publishing date (before the 1st October 2025) precedes the scheduled meeting date. Due to the consultation requirement of 60 days and to enable the final draft to go through the council review process, it is not feasible to present the final draft for endorsement at an earlier meeting. This will be the Board's only opportunity to review the results of the consultation and consider the impact of the results from the consultation.
4. note there is a cost implication in the production of the PNA, mostly for staff time which will be required across all partner organisations. Its production will impact on joint strategic needs assessment (JSNA) activity during 2024/5 and 2025/6. Any financial implications that arise as a result of any actions taken in response to this report are fully covered by existing funding, meaning that there are no changes required to the Council's existing Medium Term Financial Strategy (MTFS).
5. note that the Pharmaceutical Regulations 2013 were amended in September 2023, however most of the amendments are concerning 100- hour pharmacies, changes to contracted opening hours and arrangements regarding temporary cover these do not affect the content or timing of the PNA.

11 **LEIGHTON HOSPITAL REDEVELOPMENT STRATEGIC OUTLINE CASE**

The Board received a presentation on: A new Leighton: Strategic Outline Case (SOC). The presentation included the issues with the existing site, an outline of the 3-stage process for the business case approval, a list of the options considered, the preferred way forward, timelines, achievements to date and the next steps.

Board members supported the plan and provided comments and feedback in respect of

- Welcomed the enhanced communication and integration between community and secondary care built into the design.
- Clarity required around revenue affordability.
- Involvement required in signing off the provision of clinical capacity i.e., beds.
- Mental health services for patients with physical and mental health needs was a key issue. The SOC as it currently stood was light on

references to mental health whereas significant additional costs on caring for patients with mental and physical health needs in the A&E and on the wards was being incurred.
- Public transport between Crewe and Leighton was poor, and the SOC was silent on any aspiration to improve that position. Better transport was potentially a significant social value contributor if it could be addressed.
- Request to see the timetable for outline business case development.
- Welcome the carbon neutrality elements of the project.
- Wanted reassurance when going into the next stage that the highways network was sufficient to deal with the additional housing in the surrounding area and the additional volume of traffic that would be brought in.

RESOLVED:

That the update be noted.

12 **THE CHESHIRE EAST LOCAL PLAN**

The Board received a report on Cheshire East's New Local Plan. The Plan would look ahead into the 2040s and would identify new long-term development requirements and how they would be met.

The Plan would set out a range of policies regarding a wide range of planning considerations – landscape, biodiversity, heritage, health, housing mix, etc, - so those matters would be taken into account when deciding planning applications.

The Council had published a new Local Plan Issues Paper which announced its intention to prepare a new Local Plan and to provide an initial opportunity for feedback about the scope of the plan.

It was noted that one of the challenges faced at present was the possibility of a change in government which may have different ideas in planning reform so there was some uncertainty about the future programme.

Members asked questions and provided comments in respect of

- It would be useful to have an opportunity for the Health and Wellbeing Board to have an input in to the new policies from a healthy and safe communities' perspective.
- Could the plan include developments that people are less keen to see in the area but would be good from an economic perspective, such as care homes and retirement orientated housing developments but could create additional pressures from a health care and social care perspective?
- Would the new plan have tighter controls over older properties?

- Would the new plan have more detailed Town Plans, or would it be similar to the current Plan?

In response officers reported that

- They would have to see what was happening in terms of the planning reform agenda following the election before the next steps could be taken with the Plan.
- National Policy stated that Local Authorities would be required to do a Housing Needs Assessment, including all sectors of the community.
- Due to not knowing how much development the Council would be planning for more detail within the strategy would be required for particular towns.

It was agreed that a workshop around the Local Plan would be added to the work programme of the Health and Wellbeing Board.

RESOLVED: That the Health and Wellbeing Board

Noted that the Council has commenced work on a new Local Plan through the publication of an Issues Paper inviting initial feedback on its scope.

13 **CHILDREN'S OFSTED REPORT**

The Executive Director of Children's Services provided a verbal update in respect of the findings from the Ofsted Inspection of Local Authority Children's Services (ILACS) conducted in February and March 2024, the plans in place to improve services in relation to the findings, and monitoring arrangements from Ofsted and the Department for Education (DfE).

Whilst the judgement was disappointing, board members acknowledged that there had been improvements in other areas and that there had been no statutory failings from a Health and Wellbeing perspective.

The Chair thanked the staff in Children and Families Services who were working hard to deliver the required improvements that had been identified.

RESOLVED:

That the update be noted.

Councillor C Bulman and Deborah Woodcock, Executive Director of Children's Services left the meeting after this item and did not return.

The meeting commenced at 2.00 pm and concluded at 4.00 pm

Councillor S Corcoran (Chair)

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Agenda Item 5

Title of Report:	Lifestyle prescription update
Date of meeting:	26 September 2024
Written by:	Dr Susan Roberts, Hayley Cooper and Rachael Nicholls
Contact details:	susan.roberts@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Dr Matt Tyrer

Executive Summary

Is this report for:	Information X	Discussion ☐	Decision
Why is the report being brought to the board?	The purpose of this report to provide the Health and Wellbeing Board with updates relating to the Cheshire East Lifestyle on Prescription resource.		
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 (HWB) is asked to: • Note the update • Raise awareness regarding the Lifestyle Prescription for adults and children		
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 Public Health Senior Management Team.		
Has public, service user, patient feedback/consultation informed the recommendations of this report?	The Lifestyle Prescription for children and young people has been developed in collaboration with The Jigsaw Groups, Youth Council and Youth Club in Middlewich.		

If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	The purpose of the Lifestyle Prescription is to promote more comprehensive and holistic discussion and reflection on lifestyles in both residents and people working in Cheshire East. Promotion of holistic wellbeing and prevention are core goals of the Joint Health and Wellbeing Strategy 2023-2028 and the Blueprint Vision for health and care in 2030.

1. Report Summary

1.1. The purpose of this report is to update the Health and Wellbeing Board on the further developments of the Cheshire East Lifestyle Prescription resource: Lifestyle on prescription (cheshireeast.gov.uk)

1.2. Key updates include:

- The wording of the resource for adults has been adapted to further simplify the messaging.
- The resource for adults has been translated into three languages to promote inclusivity. Polish, Ukranian and Tetum.
- A new resource for children and young people has been developed.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to:

- Note the update.
- Raise awareness regarding the Lifestyle Prescription resources for adults and children

Reasons for Recommendations

2.2. Promotion of holistic wellbeing, the best start in life, and healthy ageing are key components of the Joint Health and Wellbeing Strategy 2023-2028, and the Blueprint Vision for health and care in 2030.

3. Impact on Health and Wellbeing Strategy Priorities

3.1. The production of the Lifestyle Prescription 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.

4. Background and Options

4.1. The Cheshire East Lifestyle Prescription was developed over the course of 2022 and 2023 through a partnership approach.

4.2. The need for such a resource to support the prioritisiation of prevention was identified through conversation within the Integrated Care Partnership cardiovascular, respiratory and prevention workstreams. The resource aligns with the Blueprint Vision for health and care in 2030 and the Joint Health and Wellbeing Strategy 2023-2028.

4.3. The resource was initially developed to be used to ‘nudge’ residents into thinking about acting upon lifestyle changes so they avoid the development of long term conditions, where possible, and see more than just the medication as a form of treatment, where long term conditions have developed.

4.4. It aims to

- Promote lifestyle changes through the application of behaviour change theory- it provides motivations for behaviour change, information about how to achieve this and opportunities for support across the local area.
- Put the Cheshire East resident at the heart of the resource by describing both local and national opportunities for support.
- Draw a clear link to our social prescribing teams, empowering residents to connect with support for challenges relating to the wider determinants of health.
- Encourage the use of outdoor spaces for health.

4.5. Intended audiences for the resource include:

- The general public, who might access the resource via our libraries, or the Cheshire East live well site.
- People diagnosed with a new long-term condition where lifestyle changes are the treatment such as pre-diabetes, hypertension, low level mental health issues, and the menopause.
- People starting a new medication for a long term condition.
- People that are waiting for a procedure or operation.

4.6. Development of the resource involved the following stages:

- A multi-partner working group, including representatives from Public Health, the Integrated Care Board, social prescribing, and general practice. A draft version also went out via the Integrated Care Board to the readers panel. The resource was then adapted according to feedback.

- The revised version was piloted during early 2023 with a small group of General Practitioners, pharmacists and social prescribers.They were asked to use the resource with their patients over a four-week period. Professionals said it added value to the conversations and allowed them to obtain more information from the patient. However, time could be a barrier to introducing the resource as part of the consultation.

- The final version of the resource was then launched during September 2023 through a series of communications and engagement events.

4.7. Further evaluation of the resource is planned for the coming year. However, the average number of website views per month has ranged from: 21-282 per week, with peaks in use around the time of the initial launch and a January campaign.

4.8. Engagement with pharmacists has been challenging and this is an area that requires further consideration and review. However, the resource has reached a wide variety of other health professionals including individuals from Cheshire Fire, Care Community Members, and the Living Well Bus, for example. Non-clinical roles have also engaged well, including, libraries, the Carers Hub and the Cheshire East Council veterans service. The resource has also been made available to support Cheshire East Council employee wellbeing via access on Learning Lounge and the Centranet. During 2024/25, the resource is to be utilised alongside the NHS Health Check in a pilot project.

4.9. The adults' version has been updated in the following ways: simplification of the language used; and changing the title to "Your Lifestyle Prescription – a guide to health and wellbeing in Cheshire East". This has resulted in just one version of the resource rather than multiple versions for different audiences, which, reportedly caused some confusion amongst professionals and members of the public.

4.10. Promotion of the adult Lifestyle Prescription highlighted that there was an appetite to develop a similar resource for our children and young people. The Public Health team worked with the Cheshire East Council Children and Young People's participation team to adapt the resource.On designing a children and young people's version of the Lifestyle Prescription resource, the team wanted to work with young people to ask what they would like to see contained within it. The Jigsaw Groups, Youth Council and Youth Club in Middlewich were shown the adult's version and were asked for their ideas on a name and the issues that matter to them. 'Your Health' was chosen as the title for their version and they wanted more of a focus on mental health and information about the risks of vaping. Alongside the sections on eating well and keeping active we also added a 'Your Links' page giving them quick access to further information and advice as this resource will currently be

downloadable only. The new resource will be live from September 2024, as we celebrate ‘One Year’ on from when the adult’s resource was launched.

4.11. Next steps in the further implementation of the Lifestyle Prescription include:

- The relaunch of the Lifestyle Prescription for adults
- The launch of the Lifestyle Prescription for children and young people and the translated versions of the adult resource (Polish, Ukrainian and Tetum)
- Exploring promoting use of the Lifestyle Prescription as part of NHS health checks.
- Exploring promoting use of the Lifestyle Prescription in secondary care.
- Further developing the evaluation approach.

A webinar on the Lifestyle Prescription is being provided on 24 September 2024. The content of the webinar is summarised at Appendix A. Participants can book to join the webinar via the following link:

https://events.teams.microsoft.com/event/3b93f7d4-cac8-4925-af70-103166ef0542@cdb92d10-23cb-4ac1-a9b3-34f4faaa2851

Access to Information

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

Name: Dr Susan Roberts

Designation: Consultant in Public Health
Email: phit@cheshireeast.gov.uk

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Cheshire East

TOGETHER for Children and Young People

Cheshire East
Make Your Mark results

September 2024

Cheshire East Youth Council is made up of a group of young people who campaign on and create positive change for others. They work with decision makers and help them to make services and the support that children and young people receive better. The group feeds into Children's Trust Board.

The group campaigns on issues that are important to young people e.g. mental health, physical health, children's rights, access to early help, support for LGBTQ+ community, period poverty, sexual harassment and sexual violence, hate crime. The group is driven by important issues not political parties.

What can leaders do to improve our Health and Wellbeing?

“Make school and public spaces safer, be able to walk around with no threat”
“safe spaces for young people to be heard and report if needed”
“mental health support available in and out of schools”
“Maintain parks and green spaces to enjoy”
“trained professionals in school, proper resources to help”
“Educate young people on being a good citizen”
“Reduce stigma about asking for help, too afraid to ask for help”
“Make sure there is enough staff in schools to provide individual support”
“Provide accessible services”
“Keep the libraries”
“People don’t ask because they think there isn’t any help, make sure there is help available no matter what”
“Make sure people know about and have the confidence to get the help they need”
“Run projects that focus on hate crime, discrimination and wellbeing to focus on these issues. Sometimes it is hard to know where to get support.”
“Spaces for young people to go where they don’t have to pay to just be, relax, be with friends. Put signs on doors so we know where we can go.”

What is Make Your Mark ?

- Make Your Mark is the largest consultation of 11-18 year olds in Europe. It gives young people the chance to have a say on what matters to them.
- Topics are presented to young people (on a ballot paper, online or on a presentation). Voting happened in schools, colleges and youth groups throughout February and the topic with the most votes becomes the newly elected MYP campaign theme for their 2 year term.
- Cheshire East Youth Council will get involved in the national Make Your Mark campaign, but they may also wish to create their own campaign based on what young people voted for locally.

Time for the results

Cheshire East Results:

7479 young people voted in total
1 – 1294 voted for “Crime and Safety”
2 – 1112 voted for “Health and Wellbeing”
3 – 1077 voted for “Jobs, the Economy and Benefits”

North West Votes:

Crime and Safety

National Votes:

Health and Wellbeing

What has happened since Make Your Mark?

- Survey on Hate Crime and Discrimination, **116 young people took part**, the group is using the information gathered to influence a Hate Crime and Discrimination Campaign aimed at:
    - Equipping professionals with how to deal with hate crime
    - Educate young people on what a hate crime is
    - Raise awareness and understanding
    - Share how to report and where to turn for support

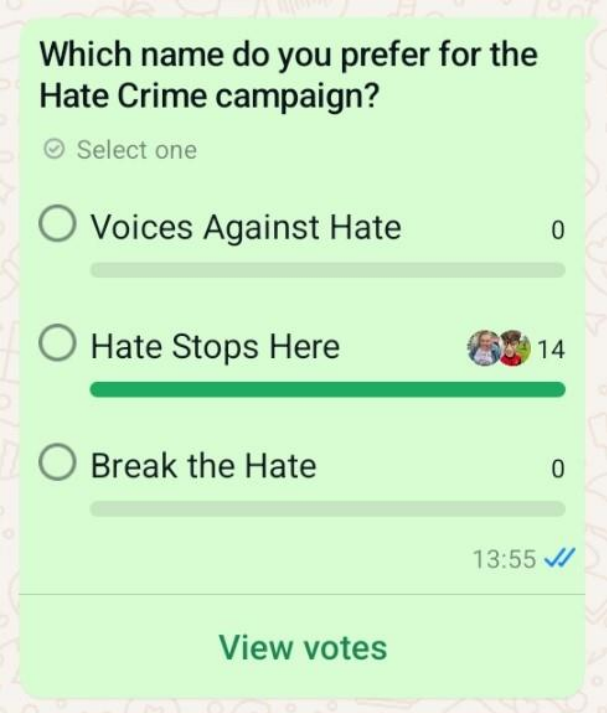
What should young people do to address bullying, hate crime and discrimination?

- Report the incident to a trusted person / tell someone who can do something about it
- More discussion in schools regularly about it / raise awareness and how to recognise it
- Learn to stand up for yourself
- Call people out on it (7 comments)
- Don’t bully / more care for others
- Give accounts from people who have experienced it to show the impact
- Videos or posters around the experience and advice / post things on social media for awareness
- Educate others around what it would be like to be on the receiving end
- Create a better sense of community / space built on respect
- Punishment in a way that deals with the problem
- More anti-bullying rules
- Therapy for those who bully to help them stop

As someone who has experienced bullying and discrimination directly, I feel that young people who are victims of hate crimes, discrimination, bullying need to speak out and share their past experiences of abuse towards them. By doing this, we can educate everyone regarding the severity of bullying and discrimination, and the impact it has on young people.

What should leaders do to address bullying, hate crime and discrimination?

- Harsher punishment / consequences for those given warnings who continue / to deter in the future
- Teach more about it / more awareness
- Provide a safe environment for people to talk in / get help
- Explain about the impact of bullying / hate crimes more such as poor mental wellbeing and trauma
- Report it to someone that will help / do something about it
- Take into consideration what the individual wants to do with the situation
- Teach children how to speak out / stand up for themselves
- Make laws/rules to prevent bullying / discriminative websites and social media content
- Stop bullying
- Address the drivers of bullying and get it sorted with an adult
- Telling an adult can often increase the bullying which makes people afraid to speak out / discretion is needed


Which name do you prefer for the Hate Crime campaign?
Select one
Voices Against Hate 0
Hate Stops Here 14
Break the Hate 0
13:55
View votes


NOVEMBER
Children's Rights Month
Remember Remember Our Rights in November
#NCRM


HATE
STOPS
HERE

Any questions? How can you help?

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A summary of responses to Cheshire East Council's

Young people's experiences of hate crime and discrimination in Cheshire East Survey

Introduction

Purpose of the survey

In February 2024, young people aged 11-18 said that “Crime and Safety” is the most important issue to them in the national youth ballot Make Your Mark.

From this, Cheshire East Youth Council are planning to develop an awareness campaign about Hate Crime and Discrimination with two clear goals:

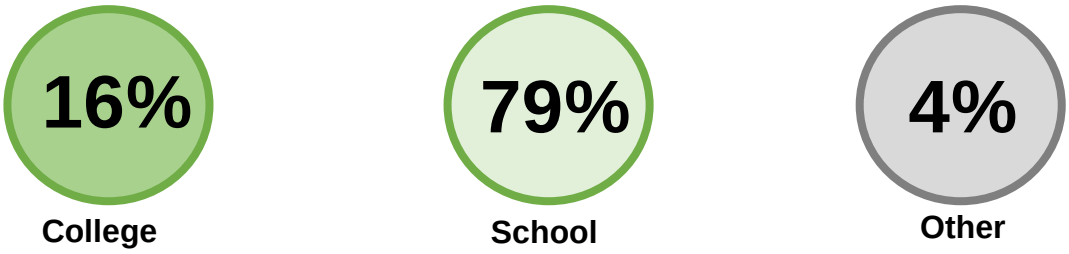
- Make sure that educators have the right resources to teach young people about hate crime and discrimination, with the skills to also deal with it when it happens.
- Help young people to have improved awareness and understanding of hate crime and discrimination, also what to do if they see it or experience it.

Therefore, Cheshire East Youth Council invited young people across Cheshire East to complete a survey to share their experiences of hate crime and discrimination anonymously to influence the campaign, which included in schools, colleges and out in the community.

Survey responses

A total of 116 responses were received to the survey, a breakdown of demographics is available in Appendix A. The educational setting of respondents is shown below.

What educational setting do you attend?



Total number of respondents 116

Section 1: Bullying

Respondents were asked if they had every bullied anyone, 15 of the respondents confirmed that they had.

Have you ever bullied anyone?

Total number of respondents 116

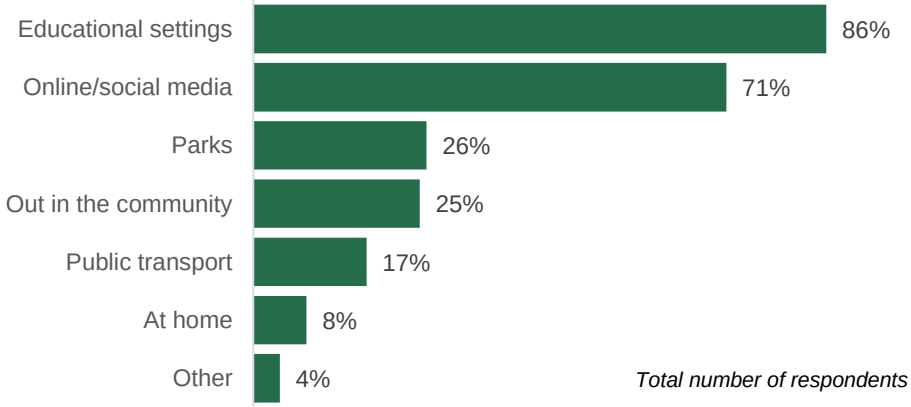
Respondents were asked if they had experienced bullying, 65 confirmed that they had, just over half of all survey respondents.

Have you ever been bullied?

Total number of respondents 116

Respondents were asked where they thought bullying was most likely to occur, Figure 1 below shows a summary of results to this question.

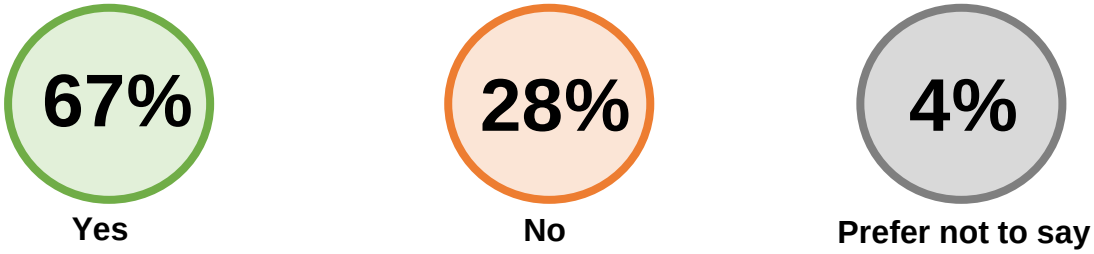
Figure 1: Where do you think bullying is most likely to occur?



Total number of respondents 115

Respondents who reported they had been bullied were asked if they had told anyone about the bullying.

Did you tell someone about the bullying?



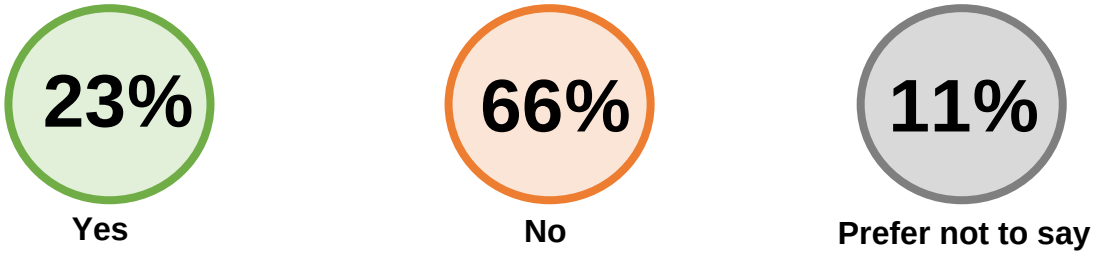
Total number of respondents 67

Respondents were most likely to tell the following people about the bullying:

- Parents (21 comments)
- Teachers (10 comments)
- School (5 comments)
- Friends (3 comments)
- Head of year (1 comment)
- No-one (1 comment)

Respondents were asked if the bullying was dealt with properly, just 23% of respondents felt that it had.

Was the bullying dealt with properly?



Total number of respondents 65

Respondents were asked if it wasn't dealt with properly what could have been done better, a total of 20 comments were left which are summarised as:

- The bully to have been punished / to have been taken more seriously (8 comments)
- The teachers could have looked out for me, was made to feel at fault / not given support or listened to (6 comments)
- More mental health support (2 comments)
- Pastoral team didn't deal with the incidents, so I didn't go to them afterwards / still continued after being 'dealt with' (2 comments)
- Telling someone so they could know (1 comment)
- Nothing (1 comment)

Section 2: Discrimination

Respondents were asked if they knew what discrimination was, 95% (108 of 114) did know what it meant.

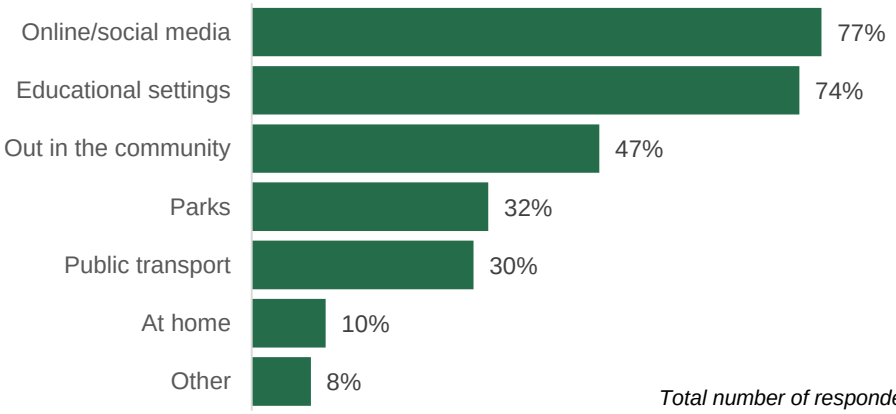
Respondents were asked if they had experienced discrimination, 50 confirmed that they had, under half of all survey respondents.

Have you ever felt discrimination?

Total number of respondents 116

Respondents were asked where they thought discrimination was most likely to occur, Figure 2 below shows a summary of results to this question.

Figure 2: Where do you think discrimination is most likely to occur?



Total number of respondents 115

Respondents who reported they had been discriminated against were asked if they had told anyone about it. Respondents were less likely to report discrimination compared to bullying (54% compared to 67%).

Did you tell someone about the discrimination?

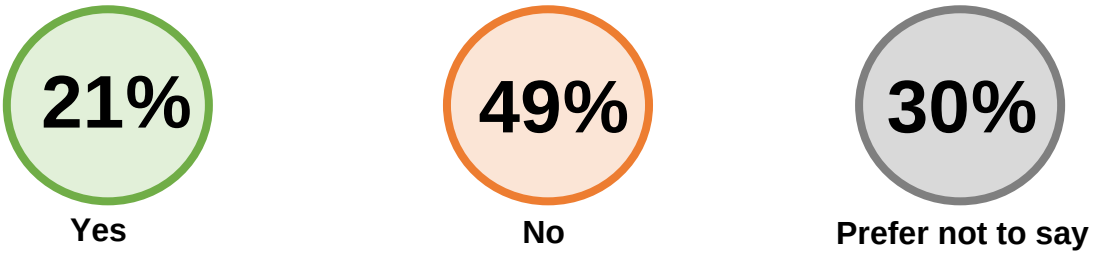
Total number of respondents 48

Respondents were most likely to tell the following people about the discrimination:

- Parents (8 comments)
- Teachers (6 comments)
- Friends (3 comments)
- School (2 comments)
- Head of year (1 comment)

Respondents were asked if the discrimination was dealt with properly, just 21% of respondents felt that it had, a similar rate to bullying.

Was the discrimination dealt with properly?



Total number of respondents 47

Respondents were asked if it wasn't dealt with properly what could have been done better, a total of 6 comments were left which are summarised as:

- The school or teachers could have handled it better / taken it more seriously (3 comments)
- More education around it (1 comment)
- Schools cannot handle the number of cases (1 comment)
- Just got used to it / stopped finding it as offensive (1 comment)

Section 3: Hate Crime

Respondents were asked if they knew what a hate crime was, 92% (107 of 116) did know what it meant.

Respondents were asked if they had ever witnessed a hate crime, 43% of respondents had.

Have you ever witnessed a hate crime?

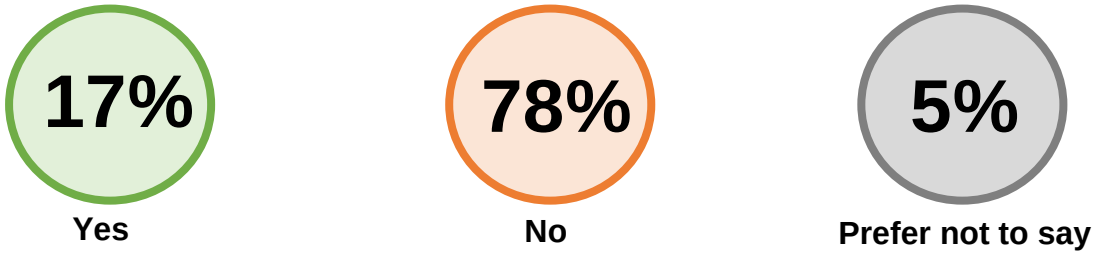
Total number of respondents 116

In terms of what respondents had witnessed the following was raised:

- Physical violence / verbal comments due to sexuality / religion / race (11 comments)
- Unable to share, school did not respond appropriately (2 comments)
- Personal experience of hate crime (1 comment)
- Making fun of someone (1 comment)
- Prefer not to say (1 comment)

Respondents were asked if they had ever been a victim of a hate crime, 17% of respondents confirmed this.

Have you ever been a victim of a hate crime?



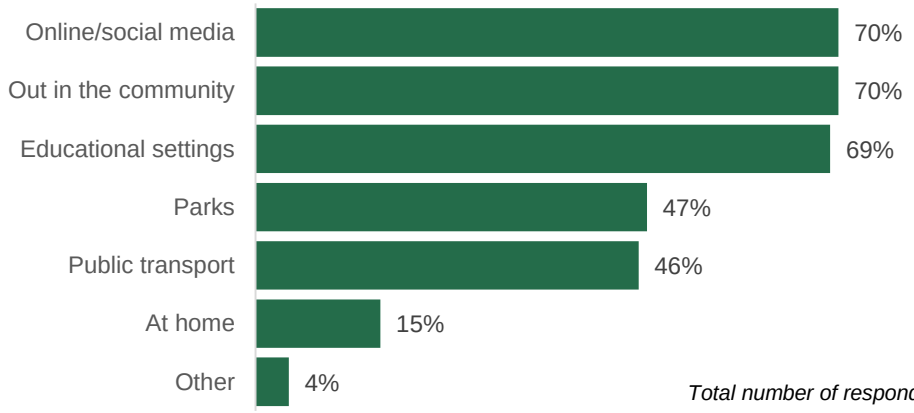
Total number of respondents 116

In terms of what respondents had experienced the following was raised:

- Verbal aggression due to race (3 comments)
- Physical violence due to race (1 comment)
- Prefer not to say/ don't feel comfortable sharing (2 comments)

Respondents were asked where they thought hate crimes were most likely to occur, Figure 3 below shows a summary of results to this question.

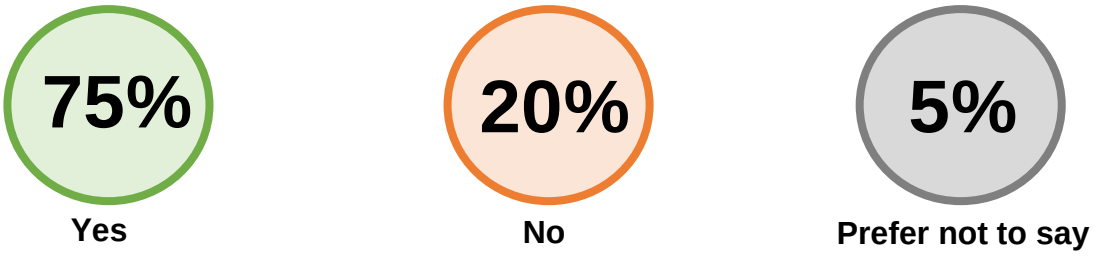
Figure 3: Where do you think hate crimes are most likely to occur?



Total number of respondents 114

Respondents who reported they had experienced a hate crime were asked if they had told anyone about it. Respondents were more likely to report hate crimes compared to both discrimination and bullying (75% compared to 54% and 67%).

Did you tell someone about the hate crime?



Total number of respondents 20

Respondents were most likely to tell the following people about hate crimes:

- Parents (3 comments)
- Teachers (3 comments)
- Friends (3 comments)
- School (3 comments)

Respondents were asked if the hate crime was dealt with properly, 30% of respondents felt that it had.

Was the hate crime dealt with properly?

Total number of respondents 20

Section 4: Your Ideas

Respondents were asked in their own words what should young people do to address bullying, discrimination and hate crime. A total of 94 comments were left to this section a summary of which is provided below:

- Report the incident to a trusted person / tell someone who can do something about it (47 comments)
- More discussion in schools regularly about it / raise awareness and how to recognise it (15 comments)
- Learn to stand up for yourself (8 comments)
- Call people out on it (7 comments)
- Don't bully / more care for others (6 comments)
- Give accounts from people who have experienced it to show the impact (6 comment)
- Videos or posters around the experience and advice / post things on social media for awareness (3 comments)
- Educate others around what it would be like to be on the receiving end (3 comments)
- Create a better sense of community / space built on respect (3 comments)
- Punishment in a way that deals with the problem (3 comments)
- More anti-bullying rules (1 comment)
- Therapy for those who bully to help them stop (1 comment)
- Youth clubs (1 comment)
- Nothing / not sure / prefer not to say (5 comments)

> *As someone who has experienced bullying and discrimination directly, I feel that young people who are victims of hate crimes, discrimination, bullying need to speak out and share their past experiences of abuse towards them. By doing this, we can educate everyone regarding the severity of bullying and discrimination, and the impact it has on young people.*

Respondents were asked in their own words what should adults and local leaders do to address bullying, discrimination and hate crime. A total of 92 comments were left to this secion a summary of which is presented below:

- Harsher punishment / consequences for those given warnings who continue / to deter in the future (23 comments)
- Teach more about it / more awareness (20 comments)
- Provide a safe environment for people to talk in / get help (9 comments)
- Explain about the impact of bullying / hate crimes more such as poor mental wellbeing and trauma (8 comments)
- Report it to someone that will help / do something about it (11 comments)
- Take into consideration what the individual wants to do with the situation (5
- Teach children how to speak out / stand up for themselves (6 comments)

- Make laws/rules to prevent bullying / discriminative websites and social media content (5 comments)
- Stop bullying (5 comments)
- Address the drivers of bullying and get it sorted with an adult (4 comments)
- comments)
- Telling an adult can often increase the bullying which makes people afraid to speak out / discretion is needed (2 comments)
- Don’t be woke (1 comment)
- Nothing will help it / they can’t stop it (1 comment)
- Don’t know / not sure (7 comments)

> *Crack down and not just punish people , but try to make them understand the impact that it has . And explain about suicide and how bullying can traumatise people for life*

> *Explain how BAD it is and Tell the back stories too. I would also like to see black history month in my school too*

> *Help give understanding of different backgrounds or cultures so people don’t discriminate or hate crime due to lack of knowledge/ obliviousness*

> *when adults are told about bullying and tell off the bully it can often increase the bullying as they see the victim as a snitch which makes people afraid to speak out so i’m unsure what can be done*

Appendix A: Demographics

Gender	Count	Percent
Female	69	60%
Male	35	30%
Non-binary	5	4%
Other	< 5	
Prefer not to say/ Not disclosed	5	4%
Grand Total	116	**100%**

Age	Count	Percent
11 – 12	17	15%
13 – 14	51	44%
15 – 16	30	26%
17 – 18	18	16%
Grand Total	116	**100%**

Ethnicity	Count	Percent
White English/ Welsh/ Scottish / Northen Irish / British	89	77%
Any other White background	7	6%
Mixed or multiple ethnic groups	< 5	
Asian / Asian British	8	7%
Black African / Caribbean / Black British	< 5	
Other	< 5	
Prefer not to say	< 5	
Grand Total	116	**100%**

Religion	Count	Percent
Buddhist	< 5	
Christian	26	22%
Jewish	< 5	
Muslim	< 5	
No religion	76	66%
Other	5	4%
Prefer not to say	5	4%

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Agenda Item 8

Cheshire East Council

NHS
Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Green Spaces for Wellbeing Update
Report Reference Number	HWB56
Date of meeting:	24th September 2024
Written by:	Ruth Morgan
Contact details:	Ruth.morgan@ansa.co.uk 01625 383673
Health & Wellbeing Board Lead:	Matt Tyrer

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision ☐
Why is the report being brought to the board?	In this report we share the progress of the Greenspaces for Wellbeing project from April 2023 - March 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 ☐		
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.	N/A		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	N/A
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.	N/A

1 Report Summary

1.1 In this presentation we share how we have designed the Green Spaces for Wellbeing programme, our delivery models, our referral and lifestyle outcomes, our approach to marketing and our priorities for 2024/25.The Annual Report for 2023-2024 is attached as Appendix One.

2 Recommendations

2.1 To note the progress made with the project

3 Reasons for Recommendations

3.1 To update the Board on an innovative health and wellbeing project.

4 Impact on Health and Wellbeing Strategic Outcomes

4.1 **Outcome one** - Cheshire East is a place that supports good health and wellbeing for everyone

- We actively support people to use our outdoor spaces for exercise, physical activity and learning.
- We support individuals and other organisations to improve their local green spaces in areas of deprivation.
- We are a commissioned service that enables people to improve their health and wellbeing

4.2 **Outcome three** – The mental health and wellbeing of people living and working in Cheshire East is improved.

- Green Spaces for Wellbeing is designed as an early intervention/prevention service.
- 73% of participants report improved mental wellbeing.
- Our participants make friends and feel less isolated.
- Our service is open to anybody aged 18+ and supports participants with learning disabilities and autism.
- Our service supports adult carers to socialise.
- We connect all of our participants to nature, proven to improve mental wellbeing

4.3 **Outcome four** – That more people live well, remaining independent; and that their lives end with peace and in dignity in their chosen place.

- Many participants report increased physical activity levels and reduced sitting time. 82% achieve 150 mins of exercise per week.
- We enable growth through learning and providing experiences, such as growing fruit and vegetables that give people the skills, knowledge and connection to improve their diet.

5 Background and Options

5.1 N/A

6 Access to Information

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

Name: Ruth Morgan
Designation: Parks and Recreation Manager
Tel No: 01625 383673
Email: ruth.morgan@ansa.co.uk

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APPENDIX ONE

2023-24 Annual Outcomes Report

Introduction

Between 1st April 2023 and 31st March 2024, Green Spaces for Wellbeing delivered 1124 hours of wellbeing sessions in Queens Park, Crewe and Victoria Park, Macclesfield. Sessions are based around the 5 Ways to Wellbeing and focus on connecting people to nature, each other, their community and to their local park. Sessions have been developed around:

- learning and developing new skills
- increasing physical activity
- reducing social isolation
- increasing a sense of purpose.

Sessions include gardening, habitat creation, wildlife identification, arts and crafts, and more recently fitness activities including Pilates and wellbeing walks, delivered by Everybody Health and Leisure (EH&L).

The programme mainly is facilitated by Environmental Rangers, who deliver structured sessions comprising of a short grounding meditation or activity, then the main themed activity, concluding with a session wrap-up allowing time for reflection and what it meant to participants. Sessions are designed to provide a holistic experience, focussing on mental and physical health and wellbeing, run over a 12-week period, catering for up to 12 participants over a two-hour period.

Recently we have introduced physical activity and exercise classes to the programme, aiming to increase people's activity levels and attracting a new target audience. Sessions are up to an hour in duration and are accessed via self and health referral. Some of these sessions have provided an important social connection and peer support network for participants, for example buggy walks for new mums.

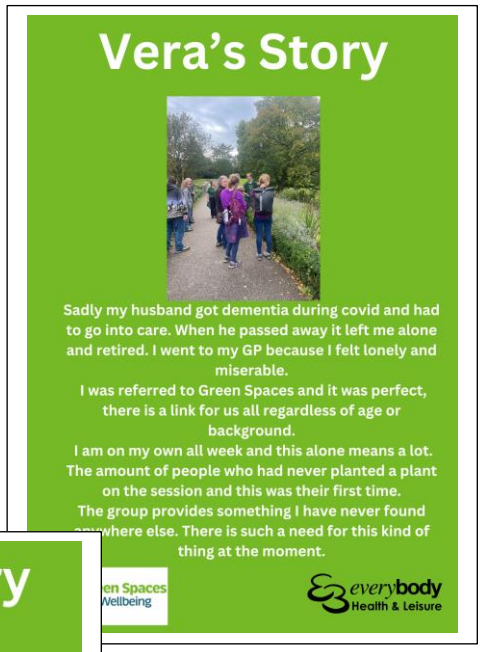
We also have incorporated drop-in sessions, targeting people who are unable to commit to 12-weeks and provide a exit pathway for those who have completed the programme offering sustainability. Drop-in sessions are planned around the core programme offer and introduce participants to wildlife friendly gardening and food production. The provision of polytunnels allows outdoor access all year round and has attracted regular participants.

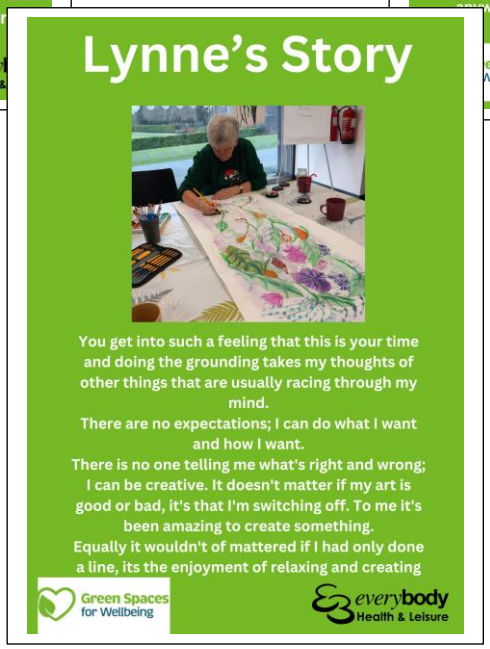
We have piloted cohort delivery models, which has posed issues. One cohort was working with Asylum Seekers in Crewe, who were transported to the session at Queens Park. We found the majority of participants were not interested in the session, they used the session as a means to leaving the hostel for a period of time. Also, there was a unpredictability of the participant numbers each week, which impacted on staff resources time to ensure sessions were safe for the participants. We recognise, however, that that this type of session model should be developed further with more stable cohorts to fully utilise the benefits of the service to the many and varied groups in Crewe.

A number of taster sessions have been delivered and proved successful and an effective way to increase awareness of the programme, on average we have delivered a taster session every 6 weeks to 65 health and social care professionals, social prescribers, local charities/organisations, support workers, Occupational therapists and mental health support workers.

APPENDIX ONE

Examples of Good News Stories





APPENDIX ONE

Data Collected April 1st 23 – March 31st 24

Programme Statistics	
Number of referrals	279 people
Number of people who took part in the programme	166 people
Number of people who did not join the programme	113 people
Number of people leaving the programme early	76 people
Number of people who completed the programme	87 people

Referring Data	
Referring Organisations	
Self-Referral	219 (78%)
Health- Referral (Mainly Social Prescribers)	60 (22%)
Reasons for Not Joining Programme – Based on 113 People	
Unable to contact	62 people
Did not attend	14
Programme Offer	12
Time/Work commitments	10
Medical	8
In appropriate Referral	4
Other – e.g. transport, weather	3
Reasons for Leaving Programme Early – Based on 76 People	
Medical Reason	25
Work/Time Commitments	22
DNA	16
Programme Offer	10
Gained Employment	1
Lack of others attending	2

Demographics Data – Based on 166 People Starting Programme		
Gender		
Female	Male	Prefer Not To Say
123 (74%)	41 (25%)	2 (1%)

Age Range					
16-29yrs	30-39yrs	40-49yrs	50-59yrs	60-67yrs	70+
11	28	19	32	52	24

APPENDIX ONE

Ethnicity				
White	Mixed	Asian or Asian British	Black or Black British	Other Ethnic Groups
162	2	2	0	0

Disability Status		
Disabled	Not Disabled	Unknown/Withheld
33	35	98

Employment Status								
Managerial & Professional	Routine & Manual	Intermediate	Full-Time Student	Carer	Retired	Unable to Work	Unemployed	Withheld
16	14	7	1	4	55	27	33	9

Behaviour Outcomes	
Reducing Inactivity (Based on 82 respondents)	71 people (87%) Increased physical activity level 5 people (6%) No change in physical activity status 6 people (8%) Physical activity levels have decreased
	67 people (82%) Are achieving 150 minutes of exercise weekly, government guidelines.
Sitting Time (Based on 82 people)	58 people (71%) Are sitting less since attending programme
	6 people (8%) No change
	18 people (22%) Reported sitting more since attending the programme
Improving Mental Wellbeing (Based on 86 respondents)	63 people (73%) Reported an improvement in their mental wellbeing
Lifestyle (Based on 86 respondents)	59 People (69%) feel like I belong to their neighbourhood
	32 People (37%) are overall satisfied with their health
	84 People (97%) feel part of nature
	81 People (94%) take time to notice and engage with everyday nature
Customer Satisfaction (Based on 75 respondents)	Participants rate the programme 4.5/5
	70 people achieved or partially achieved their gaols

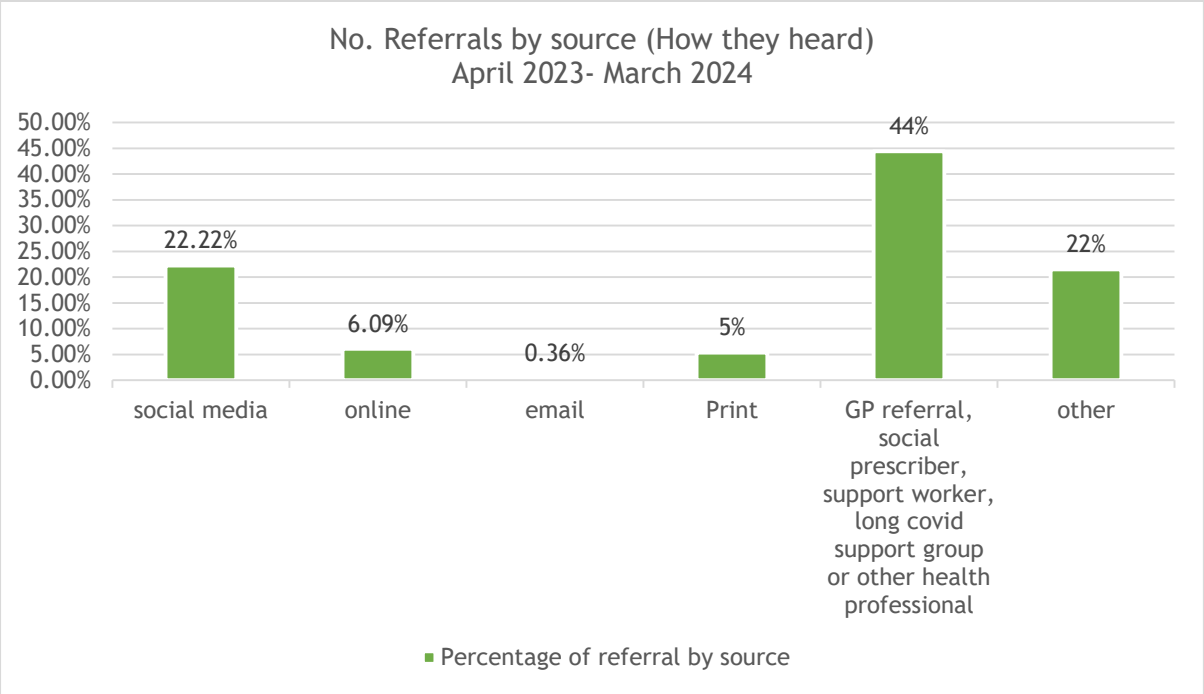
APPENDIX ONE

Green Spaces for Wellbeing Campaign Marketing Report

Early marketing of the programme was developed with an external marketing company. Following an early learning curve we partnered with Everybody Health and Leisure to develop a much more cohesive and bold marketing strategy. The marketing strategy has helped us to increase numbers and identify target areas to focus on to develop more consistent participant numbers across the range of activities. Our first campaign with EH&L included, the design of new leaflets, banners, posters and events kit. To raise awareness and promote we leafletted and placed adverts in local magazines, targeted events to raise awareness, increased and regular social media presence, paid social media adverts, radio interviews and podcast interviews. As well as raising general awareness, we have been able to identify the most effective way for us to promote the service and refine the strategy for the coming year.

*Based on data April 2023- March 2024

**Based on data during 12th October 2023 – 10th April 2024 timeframe

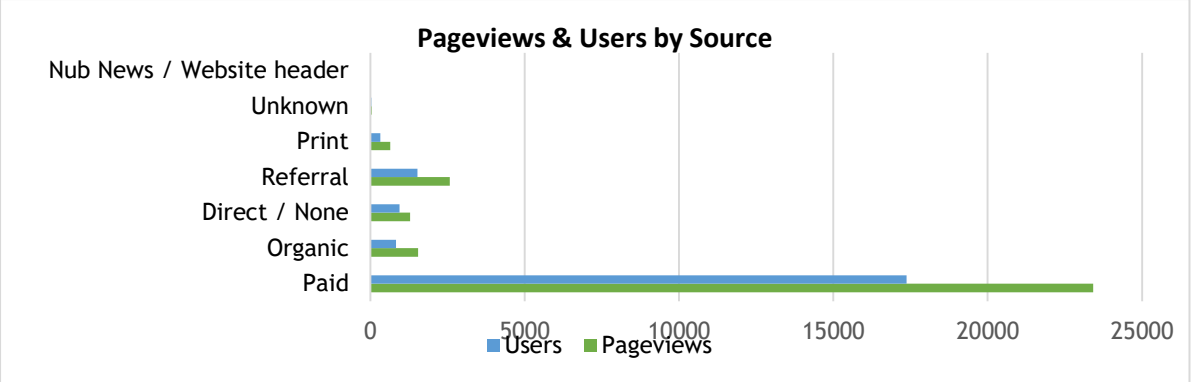


October 2023-April 2024

Landing page web visits, users

By Source	Pageviews	Users
Paid	23414	17,376
Organic	1,545	836
Direct / None	1,285	941
Referral	2569	1526
Print	644	319
Unknown	47	29
Nub News / Website header	5	2
Total	**29,509**	**21,029**

APPENDIX ONE



By Channel	Pageviews	Users
Google, Bing, DuckDuckGo, Baidu and Ecosia	9,365	7,006
META, Facebook, Tik Tok	15,594	11206
Magazine	332	151
Email	409	162
External Banner	169	97
Leaflet	65	30
Poster	45	18
Banner	32	22
Direct / None	1285	941
Referrals	2160	1364
Unknown	47	29
Nub News / Website header	5	2
Leisure Centre/ TFL Stand Crewe	1	1
Total	**29,509**	**21,029**

Green Spaces for Wellbeing social media channels

Data based on October 2023 – April 2024 following the Social Media Training Everybody Health & Leisure delivered to Green Spaces for Wellbeing staff on 3rd October 2023.

Facebook	Instagram*
Total page followers: 243 **Total page likes:** 162	**Total page followers**: 102
Reach: 25.4k (9.2% decrease**)	**Reach:** 898 (1.4 %increase)
Content interactions: 2.3k (135.5% increase)	**Content interactions**: 522 (100% increase)
Link clicks: 350	**Link clicks**: 6
Page Clicks: 3.8k	
Audience **Crewe 26.7%** **Macc 14.4%**	**Audience:** **Crewe 18.6%** **Macc 25.5%**

*The Instagram page was created in September 2023 following the recommendations from Everybody Marketing team.

APPENDIX ONE

**Paid advertising was paused on Green Spaces for Wellbeing Facebook page and focused on the Everybody Health & Leisure account which could have contributed to the decrease in page reach.

Email Marketing Campaigns

Campaign Name	Subscribers	Open Rate	Link Clicks
Everybody Healthy Newsletter* Nov 2023	97	55.26%	10
Everybody Healthy Newsletter* Feb 2024	94	48%	33

*The Everybody Healthy Newsletter sends to a network of Cheshire East health & wellbeing professionals.

Email campaigns were also delivered to a targeted list of 250 individual referrers representing healthcare, local authority and community organisations advertising the Green Spaces for Wellbeing programmes. 44% of referrals now come from this network of professionals into the programme.

The programme was also advertised through the Everybody Health & Leisure Monthly Memberzone email newsletters, delivering to circa 7k subscribers each month with an average open rate of 54%.

Public relations and printed adverts:

Media	Coverage	Readership	Referrals
Press Release - Explore nature and boost your wellbeing whilst helping local wildlife!	Macclesfield Nub News (article title: Macclesfield Leisure Centre providers to encourage connection with nature) Cheshire East Bulletin Everybody Website	Macclesfield Nub News: 80 readers	4
Crewe Lifestyle Centre to host Mental Health Awareness Day	Crewe Nub News	Everybody website 140 page views during 13th November 2023- 18th April 2024 154 readers	
Macclesfield Leisure Centre to host Mental Health Awareness Day	Macclesfield Nub News	70 readers	
6 x Magazine Adverts	Local People Macclesfield	Delivered to 31,500 homes in Macclesfield	

APPENDIX ONE

	Crewe Link Magazine	Delivered to 7,400 homes every month in the CW1 area, Haslington, Leighton, Sydney and the outskirts of Crewe.

Local People Macclesfield Artwork

December 2023 **January 2024**

Local People Macclesfield Coverage

Over two issues:

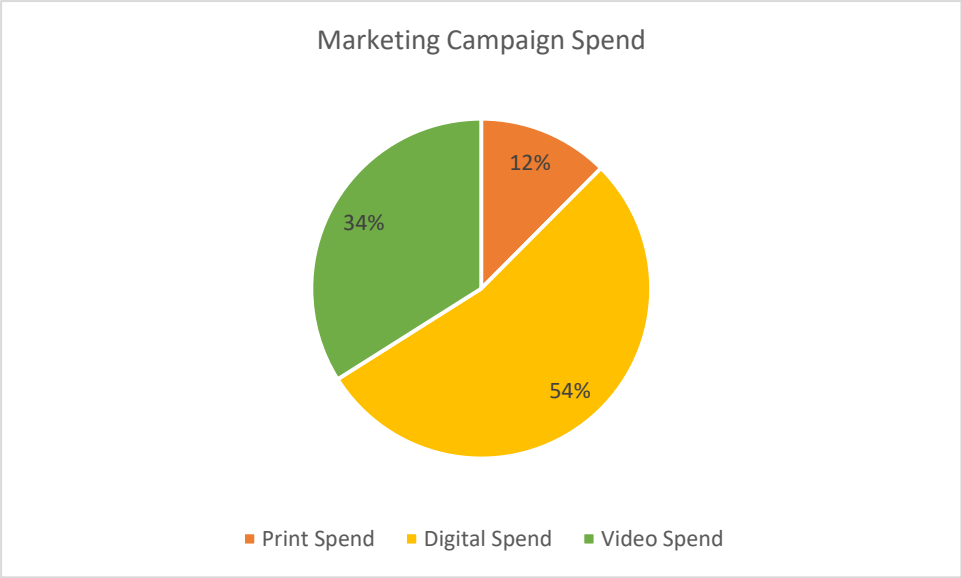
Goes directly through around 31,500 different doors (some people will get it both months)

January 2024 **February 2024** **March 2024** **April 2024**

Delivered to 7,400 homes every month in the CW1 area, Haslington, Leighton, Sydney and the outskirts of Crewe.

APPENDIX ONE

Marketing campaign spend split between paid digital ads, printed materials and video marketing



The majority of the marketing spend focused on digital marketing tactics including paid advertising on Google and social media channels (Facebook & Instagram). This generated a 1818% increase in website traffic to Green Spaces for Wellbeing landing pages and 22% of the referrals came from social media marketing.

Print materials and adverts were updated with new artwork, targeting the seasonal campaigns around 'winter wellness' generating 5% of referrals and traffic through trackable QR scans to the website landing pages.

Priorities for 2024/25

The overarching priority for 2024/25 is to Increase participant numbers and the number of people completing the programme, plus:

- Increase the number of taster sessions delivered in improve awareness and take up
- Focus on cohort session delivery targeting priority groups, e.g. day care services, mental health providers.
- Continued marketing campaign
- Development of a volunteer programme to support service delivery

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Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund end of year analysis (2023-24) and plan for 2024-25
Report Reference Number	HWB61
Date of meeting:	24/09/2024
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 x
Why is the report being brought to the board?	The following report provides an end of year overview of the Cheshire East Better Care Fund plan for the period 2023-24. In addition to this the report outlines the plan for 2024-25 which is a continuation of the plan agreed for 2023-25.		
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 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 is asked to note the progress made during 2023-24 and agree the plan for 2024-25.		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG 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.	Not applicable.

1 Report Summary

1.1 The following report provides an end of year overview of the Cheshire East Better Care Fund plan for the period 2023-24. In addition to this the report outlines the plan for 2024-25 which is a continuation of the plan agreed for 2023-25.

1.2 The following report summarises the performance of the better care fund during 2023-24 with specific reference to the discharge fund. The report includes narrative from the 23-25 plan, better care fund priorities, notable achievements, scoring of schemes, schemes which have been cancelled, metric performance to date, new schemes, expenditure, and planned schemes for 2024-25.

2 Recommendations

2.1 That the Health and Wellbeing Board notes the performance for 2023-24 and approves the plan for 2024-25.

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 Strategic Outcomes

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

5 Background and Options

5.1 Narrative update from 23-25 plan

5.2 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, Cheshire and Merseyside 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 priorities.

5.3 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.

5.4 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.

5.5 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.

5.6 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.

5.7 **Better Care Fund priorities**

5.8 The Better Care Fund priorities are noted as follows:

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.

5.9 **Notable achievements from discharge fund**

5.10 Outlines the investment, objectives, impact and outcomes of each of the below schemes currently funded:

1. Assistive Technology & Gantry Hoists to reduce double handling care packages
2. East Cheshire NHS Trust ED/GP out of hours 7 Days per week
3. Carers Payments to Facilitate Rapid Discharge
4. Integrated Community for the Community and Discharge Support Team
5. Hospital Discharge Premium Payment & Prevention Scheme (Winter Support - Oct 2023 to Mar 2024)
6. Increased General Nursing Assistant Capacity care at home via Central Cheshire Integrated Care Partnership (CCICP)
7. Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital
8. Approved Mental Health Professional Cover, evenings & weekends for ECT and MCHFT
9. Mental Health Rapid Response Outreach
10. Home First Occupational Therapist
11. CAH Investment Increase 2023/24 Non-Recurrent
12. Hospice Beds (Winter Support - Oct 2023 to Mar 2024)

5.11 **Scoring schemes from 2023-24**

5.12 The 2023/24 schemes scored were against criteria noted below, this follows the process undertaken in 2023 with respect to the winter schemes:

- BCF metrics
- Strategic Goals -Will project contribute to strategic goals
- Innovation - What level of innovation can be attributed to this service/proposal, to improve health outcomes.
- Strength of evidence. What is the strongest evidence that the proposed service / intervention has a positive effect?
- Magnitude of the clinical benefit to the individual patient (compared to existing provider if relevant)
- Numbers of people that will benefit (compared to existing provider if relevant)
- Patient Acceptability e.g., service location or method of treatment (compared to existing provider if relevant)
- Quality of Life e.g., disability reduction, independence, pain reduction, improving social relationships (compared to existing provider if relevant)
- Access & Equity - enables more equitable access to health care and/or reduces health inequalities (compared to existing provider if relevant)
- Prevention - the proposal significantly reduces ill health and/or need for further health and care services (compared to existing provider if relevant)
- Only treatment or alternative N/A
- Risk of not achieving target.
- Financial Risk what is the risk if the project does not go ahead.
- Political/Reputational risk, what is the risk if the project does not go ahead
- Clinical Risk what is the risk if this service is not implemented
- Impact on other services or provider/s if goes ahead.
- Rate of return - How quickly can the project be delivered.
- Resources - how many people will be engaged in delivering the project
- Resources - what is the estimated cost of delivery (pump priming, project costs, investment)
- Estimated savings - annual
- Return on Investment- how quickly will the initial investment be paid back

5.13 **Scheme cancelled from 2023-24**

5.14 As a result of underutilisation, the following 6 schemes have been cancelled which are as follows:

ID	Scheme Name	Brief Description of Scheme	Previously entered Expenditure for 2023-24 (£)
1	East Cheshire NHS Trust ED/GP out of hours 7 Days per week	These schemes will support facilitated discharge and the ongoing implementation of the Home First model of support.	£120,000
5	Carers Payments to facilitate rapid	These schemes will support facilitated discharge and the ongoing implementation of the Home First model of	£30,000

	discharge	support.	
7	Hospice Beds (East Cheshire Hospice). (Winter Support - Oct 2023 to Mar 2024)	These schemes will support facilitated discharge and the ongoing implementation of the Home First model of support.	£90,000
15	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 still have care needs that can be met in the service users' own home.	£647,328
17	iBCF 'Winter Schemes	Additional capacity to support Additional capacity to support the local health and social care system to manage increased demand over the winter period.	£500,000
30	BCF Trusted assessor service	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.	£109,995

5.15 **Schemes added for 2024/25**

5.16 The following new schemes have been added for 2024-25:

5.17 **30. Care communities (£500,000)**

5.18 This funding is on a bid basis from each of the 8 Care Communities to rapidly mobilise local initiatives that support Place strategic Priorities. Conditions of the funding are as follows:

- Applications for Funding will align to the Frailty Agenda. This can be tailored to local population health need within each Care Community but must support improvements in care and wellbeing for residents living with frailty and aligned to one or more of the Priority Target areas below
- Applications will be submitted on the attached template
- Contribute to local systems in managing demand effectively and ensure people remain safe and well. Especially over Winter months
- Projects must have an evidence base and have a clear set of metrics that can demonstrate any improvements or impact.
- Projects must also be deliverable within 2024/25
- And where possible support the system to get up stream ahead of winter.
- Plans should not duplicate existing Commissioned services but provide additionality to what is already in place or support new ways of working to improve health outcomes.
- Priority Targets: admission avoidance, falls, social isolation, dementia
- Development of integrated holistic models of care within existing resources
- Enhanced Care in Care Homes, Virtual Wards, 2 Hour Urgent Crisis Response Programmes included
- Dying well

5.19 Care Community Managers and Clinical Leads are strongly encouraged to use your Care Community Dashboards to inform the development of your local plans and metrics. Care Communities can revisit any initial schemes submitted as part of Winter Pressures and consider their relevance in the context of the BCF asks.

5.20 **31. Accident and Emergency Department in reach (£220,584)**

5.21 The service will provide 168 hours per week of support:

5.22 12 hours of support daily in each A&E site over 7 days per week, between the hours of 8am and 8pm (this could be flexed after 3-month review depending on what is required once the service commences and agreed with commissioners)

5.23 The additional rapid response capacity will only be provided within the Cheshire East footprint.

5.24 The attending staff member will be a current/new ISL employee already working in mental health/crisis services. They will have all received their mandatory training and induction and all recruitment checks including enhanced DBSs will be in place. Attending staff will be Mental Health Support Workers with foundations in:

- Safeguarding
- Mental Health and Dual Diagnosis
- Learning disabilities
- Substance Misuse
- Managing behaviours that challenge
- Conflict resolution and De escalation
- Effective Communication

5.25 **32. Residential care home competence nurse (£48,451)**

5.26 In January 2023 Central Cheshire Integrated Care Partnership (CCICP) launched a 12-month secondment project for a Competency Nurse Role which was funded by the Cheshire East Better Care Fund. The project was for a whole-time band 6 registered clinician.

5.27 The objective of the role was to reduce preventable skin damage and improve patient care to avoid unnecessary hospital admissions for elderly residents. Over the last 11 months the Competency Nurse has worked alongside care home managers and care staff to develop and deliver bespoke face-to-face training sessions providing clinical expertise and demonstrating evidenced based clinical skills and best practices to achieve this.

5.28 **33. Community Support Connectors In TOCH (£241,000)**

5.29 To provide recurrent funding for the following Communities staff, from BCF monies, in the continuance of their discharge work at Mid and East Cheshire Hospitals and support in avoidance of Adult Social Care services: 1x Senior Community Development Officer G10, 4x Community Connectors G7. The team have established themselves in each setting in September 2022, as a critical part of the Transfer of Care Hub (TOCH). With the support of the BCF funded Integrated Community Support Commission, and an array of VCSFE groups, the Community and Discharge Support Team enable discharge of patients from each location, leading to improved through put in the hospital. In addition, the wrap around support is provided in the Community leading to avoidance of readmission to hospital and increased care packages in the Community.

5.30 **34. Adult social workers linked to safeguarding (£496,717)**

5.31 The aim of this scheme will be to provide a dedicated social work function and social work assessments across a range of settings.

5.32 **35. Proportionate care (£135,134)**

5.33 The focus of this scheme is on those individuals already in receipt of double handed care, not those awaiting hospital discharge. However, it would be anticipated that NCtR would be reduced through the reduction of existing double handling packages, therefore releasing more home care hours and care agencies being better able to provide timely care for discharge. Following the anticipated delivery of savings from this scheme, it would be beneficial to capture the ongoing benefits on hospital discharge as a second phase of the scheme.

- Reduce the number of existing disproportionate packages of care with double handling, ensuring people are in receipt of proportionate care packages to meet needs safely. Reducing care packages will also release financial efficiencies for the council, contributing to the MTFS for 24-25.
- Drive the standards of manual handling up across domiciliary care agencies within Cheshire East footprint.
- Enable domiciliary care agencies to deliver single handed care competently and able to offer increased care provision with single handed care practice.

5.34 **36. Business case – Handyperson (£177,000)**

5.35 Since 2020/21 there has been on average a 10% increase in demand for the service year on year (see table below). If this trend in increased activity continues the projected total number of minor adaptations to be completed in 2024-25 is 2,523, based on a projected 10% increase on 2023/24 activity. This figure is approximate because it is based on the number of minor adaptations completed, in some cases there may be more than one minor adaptation completed for an individual.

5.36 Cheshire East residents who have minor adaptations installed within their home to enable them to live independently in their own home and/or enable safe discharge from hospital to home.

5.37 **37. HomeFirst social work support (£174,136)**

5.38 To support with the Home First programme and work alongside the care communities and virtual wards to enable people to remain at home. It is also to support those discharged home with reablement support to be reviewed quickly to ensure flow and capacity within the service.

5.39 Currently we have a bespoke reablement/ routes review team (RRTE) within Macclesfield Social work team which is 2.4 FTE Social Care Assessors and a short-term health funded Agency Social Worker. The remit grew with virtual wards having reablement input for 100 hours to support hospital avoidance and again assessment of needs for longer term care required after 72 hours.

5.40 This team are unable to meet the increased demands and are only based in one area. This proposal is to have a specific social worker for each team to increase capacity and flow. There would also be a spread of knowledge for the specific areas and closer working with the community teams. The need for qualified social workers rather than social care assessors has become apparent with the complexities of safeguarding and mental capacity issues.

5.41 **38. Reablement system investment (£420,000)**

5.42 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.

- Support Urgent Crisis Response and respond to paramedics to reduce hospital admission.
- Emergency Department discharge to home to avoid admission where identified.
- Support Frailty, Medical Assessment Unit & District Nurse Teams where a rapid response is required.

- Support Virtual Wards – frailty, palliative care, complex
- Continue with direct Reablement support, in-depth assessments, and reviews of long-term care packages.
- Work with system partners to support people by way of bridging care packages
- Increase referrals into Reablement where no care needs were previously required to maximize a return to full independence for people.
- Identify if assistive technology will benefit can be safely and effectively used to support people.
- Falls prevention – linking in with community therapy

5.43 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.

5.44 **39. Business case – Advice and signposting self-fund care (£83,281)**

5.45 Cheshire East has a high number of residents who are over the threshold in savings currently set at £23,000 to qualify for funding from the local authority for social care needs. Under the Care Act we have a duty to assess people who request an adult needs assessment to identify their eligible care needs. We also signpost and advice residents who approach the local authority for support. Additionally, we provide information on our Live Well site on available care and support. There are a significant number of residents and carers who ask for an assessment, and this does add to the demand on the operation teams. It is also an added pressure for hospital discharge where individuals and families are trying to make their own arrangements and are unfamiliar and unsure how to proceed hence resulting in delays to discharge.

5.46 The proposal would be for a grade 7 social care assessor and a grade 6 finance officer to pilot this concept for 12 months. This will be run as on an appointment basis either face-to-face, teams or telephone to minimise travel time and a timely response. This would be an effective and efficient use of staff time and as previously stated be beneficial for team waiting lists.

5.47 **40. Adult Contact Teams Service – CHC Administrator proposal (£32,432)**

5.48 An administrative worker to be within CEC CHC team working across our children and adult teams to be a main point of contact for CHC referrals and subsequent CHC assessments and outcomes.

5.49 The aims and objectives of this proposal are in line with those identified in the All Age CHC Care Review:

- Optimised timely pathways to reach care through appropriate assessments and effective partnership working within Cheshire East Council, ICB and other partner agencies including Secondary Care Services and Commissioned Providers
- Person-centred, inclusive of family, as an integral part of personalised care that includes effective and accessible communication in a timely way
- To work towards a more skilled sustainable workforce and leadership
- Continual improvement through audit, feedback received and responded to, qualitative (e.g. complaints/reviews) and quantitative measures (KPI's/performance reports)
- Care delivered within robust governance to ensure patient safety, consistent and high-quality care and provides assurance to the ICB
- Care provision to individuals is effective, affordable through right to have personalised care through best mechanisms available to ICB

5.50 **Programme activities for 2024/25:**

5.51 A number of activities are underway to improve the programme for 2024/25, this includes: Changeology support action plan project, improving the highlight report process, capacity and demand project, discharge to assess analysis project, scheme deep dive project & linking scheme performance to national metrics.

5.52 **Changeology support action plan project**

5.53 The national Better Care Support Programme commissioned Changeology to analyse capacity and demand planning capabilities across 21 Health and Social Care systems at Place level. Cheshire East Place was part of this commissioned support. The objective was to understand the barriers and identify opportunities to improve capacity and demand planning capability to enhance overall system resilience.

5.54 Changeology produced a report following a project in Cheshire East, the purpose of the report was to inform the system leaders on strategic decisions about enhancing capacity and demand planning capability to optimise and align resources with the system's operational requirements both now and in the future.

5.55 The following process was undertaken in Cheshire East: 1. Stakeholder interviews and an assessment of maturity in relation to "Managing Transfers of Care: A High Impact Change Model", (HICM). Stakeholder interviews were conducted, across senior leadership and frontline operations roles to gather insights into strengths, weaknesses, and opportunities for improvement. As part of the process, interviewee responses were also evaluated in two key areas: Firstly, their responses to interview questions were scored against key competencies related to capacity and demand planning criteria and a visual scoring matrix produced to depict the system's current resilience against what good looks like Secondly, participants were assessed on their maturity level in relation to a High Impact Change Model.

5.56 The project concluded with a range of recommendations and a action plan aligned to the following areas:

- Establishing Goals and Objectives That Align with the System Vision
- Enhancing Discharge Processes System-Wide
- The Need to Improve Resource and Utilisation Levels
- Ways of Working to Improve Communication
- Financial Understanding of Reduced Funding and Increased Demand
- IT Interoperability
- Early Discharge Planning
- Proactive Capacity and Demand Planning
- Care Transfer Hubs and Multi-Disciplinary Working to Coordinate Discharge
- Home First
- Discharge To Assess and Effective Intermediate Care
- Flexible working patterns
- Trusted assessments
- Engagement and Choice
- Improved Discharge to Care Homes
- Housing and related services

5.57 **Highlight reports**

5.58 A new highlight reporting template and reporting process has been put in place for new and existing schemes to ensure regular reporting of performance by schemes which form part of the Better Care Fund Porgramme. The highlight report considers in month spend, cumulative spend to date, in month activity, cumulative activity to date and the impact that the scheme has had.

5.59 **Capacity and demand project**

5.60 A project is underway to more readily understand the demand that we have for services and the capacity that is required to meet that demand. The first step is to map our existing system capacity, with this in mind scheme leads have been asked to provide the following information:

- What is the capacity and demand
    - Expected number of service users per month
    - Capacity of the service per month
    - Average length of stay

- Cost avoidance
    - Expected number of bed days saved

- Source of referral
    - Community
    - Hospital

- Value for money (cost per unit)

- Number of units produced (hours, bed days)

- What are the outcomes
    - Those who go onto long term services
    - No further needs

- Benchmark -how does the service compare to
    - Customer journey
    - Cost per package

- How long does it take to access the service

- Cost to the service user of the service

5.61 **Discharge to assess bed analysis project**

5.62 The system has in place a number of discharges to assess beds which form part of Pathway 2 from hospital discharge. Discharges to a community bed-based setting which has dedicated recovery support. New or additional health and/or social care and support is required in the short-term to help the person recover in a community bed-based setting before they are ready to either live independently at home or receive longer-term or ongoing care and support.

5.63 A project is underway to asses current demand for discharge to assess beds and consider the current capacity that the system has in place to ensure there is sufficient capacity in place. The project will consider the current position, the demand requirements for discharge to assess, the capacity of current pathway 2 discharge services, any alternatives and finally recommendations, considerations and next steps.

5.64 **Scheme deep dive project**

5.65 A deep dive will be undertaken into a range of services to better understand performance and effectiveness, the deep dive will cover the following components:

1. Aim and overview of the service:
    a. The purpose of the service
    b. Who the service is focused on
    c. Budget of the service
    d. The number of staff

   e. How the service is accessed
   f. How the service links to strategy
   g. How the service links to the rest of the system
   h. Overview of customer journey, including time from referral, acceptance onto service, length of service provision.
2. Overview of performance
   a. Number of packages planned per year
   b. Cost per package
   c. Cost reduction to the system
   d. Outcomes
   e. Benchmark of performance
3. SWOT analysis

5.66 The following services are in scope for a deep dive:

Scheme
1. Disabled Facilities Grant
4. British red cross 5. Carers
6. Community equipment 7. Handyperson 8. Assistive Technology & Gantry Hoists to reduce double handling care packages 9. BCF Assistive technology
10. Combined reablement / 11. Reablement system investment 11. GNA / 12.iBCF General Nursing Assistant (within BCF Early Discharge scheme (with BRC)
12. VCFSE Grants 13. St Pauls Extra Miles 14. Community Support Volunteers 15. Community Support Connectors In TOCH
16. HomeFirst social work support 17. "Adult Contact Teams Service –CHC Administrator proposal" 18. Advice and signposting self-fund care
19. Mental Health Reablement – Rapid Response Service 20. AED in reach
21. Adult social workers linked to safeguarding 22. iBCF Social work support 23. Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital

5.67 **Linking scheme performance to national metrics**

5.68 We are undertaking a process to better link our scheme performance to the national metrics which form part of the better care fund. The national metrics are as follows: avoidable admissions, falls, discharge to normal place of residence and admission to residential and nursing. As part of this we have reviewed schemes and remapped them against the metrics, we have also pulled out the narrative from each scheme linking them to metrics. The next step is then to attribute local scheme performance to the national metric to understand the level of impact they are having.

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 Lead
Tel No: 07803846231

Email: Alex.t.jones@cheshireeast.gov.uk

Appendix 1 - Better Care Fund planned expenditure 2024-25

	2024-25		
Running Balances	Income	Expenditure	Balance
DFG	£2,554,801	£2,554,801	£0
Minimum NHS Contribution	£32,094,566	£32,094,566	£0
iBCF	£8,705,870	£8,705,870	£0
Additional LA Contribution	£550,000	£550,000	£0
Additional NHS Contribution	£182,860	£182,860	£0
Local Authority Discharge Funding	£2,034,249	£2,034,249	£0
ICB Discharge Funding	£3,297,743	£3,297,743	£0
Total	**£49,420,088**	**£49,420,089**	**-£1**

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).

	2024-25		
	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£9,120,365	£22,475,652	£0
Adult Social Care services spend from the minimum ICB allocations	£9,237,025	£9,889,815	£0

Appendix 2 - Better Care Fund schemes 2024-25

Scheme ID	Scheme Name	New/ Existing Scheme	Updated Expenditure for 2024-25 (£)
1	Approved Mental Health Professionals Cover, evenings & weekends for ECT and MCHFT	Existing	£85,000
2	Assistive Technology & Gantry Hoists to reduce double handling care packages	Existing	£50,000
3	Care at Home Investment Increase	Existing	£2,034,249
4	Home First Occupational Therapist	Existing	£126,000
5	Hospital Discharge Premium Payment & Prevention Scheme	Existing	£125,000
6	Increase General Nursing Assistant Capacity care at home via CCICP	Existing	£133,000
7	Mental Health Reablement – Rapid Response Service	Existing	£90,000
8	Integrated Community for the Community and Discharge Support Team	Existing	£120,000
9	Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital	Existing	£300,000
10	iBCF Care at home hospital retainer	Existing	£49,896
11	iBCF Rapid response	Existing	£647,328
12	iBCF Social work support	Existing	£505,613
13	iBCF Enhanced Care Sourcing Team (8am-8pm)	Existing	£870,000
14	iBCF General Nursing Assistant (within BCF Early Discharge scheme (with BRC)	Existing	£332,640
15	iBCF Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care)	Existing	£6,300,393
16	BCF Disabled Facilities Grant	Existing	£2,554,801
17	BCF Assistive technology	Existing	£757,000
18	BCF British Red Cross ‘Support at Home’ service / Early Discharge	Existing	£486,651
19	BCF Combined Reablement service	Existing	£5,372,663
20	BCF Carers hub	Existing	£389,000
21	BCF Programme management and infrastructure	Existing	£541,801
22	BCF Winter schemes ICB	Existing	£500,000
23	BCF Home First schemes ICB	Existing	£19,973,121
24	BCF Carers hub	Existing	£324,000
25	BCF Community Equipment service	Existing	£550,000
26	BCF Community Equipment service	Existing	£2,231,630
27	VCFSE Grants	Existing	£182,860
28	Spot purchase beds and cluster model	Existing	£1,200,000
29	Practice Development Nurse	Existing	£58,708
30	Care communities	New	£500,000
31	AED in reach	New	£220,584
32	Residential care home competence nurse	New	£48,451
33	Community Support Connectors In TOCH	New	£241,000
34	Adult social workers linked to safeguarding	New	£496,717
35	Proportionate care	New	£135,134
36	Handyperson	New	£177,000
37	HomeFirst social work support	New	£174,136
38	Reablement	New	£420,000
39	Advice and signposting self-fund care	New	£83,281

40	Adult Contact Teams Service	New	£32,432

Appendix 3 - Better care fund performance metrics 2024-25

8.1 Avoidable admissions

*Q4 Actual not

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Plan	2023-24 Q4 Plan
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	186.3	177.1	159.6	157.6
	Number of Admissions	925	879	-	-
	Population	400,528	400,528	-	-
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
	Indicator value	129.1	120.3	129.4	121.8

This target is based on avoidable admissions data provided by Cheshire and Merseyside ICB. As advised in guidance, 0 days lengths of stay are omitted. These figures differ from those provided within the national data pack. Clarification on what is being included in the national data pack was queried at the BCF Plan and Metrics drop-in session on 04/06/24. If clarification affects the figures provided by the ICB, then the plan figures may need to be amended. The ICB information provided for different scenarios. From these scenarios, a 3% cut in the number of avoidable admissions was set as a realistic ambition.

The following schemes support our ambition to reduce avoidable admissions - Care communities - All five care communities in East Cheshire have been engaged in working with high intensity users and frailer populations to a limited extent. Proactive management of frailty within HIUs and Pts registered with a GP Practice with a frailty syndrome and within a RUB of 4 or 5. Reduce number of unplanned or crisis contacts, proactive case management through risk stratification, Reduce LOS and emergency hospital admissions, Improved Pt experience and quality of Care.

Eastern cheshire care community - Scope: Proactive management of frailty within HIUs and Pts registered with a GP Practice with a frailty syndrome and within a RUB of 4 or 5. Reduce number of unplanned or crisis contacts, proactive case management through risk stratification. Reduce LOS and emergency hospital admissions. Improved Pt experience and quality of Care

Nantwich and Rural and SMASH Care Community Scope: All HIU will be registered with a Nantwich/SMASH GP. Focus will be on high intensity users: Acute Services (ED attends/NWAS callouts), Community Services, General Practice. Aim: To reduce the number of unplanned or crisis contacts by proactively case managing a cohort of patients using an MDT model of care by identifying caseload, setting up HIU MDTs, Establishing MDT model, medication optimisation.

Crewe Care Community Scope: Working in collaboration with colleagues in the frailty team in secondary care we will produce a framework for a high-quality unified service while recognising the value of continuity of care for the most vulnerable patients and their carers. The service will be delivered in the leg club model of multi-disciplinary team working. All HIU will be registered with a Nantwich/SMASH GP. Focus will be on high intensity users. Aim: Reduction in acute presentation or Emergency admission with Care Plan in place, Reduction in presentation in crisis to out of hours teams, Reduction in the number of falls which could have been prevented, Increasing Patient and Carer satisfaction rates, Continuity of care measures – District Nurse team and in Primary Care

8.2 Falls

		2023-24 Plan	2023-24 estimated	2024-25 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,188.5	2,291.5	2,223.5
	Count	2,141	2186	2121
	Population	94,555	91374	91374

The 24/25 Plan is based on a 3% cut in admissions. The population figures used for 23/24 estimated and 24/25 plan are consistent with population figures currently being used in the national data pack. It has been acknowledged that the national data pack population figures require updating but this has not been possible due to capacity issues but are due to be updated following the reporting round. When the updated figures are available, this may slightly change the Plan figure.

The following schemes are focused on meeting our ambition:

- Falls prevention classes - Our gentle exercise programme is suitable for anyone over 65, who is looking to improve strength, balance and mobility. the person will first attend an initial assessment with one of our qualified Health & Wellbeing Coaches before joining a class. The person will then work with them to learn exercises that will help the person feel more stable. The programme lasts for 26 weeks and are held once a week for 60 minutes. The simple exercises are designed for older adults and are adaptable to match all abilities and circumstances. Most of them can be done seated if required.
- Competency Nurse has worked alongside care home managers and care staff to develop and deliver bespoke face-to-face training sessions providing clinical expertise and demonstrating evidenced based clinical skills and best practices to achieve this.
- 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. This will entail: Increasing the independence of people living with long term conditions and complex care, supporting carers to maintain their caring role.Improving access to the right service at the right time. The scheme will continue to support the existing assistive technology services. But will also involve piloting assistive technology support for adults with a learning disability (both living in supported tenancies and living in their own homes). Assistive technology has predominately been focused on maintaining the independence of older people in a community setting.
- Finally a Joint Strategic Needs Assessment - A review of falls across Cheshire East Led by Cheshire East Council and the NHS was carried out in August 2023, this told us the following: Who is at risk of falling, Who and how many people might be at risk of falling in the future, What support services are in place to help stop people falling, What support services are needed but not yet provided, Which communities and organisations may be able to work together to fill the gaps.
- The support available in Cheshire East is as follows:
    - One You Cheshire East – Stand Strong classes for anyone looking to improve their strength, balance and mobility (https://oneyoucheshireeast.org/stand-strong/)
    - Medication reviews – To check that you are prescribed the most appropriate medicine
    - Home hazard assessments – Undertaken by occupational therapists who check for hazards in the home

- Free NHS eye tests – Available to all adults aged 60 and over
- Assistive technology – These include a range of electronic gadgets to help you live independently in your own home such as a pendant alarm
- Fire service safe and well checks – The fire service also provide advice on slips, trips and falls as part of wider health and fire safety checks. Must be referred to by a partner organisation and are available to all adults aged 65 and over
- Other NHS services (such as podiatry)

8.3 Discharge to usual place of residence

*Q4 Actual not

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	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)	Quarter (%)	89.0%	89.1%	89.0%	89.9%
	Numerator	7,540	7,543	7,416	7,153
	Denominator	8,474	8,469	8,333	7,957
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
	Quarter (%)	89.4%	89.5%	88.8%	89.1%
	Numerator	7,997	8,028	8,057	7,976
	Denominator	8,950	8,973	9,078	8,952

Although there has been a small improvement on 22/23 performance. Cumulative performance in 23/24 is still 4.3 percentage points below the national position, which is the same as the gap last year. The plan is to improve the reporting rate which is currently below the C+M average (92.6%), currently expected to achieve 89.2% by March 2025 with a plan to reach 89.1% by March 2025.

The following services support our ambitions to increase discharge to usual place of residence:

- Assisted Discharge Service - From April 23 – December 23, 835 people were referred to the Assisted Discharge Service. 12 referrals were declined due to not meeting the referral criteria.
- Support at Home - From April 23 – December 23, 715 people have been referred to the Support at Home service. Some referrals were declined due to not meeting the criteria, some were declined by the service user and 37 were declined due to service capacity. 630 of the 715 people referred were accepted and received services. 106 individuals had previously received support from British Red Cross.
- Reablement - BCF Combined Reablement service - Community Reablement Service has worked on the Home First Agenda over the past 12 months to provide:
    - A concise assessment of people`s need using a person-centred, holistic approach and Reablement ethos.
    - To support Pathway.1 discharges to reable back to independence or complete an holistic care need assessment including Trusted Assessors to prescribe low level equipment to aid mobility and independence.
    - To help prevent hospital admission working with Urgent Community Response and Virtual Wards aimed at supporting someone in a health crisis reabling back to independence over a 72hour – 2-week period, working holistically to enable the person to access other services identified such as volunteers, Carers Scheme, Community Connectors. This also includes any long-term assessment of need.

- The service has aligned with the General Nursing Assistant and a joint competency training pack has been designed this includes staff now trained to provide low-level health tasks such as NEWS2, First line dressing.
- Worked with Leighton Pharmacy to develop a medication process and risk assessment for safe transfer of medication after discharge to reduce the delay in discharge when under extreme pressures and a competency framework for medication.
- Mobile Nights working with the Out of Hours District Nurse Teams and Emergency Department to respond to supporting people home overnight and emergency call outs overnight.
- Worked with people in pathway.2 in a bedded unit to prepare discharge home into reablement.
- Created a new senior role who works in the Transfer of Care Hub at Leighton Hospital to manage and facilitate hospital discharges into reablement, including Home Visits prior to discharge, introducing the service for a smooth transition home, ensuring any equipment and medication is ready to avoid any discharge delays.
- Worked with the End-of-Life Partnership to provide palliative care competencies
- Continued to develop the skills of the team in providing therapy exercises.

- GNA - Expand GNA service to continue to support bridging patients awaiting domiciliary care at home in the East locations of Cheshire East. Patients continue to be discharged earlier from acute settings via the GNA bridging scheme. Ongoing flow into long term services are efficient via MDT huddle working and effective links with the Brokerage Team. During Quarter 3, a total of 1573 hours of care and support were delivered, which continued to help enable and facilitate hospital discharges. During October, 572 hours of care were delivered and approximately 50% of patents go on to be independent with no long-term social care needs. In November, 564 hours of care was delivered and 33% of patients became independent after bridging package. In December, 437 hours of care was delivered and 48% went on to be independent with care needs; with a further 33% of patients became independent after bridging package. Within Quarter 3 a total of 156 patients were supported by this scheme.

8.4 Residential Admissions

		2022-23 Actual	2023-24 Plan	2023-24 estimated	2024-25 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	754.6	680.0	659.9	666.3
	Numerator	679	643	624	642
	Denominator	89,985	94,555	94,555	96,357

The estimated actual for 2023 has been analysed by single year of age and then the projected population change for each has been applied to give a starting position of 642 admissions in 24/25. In 2023/24, 76% of admissions were aged 80 or above (this was the same percentage as in 22/23). It is projected that the population for this age group will increase by 4.2% compared to last year.

We have the following services focused on meeting our ambition

- Reablement - Community Reablement Service - Reablement is a period of short-term, intensive support that is designed to help the service user manage independently following a period of illness or a fall, or if the service user have lost some of the skills, they need to maintain their independence. Support is provided in the service user's own home. Following support from the reablement service,

many people will not require any further assistance. However, if they do, a care and support plan will be developed to ensure that their needs are met.

- Mental Health Reablement Service - One in four people may experience mental health issues during their lives. Together with our health partners, the Council offers a Mental Health Reablement Service. The support focuses on coping techniques, promoting social inclusion, building self-esteem and goal setting. This may include providing support with housing, debt, low self-esteem and isolation, accessing social groups or voluntary work.
- 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

Appendix 4 - Better Care Fund scheme performance 2023-24

Scheme ID	Scheme Name	New/ Existing Scheme	Updated Expenditure for 2024-25 (£)
1	Approved Mental Health Professionals Cover, evenings & weekends for ECT and MCHFT **Scheme Description** - Timely Mental Health Act assessments which will impact upon person, family/ carers, psychiatrists, CWP, ED departments, police, and other partnership agencies. **Spend** - In total, this scheme received an allocation of £60,000. Of this allocation £62,331.66 has been spent during 2023/24. **Impact** – The Approved Mental Health Professional is working 3 x 2-10 shifts in the week and Saturday and Sundays 10-6 to support these more challenging times. These assessments commence typically later in day from approx. 4pm and before EDT handover ensuring continuity in response from service from day to out of hours. During Quarter 3, this scheme has supported 28 cases. The AMHP continues to make a significant contribution to the delivery of MHA assessments on a timely basis. The average number of weekly assessments for 2023 was 16 which compares to the pre-covid average of 11, a percentage increase of 45%. Demand on the service remains high. The AMHP cover supports both the day time and evening/night/weekend service delivered by EDT. Between February 2023 and Dec 2023, the AMHP undertook 57 assessments.	Existing	£85,000
2	Assistive Technology & Gantry Hoists to reduce double handling care packages **Scheme Description** – To purchase additional gantry hoists to facilitate more rapid discharge from hospital. This provides an alternative to the provision of ceiling track hoists which are time consuming to deploy. **Spend** - In total, this scheme received an allocation of £50,000. **Objective** - Assistive Technology Service to promote more rapid discharge from hospital / to prevent admission. This funding will support out of hours delivery of the service through peripheral stores and will increase the range of devices that are available**.** **Impact** – The scheme has helped to decrease domiciliary care packages through the ability to use single-handed care, alongside the technology. The scheme has facilitated timely discharges from hospital for people. A Bariatric gantry was purchased to support patients with these needs when they are discharged from hospital. In Quarter 3, the scheme has assisted 26 people. The scheme will be funding key safes to support hospital discharges for	Existing	£50,000

	people, as this has been identified as area that can contribute towards delayed discharges. This is due to be rolled out shortly so an update can be provided in Q4 on its performance and impact.		
3	Care at Home Investment Increase **Scheme Description** – To ring fence the whole £1.2 million allocation of the Adult Social Care to provide a fee increase to Cheshire East Care at Home providers to ensure ongoing sustainability, growth and ongoing investment across the sector. **Spend** - In total, this scheme received an allocation of £1,200,000. This will contribute to a new pricing model for the commissioned Care at Home providers within the borough. This will also be used as an incentive to grow their customer base by 10% in the first six months of 2023/24. **Impact** – Hours delivered by Care at Home providers represented a growth of 15.46% during 2023/24. As of 20th December 2023, 12 people were awaiting Care at Home, compared to 63 on 10th April 2023. This equated to 151.25 hours of outstanding care, which demonstrates the impact the scheme has made. These figures exclude service users whose care is currently delivered by a provider who is not a Prime or Framework provider. The Council is in the process of transferring these care packages to Prime and Framework providers as the capacity becomes available.	Existing	£2,034,249
4	Home First Occupational Therapist **Scheme Description** – The role of the Occupational Therapist (OT) is a project which is part of the implementation of the Home First model across Cheshire East place and will have a primary focus on specific tasks to ensure that we continue to keep people at home following an escalation in their needs and/or to support people to return home as quickly as possible, with support. **Spend** - In total, this scheme received an allocation of £63,000. The full amount has been spent on the recruitment of this role. Which is a fixed term contract until 31st March 2024 (Full-time Band 6). **Impact** – During Quarter 3, 80 people have been supported through the scheme. Timely assessments that may not be able to reduce care however it quickly identifies long term care needs and refer on and provide assessment for social care team preventing delays in moving people in. There are now 76 General Nursing Assistants (GNA) and ongoing work to support with a rehab approach to care.	Existing	£126,000
5	Hospital Discharge Premium Payment & Prevention Scheme Hospital Discharge Premium Payment & Prevention Scheme	Existing	£125,000

	(Winter Support - Oct 2023 to Mar 2024) – Repurposed to: Cheshire East Council Community Support Connectors in TOCH (NHS Trusts) Scheme Description – The Community Support Connectors can provide community support packages around hospital and care at home for Pathway 0, 1 and 2 patients; located at Mid Cheshire Hospital Foundation Trust and East Cheshire NHS Trust. Spend - In total, this scheme received an allocation of £125,000. Of this allocation £59,622.00 has been spent in 2023/24. During Quarter 3, this scheme has received referrals for and supported 396 patients with their discharge. This equates to a cost saving of at least £213,218. This is based on 1 bed costing £500 per person supported.		
6	Increase General Nursing Assistant Capacity care at home via CCICP **Scheme Description** – Expand GNA service to continue to support bridging patients awaiting domiciliary care at home in the East locations of Cheshire East. **Spend** - In total, this scheme received an allocation of £125,000. Of this allocation £93,750.00 has been spent in half one of 2023/24. **Impact** - Patients continue to be discharged earlier from acute settings via the GNA bridging scheme. Ongoing flow into long term services are efficient via MDT huddle working and effective links with the Brokerage Team. During Quarter 3, a total of 1573 hours of care and support were delivered, which continued to help enable and facilitate hospital discharges. During October, 572 hours of care were delivered and approximately 50% of patents go on to be independent with no long-term social care needs. In November, 564 hours of care was delivered and 33% of patients became independent after bridging package. In December, 437 hours of care was delivered and 48% went on to be independent with care needs; with a further 33% of patients became independent after bridging package. Within Quarter 3 a total of 156 patients were supported by this scheme.	Existing	£133,000
7	Mental Health Reablement – Rapid Response Service Service will deliver 46 hrs per week; service is supporting on average 11 people per week., Individuals with mental health support needs. This service is available support individuals 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 intervention. The service will not provide any type of clinical interventions or physical restraint in the event of physical violence. The service will not provide personal care. Follow an acute stay, the service aims to support patients with mental health support needs who would benefit from some outreach support at home to support them with medication	Existing	£90,000

	management, establishing routines, connecting with other services, welfare checks, attending health or social care related appointments and reintegrating back into their local community.		
8	Integrated Community for the Community and Discharge Support Team **Scheme Description** – Hospital facilitated discharge and home support service provided by St Paul's. Support includes: • Home welfare and health & safety checks • Follow up where necessary • Settling in and linking up • Deliver 7-day support package • Bespoke or social support to ensure maximum benefit is realised in each case • Additional support to reduce hospital admission **Spend** - In total, this scheme received an allocation of £120,000. Of this allocation £82,602.48 has been spent in 2023/24. **Impact** – In Quarter 3 the service has helped facilitate 124 discharges. This has resulted in savings of approximately £70,275. This is based on 1 bed costing £500 per person supported. Savings broken down by month for Quarter 3 – • October - £24,658 • November - £28,581 • December - £17,036	Existing	£120,000
9	Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital **Scheme Description** – Increase workforce to improve assessments and onward form completion for people who are ready for discharge. Review all patients over 14 days to reduce the length of stay. **Spend** - There was a total investment of £300,000 into this scheme for 2023/24 split into £75,000 for each of the following areas: • East Cheshire Trust Transfer of Care Hub Nurses • Short Term Service East Social Workers in ED • Mid Cheshire Hospital Foundation Trust Transfer of Care Hub Nurses • Short Term Service South Social Workers in ED. Of the allocation, the spend for 2023/24 half one is £213,510. **Impact** - During Quarter 3, the scheme supported 918 discharges from hospital. In Quarter 3, the average wait for a package of care (CEC social) was 5.13 days (increase), the	Existing	£300,000

<table>
<tr><td></td><td>average wait for a package of care (IPOCH) was 3.76 days (decrease) and the average total LOS from referral to TOCH to discharge was 8.17 days.</td><td></td><td></td></tr>
<tr><td>10</td><td>iBCF Care at home hospital retainer

In total some 21 individuals , were supported to retain their current Care at Home provider who required the retainer to be extended over the 14 days, which is over 14 different providers. The hospital retainer will support a timely hospital discharge as it reduces the requirement for the package to be resent to the long-term market alongside continuity of care for the individual. In addition, it supports with discharge to normal place of residence and reduces the number of care home admissions .</td><td>Existing</td><td>£49,896</td></tr>
<tr><td>11</td><td>Routes have been delivering the Rapid Response service to support hospital discharges from East Cheshire Trust (Macclesfield Hospital).

Number of people supported from April 23 – December 23 – 211

<table>
<tr><td>Start Year</td><td>2023</td></tr>
</table>

<table>
<tr><th>Start Month</th><th>Clients</th></tr>
<tr><td>April</td><td>16</td></tr>
<tr><td>May</td><td>15</td></tr>
<tr><td>June</td><td>15</td></tr>
<tr><td>July</td><td>30</td></tr>
<tr><td>August</td><td>34</td></tr>
<tr><td>September</td><td>33</td></tr>
<tr><td>October</td><td>17</td></tr>
<tr><td>November</td><td>23</td></tr>
<tr><td>December</td><td>28</td></tr>
<tr><td>Grand Total</td><td>211</td></tr>
</table>

Hours of support provided from April 23 – December 23 – 7235 hours

<table>
<tr><th>Month</th><th>Hrs</th></tr>
<tr><td>Apr</td><td>757.42</td></tr>
<tr><td>May</td><td>842.75</td></tr>
<tr><td>Jun</td><td>717.75</td></tr>
<tr><td>Jul</td><td>746.25</td></tr>
<tr><td>Aug</td><td>889.00</td></tr>
<tr><td>Sep</td><td>881.08</td></tr>
<tr><td>Oct</td><td>900.75</td></tr>
<tr><td>Nov</td><td>710.75</td></tr>
<tr><td>Dec</td><td>789.25</td></tr>
<tr><td>Grand Total</td><td>7235.00</td></tr>
</table>
</td><td>Existing</td><td>£647,328</td></tr>
<tr><td>12</td><td>iBCF Social work support

In total 11 staff (10 out of 11 were agency staff) were employed</td><td>Existing</td><td>£505,613</td></tr>
</table>

	via BCF funding, supporting to date 539 new cases (anticipated to be 660 by the end of the financial period), closing 577 down (anticipated to be 700 by the end of the financial period), completing 281 assessments (anticipated to be 350 by the end of the financial period) and supporting with 23 safeguarding concerns/ inquiries (anticipated to be 25-30 by the end of the financial period), additionally they have supported duty days and wider tasks which ASC / the local authority are required to complete. There has also been an increase in COP cases, which are due to their nature complex and time consuming. As above, this covers a number of settings which includes: Station house, Stepping Hill, Leighton Hospital, Macclesfield Hospital. In previous years this scheme also provided additional capacity at Macclesfield and Leighton hospital during core hours through the weekends,		
13	iBCF Enhanced Care Sourcing Team (8am-8pm) Referral Metrics: • Care at Home referrals - 1884 (732 hospital discharges to normal place of residence) • Pathway three referrals (East Cheshire Trust) - 72 • Pathway three referrals (Mid Cheshire Trust) - 179 • 30+ discharges in one day achieved at mid Cheshire trust December 23 (new record) • Residential referrals - 1391 • Complex Care referrals 251 Brokerage Team Targets: • To obtain a first reasonable offer for Care at Home within 24 Hours • Zero-hour Care at Home wait list – achieved December 2023 Brokerage forms within Liquid Logic have replaced SharePoint to provide much richer data: • Time taken to source packages of care (identifying where the delays sit in the system) • Cost avoidance activity through negotiations • Brokerage Dashboards – live case status • Performance monitoring • eBrokerage performance reports Relationship Management • We continue to co-locate with ICB colleagues in the Transfer of Care Hubs at both East Cheshire Trust and Mid Cheshire Trust, ensuring that we continue to develop as an integrated team • Provider engagement on the eBrokerage system – improvements established, and system re-launched • Brokers attend the Care at Home provider contract meetings • Brokers contact service users directly with offers of care at home, saving valuable SW time (we will expand this offer to residential placements in due course) • Brokers starting to visit residentials homes • Brokerage will manage the Carers Hub and Carers support payments moving forward	Existing	£870,000

	Peer Review Brokerage underwent a Peer Review from Staffordshire Brokerage to assist in the modelling for the re-structuring of the team. One significant outcome was the reporting aspect from which we have learned and adopted operationally in our new brokerage form and subsequent reporting suite. In addition, the team reported that they felt there was a divide between the East and South Community Teams, and this has been recognized in the proposed new team model by having one community team based in Macclesfield Town Hall where we can address and improve culture and efficiency to become a high performing team.		
14	iBCF General Nursing Assistant (within BCF Early Discharge scheme (with BRC) 6737 care calls were delivered during Q1 of 2023/24. 1965 hours of care and support were delivered during Q2. 1573 hours of care and support were delivered during Q3. Total of 156 patients were supported by this scheme during Q3.	Existing	£332,640
15	iBCF Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care) 20.6% growth in hours delivered by commissioned Care at Home providers, exceeding 10% growth target. Currently 18,124 hours compared to 15,030 in April 2023. 19.8% increase in number of service users receiving Care at Home from a commissioned care provider – currently 1,327 service users compared to 1,108 in April 2023. 90% reduction in number of people awaiting a Care at Home package – from 139 service users on 10th April 2023 to 14 service users on 17th January 2024 91.7% reduction in hours needed on Care at Home waiting list - from 1,721.5 hours on 10th April 2023 to 143.5 hours on 17th January 2024 Care providers now inform us that they have available capacity in some areas of the Borough – this situation was unimaginable prior to April 2023. The metrics above suggest a positive impact on discharge to normal place of residence and avoidable hospital admissions since more people are able to access the care and support they need in a more timely manner.	Existing	£6,300,393
16	BCF Disabled Facilities Grant In the year to date (01/04/2023 – 31/12/2023):	Existing	£2,554,801

- 382 new Occupational Therapy referrals have been received for people who will benefit from adaptations.
- 232 new grants have been approved.
- 71 referrals have been cancelled.
- 277 disabled people have benefited from adaptations being completed in their homes.
- The financial resource needed to meet all referrals currently in the DFG scheme stands at £5.67million.

Referrals:

There has been a 15% reduction in the number of referrals from the Occupational Therapy (OT) service compared to the same period last year. The reduction in referrals can be attributed to staff vacancies in the OT service.

Approved grants:

There has been a 20% reduction in the number of approved grants compared to the same period last year, and a 12% reduction in the value of grants approved. The principal reasons for the reduction in approved grants are:

- Delays receiving permissions and asbestos management information from social landlords
- An increase in the number of extensions that require planning permission
- A shortage in capacity in the technical staff team for designing and facilitating the adaptations work

The average value of grants that have been approved is £5,357, compared to £4,868 last year and £5,558 in 2021-22.

Childrens' cases remain a small percentage of the number of referrals, but the financial impact is greater. 5.6% of approved grants year to date were for children, while expenditure was 30.5% of the budget.

Cancelled referrals:

The attrition rate for the year to date is 18.6%, compared to 20.5% in the same period last year. The reasons for attrition remain similar to previous years – principally connected to the financial assessment (either individuals not qualifying for a grant due to their financial circumstances or refusing to undertake the financial assessment).

Completed adaptations:

There is a 10% reduction in the number of completed adaptations compared to the same period last year. The reduction in the number of referrals and approved grants are both impacting on this metric.

Financial pressure:

The financial pressure has continued to build year on year, and for several years the demand has exceeded the available budget. The principal reasons for this are:

- the increased demand for adaptations with an ageing

	population and improvements in healthcare meaning people are living at home for longer; • the complexity of individuals' needs that we are meeting with higher value adaptations; • the continued inflationary increases in the construction sector; and • a reduction in the voluntary contributions received from social landlords (£303,217 year to date, compared to £530,909 in the same period last year). Summary: Delivery of the Disabled Facilities Grant scheme continues at pace, and while the metrics above would indicate a decline in performance, the metrics are restoring to a more normal level following 2 years of significant increased demand. There is still latent demand in the system, demonstrated by the financial pressure on the scheme. We don't envisage demand reducing to a level that would be within the scheme budget and we continue to highlight this to the Council as part of the MTFS process.		
17	BCF Assistive technology The provider is Livity Life – After Millbrook rebranded their Technology Enable Care service the contract was novated over. Demand for the service has continued to be high with the average number of referrals a month at 225 with installations averaging 188 per month. The below KPI's are the average from April-December 2023 • Installations - URGENT to completed within 24 hours i.e. Hospital discharges – 96% within this KPI • Installations - STANDARD to be completed within 5 working days – 98% within this KPI • Maintenance/Faults – CRITICAL within 24hours - 100% on this KPI • Maintenance/Faults – NON-CRITICAL within 7 working days – 98% within this KPI • Withdrawals - STANDARD within 7 working days - 100% on this KPI • Response – Calls answered within 180 seconds – 95% within this KPI • Response – Calls answered within 60 seconds – 86% within this KPI • Response – When a mobile response is required it will be within 45 minutes of the initial call – 96% on this KPI • Total number of Telecare clients – 2,936 at the end of December 2023	Existing	£757,000
18	BCF British Red Cross 'Support at Home' service / Early Discharge **Assisted Discharge Service** From April 23 – December 23, 835 people were referred to the Assisted Discharge Service. 12 referrals were declined due to not meeting the referral criteria.	Existing	£486,651

	Support at Home From April 23 – December 23, 715 people have been referred to the Support at Home service. Some referrals were declined due to not meeting the criteria, some were declined by the service user and 37 were declined due to service capacity. 630 of the 715 people referred were accepted and received services. 106 individuals had previously received support from British Red Cross.		
19	BCF Combined Reablement service Community Reablement Service has worked on the Home First Agenda over the past 12 months to provide: • A concise assessment of people`s need using a person-centred, holistic approach and Reablement ethos. • To support Pathway.1 discharges to reable back to independence or complete an holistic care need assessment including Trusted Assessors to prescribe low level equipment to aid mobility and independence. • To help prevent hospital admission working with Urgent Community Response and Virtual Wards aimed at supporting someone in a health crisis reabling back to independence over a 72hour – 2-week period, working holistically to enable the person to access other services identified such as volunteers, Carers Scheme, Community Connectors. This also includes any long-term assessment of need. • The service has aligned with the General Nursing Assistant and a joint competency training pack has been designed this includes staff now trained to provide low-level health tasks such as NEWS2, First line dressing. • Worked with Leighton Pharmacy to develop a medication process and risk assessment for safe transfer of medication after discharge to reduce the delay in discharge when under extreme pressures and a competency framework for medication. • Mobile Nights working with the Out of Hours District Nurse Teams and Emergency Department to respond to supporting people home overnight and emergency call outs overnight. • Worked with people in pathway.2 in a bedded unit to prepare discharge home into reablement. • Created a new senior role who works in the Transfer of Care Hub at Leighton Hospital to manage and facilitate hospital discharges into reablement, including Home Visits prior to discharge, introducing the service for a smooth transition home, ensuring any equipment and medication is ready to avoid any discharge delays. • Worked with the End-of-Life Partnership to provide palliative care competencies. • Continued to develop the skills of the team in providing therapy exercises.	Existing	£5,372,663
20	BCF Carers hub Following a recommission the new contracted provider of the Carers Hub is Making Space and the contract commenced 1st January 2023. Performance data – Jan to December 2023.	Existing	£389,000

	• 6289 adult carers & 823 young carers registered with the Hub • 1419 adult, 254 parent & 183 young carer referrals received • 652 adult statutory carers assessments completed • 370 contingency card & plans provided • The biggest sources of referrals are from carers themselves via self-referrals, also Adult Social Care, Dementia Reablement, Cheshire & Warrington Carers Trust and Health sources including social prescribers. • Adult Carers accessing support - % of interaction type: • Info & Advice Only – 1% Low – 36% Moderate – 56% High – 5% Intensive – 1% • Parent Carers accessing support - % of interaction type: • Info & Advice Only – 0.8% Low – 40% Moderate – 56% High – 3% Intensive – 0.9% • Young Carers accessing support - % of interaction type: • Info & Advice Only – 0.2% Low – 60% Moderate – 36% High – 3% Intensive – 0.4% • Outcomes following review – based on needs assessment: • 51% of adult carers showed improvement in being able to get out into the community, 41% indicated improvements in being able to maintain their home, 56% noted an improvement in being able to take part in leisure, cultural or spiritual activities, 28% indicated an improvement to their mental wellbeing and 38% to their physical health. • 116 adult and parent carers provided with a break with the Take a Break service • 165 adult and parent carer group sessions delivered – providing 730 carers with a break • 124 young carer sessions delivered – providing 523 young carers with a break • 15 training courses delivered to carers – providing them with skills in emergency first aid, infection prevention and control, safe handling of medication, basic food safety and manual handling. Hospital Discharge Scheme – Between April 23 – December 2023, 152 carers were referred to the Carers Hub for support through the Hospital Discharge Scheme. These carers were then able to support the cared for person to be able to return to their home from hospital.		
21	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. • Additional commissioning capacity might be required to support the review of existing contract and schemes and the procurement of alternative services. • To provide enabling support to the Better Care Fund programme, through programme management and other support, as required. • To develop and maintain adherence to governance	Existing	£541,801

	arrangements including the s75 agreement and commissioning capacity. • The delivery of the Better Care Fund relies on joint commissioning plans already developed across the Cheshire East Health and Social Care economy. • Submission of all financial information on time of all NHSE and other central returns. • Financial support for remedial action / development of new initiatives where needed to maximise the impact of the BCF investment (including performance against the national metrics). • Financial administration to support the BCF, invoicing etc. • Financial advice and support to scheme managers as required. • Contribution to budget papers and other reporting to governing bodies/committee as required. • Contribution to governance mechanism's such as S75 statements, BCF Governance Group. • Production of year-end information, notes to the accounts etc.		
22	BCF Winter schemes ICB This winter funding supports the systems winter flow plan. As a system we recognise that capacity and demand fluctuations occur across the year and can be planned for to manage the flow of patients safely and effectively throughout the Health & Social Care system. The Challenges noted in recent years include: unprecedented urgent care demand, new urgent care standards to achieve whilst continuing to manage the effects of the COVID pandemic, increasing issues with workforce availability, elective care backlogs and recovery trajectories, predictions of high flu circulation, Respiratory Syncytial Virus (RSV) in children and increased Mental Health demands, as well as pressures from neighbouring areas, winter illnesses and weather effects. Please note a deep dive of the following scheme is underway.	Existing	£500,000
23	BCF Home First 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. Please note a deep dive of the following scheme is underway.	Existing	£19,973,121
24	BCF Carers hub	Existing	£324,000
25/26	BCF Community Equipment service	Existing	£550,000

	The below are some of the main KPI's the provider has achieved from April-December 2023 with average compliance over this period. Actual projected spend is £5M p.a. for all partners (CEC, CWAC and CCCG) or £2.5M for just the CE area. The total spend across East Cheshire for the Council & ICB in this period - £1,915,279. Projected council spend at the end of the financial year - £520,000. • Deliveries within 1 Day (urgent) – 99% • Deliveries within Same Day (4 hours) (Critical) – 95% • Deliveries within 5 Days (standard) – 96% • Items collected within 5 Days (standard) – 95% • Items collected within 1 Day (urgent) – 87% • All routine repairs shall be completed within 5 Days – 98% • Percentage of equipment that has been recycled – 79% (generating an average £118k/month in credits) • Equipment Issue Codes – As indicated by the prescriber (cost of equipment and associated activities) • Hospital Discharge – 19.9% (cost £526,842) • Maintain without Care Package – 6.1% (cost £161,585) • Prevent Placement – 7.3% (cost £192,142) • Reduce Care Package – 0.5% (£11,908) • Maintain/Enable Independence – 21.5% (cost £569,169) • Support Formal Carers – 24.3% (cost £642,026)		/£2,231,630
27	VCFSE Grants **Mental Health Support and Interventions** Healthbox CIC - £9,221 Early intervention mental health and counselling service. It will comprise of 1 trained counsellor working part time (2 days per week) as a mental health lead and 5 placement counsellors providing 1-2-1 counselling sessions as required. This service will be targeted towards adult (18+) Cheshire East residents with low level mental health issues. Number of service users: 29, Number of volunteer hours contributed: 43. Knutsford Together - £10,000 A service to connect all those in need in Knutsford with the help they require and, when necessary, being their advocate. 100 new individuals across Knutsford will benefit up to 1st April 2024. Number of service users: 82. Time Out Group - £11,679 Together Time, is a project that improves the mental health and emotional wellbeing of adults with learning disabilities and/or autism. Together Time is a bespoke programme that helps people to explore how they feel	Existing	£182,860

	and to develop the skills they need to cope with life's challenges. Together Time will be attended by 50 adults in Wilmslow. providing 51 full day sessions, over 250 hours of contact time and 24 hours of 1-on-1 counselling. Number of service users: 234, Number of volunteer hours contributed: 197. Wilmslow Youth - £19,951 Oversight and coordination of a multi-organisational approach to referral and support for young people experiencing mental ill-health, offering three levels of support. This project will benefit 200 young people aged 11-18 living within the CHAW footprint. Number of service users: 164, Number of volunteer hours contributed: 1213. The Dove Service - £15,665 Specialist 1:1 counselling and group support across Cheshire East, with outreaches in Crewe, Congleton and Macclesfield to support those of any age, experiencing issues around grief and loss. Number of service users: 244, Number of volunteer hours contributed: 439. **Physical Health and Wellbeing** Petty Pool College - £20,000 Supporting those young people living with LD to access additional activities in Macclesfield and surrounding area to improve skills linked to Education and Health Care Plans. Number of service users: 10. Number of volunteer hours contributed: 35 Community and Voluntary Services Cheshire East - £19,965 Engaging with VCFSE Organisations in 20% Most deprived areas. This will support 20 Groups to access support and to develop walking groups in the areas to help improve health of population within these areas. Number of service users: 12 Number of volunteer hours contributed: 195. Everybody Health and Leisure - £14,339 Junior Activity Referral Scheme will target young people aged 12-18 years in Crewe and surrounding areas with long term health conditions to engage them in 12-week programme to encourage and facilitate exercise. Number of service users: 38. Down Syndrome Cheshire - £3,203 Providing opportunities for people living with Downs Syndrome in Macclesfield and surrounding areas to take part in regular, accessible, and inclusive dance classes. Number of service users: 350, Number of volunteer hours contributed: 20. Crewe Central Table Tennis Club CIC - £3,500 Deliver tailored sessions for people with long term health conditions and to expand provision to young people. This will work to support people with a range of conditions including Dementia, Parkinson’s, and physical disabilities to help manage and alleviate symptoms, enjoy achievements and raise activity levels and improve confidence. Number of service users: 20, Number of volunteer hours contributed: 214. Connecting Chelford - £4,570 Working with Care Community to engage older people to reduce isolation and loneliness. Activities including weekly friendship groups, developed a Digital Friends Scheme, First Aid in the community, Dementia Carers Support Group. Number of service users: 459, Number of volunteer hours		

	contributed: 612. Cheshire Deaf Society - £9,922.90 Health, Advice 'n' Deafness-HAnD Project- will provide support and improve engagement to reduce health inequalities experiences by the deaf community across Cheshire East. Number of service users: 23, Number of volunteer hours contributed: 4. Cheshire Young Carers - £7,982 Delivering 70 activities across 5 schools in Cheshire East to improve health of young carers to improve activity levels and develop support networks. Number of service users: 51. Central Cheshire Buddies Scheme - £7,982 CCBS supports children and young people living with a disability and their siblings delivering a range of activities to increase confidence and self-esteem and reduce social isolations through shared activities with friends and siblings. Number of service users: 56, Number of volunteer hours contributed: 324. Audlem and District Community Action - £12,310 ADCA aims to make Audlem 'dementia friendly' by delivering targeted activities, raising awareness and supporting carers. Number of service users: 48 Number of volunteer hours contributed: 540 Visual Impairments Hopes and Beams - £14,600 A peer-support and social group for young adults across South Cheshire who have sensory issues, including visual impairments and hearing loss. 50 potential users through partnership work with Cheshire East Council's Sensory Support and Communities teams. A mixture of structured and unstructured sessions within the group, allowing the users to socialise with each other, access support or learn new skills such as cooking or art. Number of service users: 8 Number of volunteer hours contributed: 63. Wishing Well - £7,000To provide additional support services to the growing drop-in sessions that are now based at Jubilee House in Crewe. Working in partnership with IRIS. To provide specialist support, particularly for those who have little to no vision. This project will benefit a minimum of 60 people across South Cheshire. Number of service users: 103, Number of volunteer hours contributed: 476.		
28	Spot purchase beds and cluster model • Centralised cluster of D2A facilities strategically positioned across Cheshire East Place have ensured that people are discharged to a D2A bed as near to their local community as possible. • 158 beds have been added to the system to ensure people are discharged from hospital for a period of further treatment, assessment, and rehabilitation. • Seamless discharge and transition to D2A beds has been achieved with the removal of unnecessary authorisation processes. • A reduction in Length of Stay has been achieved. • Transformation towards a financially sustainable model for step up and step-down beds.	Existing	£1,200,000

	• 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, creating acute bed base capacity. • Increased patient flow through the hospital. • Supporting people out of hospital, to streamline discharge to enable 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. • People require lower levels of formal care on return home due to successful period of rehabilitation. • Optimisation prior to return home increases the success rate of discharges and reduces the risk of re-admission.		
29	Practice Development Nurse	New	£58,708
30	Care communities	New	£500,000
31	AED in reach	New	£220,584
32	Residential care home competence nurse	New	£48,451
33	Community Support Connectors In TOCH	New	£241,000
34	Adult social workers linked to safeguarding	New	£496,717
35	Proportionate care	New	£135,134
36	Handyperson	New	£177,000
37	HomeFirst social work support	New	£174,136
38	Reablement	New	£420,000
39	Advice and signposting self-fund care	New	£83,281
40	Adult Contact Teams Service	New	£32,432

Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Cheshire and Merseyside Commitment to HIV Fast Track Cities Approach
Report Reference Number	HWB64
Date of meeting:	24th September 2024
Written by:	Dr Matthew Atkinson, Consultant in Public Health
Contact details:	Matthew.Atkinson@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Director of Public Health

Executive Summary

Is this report for:	Information ☑	Discussion ☐	Decision ☐
Why is the report being brought to the board?	To gain the board's support for Cheshire East to become part of the Cheshire and Merseyside work to end new HIV transmission in the sub-region by 2030.		
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 ☐		
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.	That members/councillors support the sign up to the HIV Fast Track Cities agenda, and therefore commit to the Paris and Sevilla declarations. All nine local authorities in Cheshire and Merseyside intend to make this pledge; That the Cheshire & Merseyside Sexual Health and HIV Commissioners network be the main strategic group to map needs and gaps and develop a relevant regional plan, reporting to Directors of Public Health on a minimum quarterly basis;		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The report will be considered at the November meeting of the Council's Adults and Health Committee.
Has public, service user, patient feedback/consultation informed the recommendations of this report?	This will inform the action plan that will be developed in the future.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Residents will benefit from expertise across Cheshire and Merseyside and from economies of scale in developing plans, resources and campaigns. Residents will benefit from a coordinated and consistent offer for HIV prevention, diagnosis and treatment across the sub-region so that best practice is shared and adopted at scale.

1 Report Summary

1.1 With an early diagnosis and the provision of treatment, people with HIV can have a normal lifespan and will not develop AIDS-related illnesses. Effective treatment lowers the virus to undetectable levels which means that it will not be transmitted to sexual partners. Pre-exposure prophylaxis (PrEP) for HIV-negative people at risk of exposure reduces the risk of transmission.

1.2 The HIV Fast Track Cities initiative aims to make testing, treatment and prevention available to all who could benefit by bringing partners together in a single programme.

1.3 FTC was launched in 2014 as an international, multi-agency partnership. Places join by agreeing to the Paris Declaration on Fast-Track Cities and the supplementary Sevilla Declaration.

1.4 This report proposes expanding the HIV Fast Track Cities (FTC) initiative across Cheshire and Merseyside, building on early successes in Liverpool and learning from work across Greater Manchester.

1.5 FTC will help us reduce rates of HIV infection and the number of people diagnosed at a late stage of infection.

1.6 FTC will help us reduce inequalities between men and women and improve care for marginalised groups, including the provision of pre-exposure prophylaxis (PrEP).

1.7 Our sexual health service (provided by Axess) will be key local and regional partners. Our service has performed well on HIV testing and the provision of PrEP to those at risk and has run campaigns to improve access to testing and treatment for women.

2 Recommendations

2.1 That members/councillors support the sign up to the HIV Fast Track Cities agenda, and therefore commit to the Paris and Sevilla declarations. All nine local authorities in Cheshire and Merseyside intend to make this pledge;

2.2 That a Consultant in Public Health be put forward as a key representative from our local sexual health and HIV partnership to be the nominated 'Key Opinion Lead' for Cheshire East;

2.3 That the Cheshire & Merseyside Sexual Health and HIV Commissioners network be the main strategic group to map needs and gaps and develop a relevant regional plan, reporting to Directors of Public Health on a minimum quarterly basis;

2.4 That members/councillors support the planning and delivery of an HIV Fast Track launch event for Cheshire and Merseyside (date to be confirmed).

3 Reasons for Recommendations

3.1 The Cheshire and Merseyside Fast Track Cities (FTC) approach will build on the partnership approach in Liverpool that has led to significant change. Cheshire and Merseyside is exploring the replication of a model that has shown promise in Greater Manchester.

3.2 Manchester's Fast Track City status covers the Greater Manchester (GM) region and this cross-borough arrangement has driven regional innovation and progress towards better (and more equitable) support for residents living with HIV as well as those at higher risk of the virus.

3.2 Prior to FTC, 91% of people with HIV in GM knew their HIV status, 98% were successfully in treatment and care, and 96% had undetectable levels of HIV. An estimated 115-120 people were still undiagnosed. 5 years later, and those statistics are 95%, 99% and 98% respectively, with only 45-50 people estimated to be undiagnosed. This is significant progress;

3.3 Recent years have seen an increase in HIV prevalence across Cheshire and Merseyside (lower in Cheshire East than other areas but still rising).

3.4 Though infection rates are relatively low in Cheshire East, more than 50% of those diagnosed in 2021/22 were at a late stage of infection in (as were those in Halton, Wirral, Cheshire West and St Helens);

3.5 Furthermore, testing rates across certain areas of the region have been declining, most notably amongst women, with the percentage of eligible attendees accepting an HIV test in specialist services declining since 2020. Women have also represented a larger cohort of those who have late diagnoses;

3.6 On the whole there are a higher number of males seen for care across the region, and more men are testing than women. Therefore, targeted work and campaigns are required collectively across the region (e.g. the Axess Empowherment campaign covering Cheshire East);

3.7 Access to PrEP is not equitable across the region either. This picture is mirrored nationally, with the drug largely being accessed by gay and bisexual men and other men who have sex with men (GBMSM). FTC would provide the opportunity to action plan and improve access for currently under-served communities, particularly Black and Minority Ethnic communities and also women, building on the work already being done by axess. It would also help us improve the rates of identification of PrEP need by area, to ensure everyone eligible receives the offer of PrEP;

3.8 FTC would further provide the opportunity for Cheshire East to sign up to be a pilot area to use the National AIDS Trust (NAT) stigma charter mark, and invite partners and trusts forward for training and support around stigma reduction. In doing so, Cheshire East would be one of the first areas to adopt and drive this;

3.9 A Cheshire East sign up to the FTC approach allows a regional commitment to re-creating our own 'Positive Voices' survey to understand people's attitudes and opinions around HIV to help us formulate a clear response and create a baseline figure in our ambition to reduce HIV associated stigma.

4 Impact on Health and Wellbeing Strategic Outcomes

4.1 Joining the Cheshire and Merseyside approach will help Cheshire East support good health and wellbeing for everyone by reducing inequalities between men and women and for those in marginalised communities, reducing the risk of HIV transmission across the Borough.

4.2 Early diagnosis and effective treatment of will help more people live and age well.

5 Background and Options

5.1 HIV (human immunodeficiency virus) is a virus that attacks the body's immune system.

5.2 Whilst there's currently no cure for HIV, there are very effective drug treatments that enable most people with the virus to live a long and healthy life. With an early diagnosis and effective treatments, most people with HIV will not develop any AIDS-related illnesses and will have a normal lifespan.

5.3 The development of HIV treatment has meant the virus can now be lowered to undetectable levels in a person's blood. A person who has undetectable levels of virus in their blood does not pose an infection risk to their sexual partners.

5.4 Pre-exposure prophylaxis (PrEP) has also been developed and available in the UK. PrEP is a drug taken by HIV-negative people before sex that reduces the risk of getting HIV. Taking PrEP before being exposed to HIV means there's enough drug inside you to block HIV if it gets into your body.

5.5 These medical developments transform the way that HIV is considered, with enormous implications for what it now means to live with HIV and the best ways to prevent it. We are at a time where due to these developments we could effectively eradicate HIV through better prevention measures applied to both those not yet infected with and those living with HIV.

5.6 The Fast Track Cities (FTC) initiative on HIV was launched globally in 2014 through the Paris Declaration, developed and led by the International Association of Providers of Aids Care (IAPAC) (see Appendix 1). It is a global partnership between cities and municipalities around the world and four core partners: IAPAC, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Human Settlements Programme (UN-Habitat), and the City of Paris.

5.7 Mayors and other city/municipal officials designate their cities as Fast-Track Cities by signing the Paris Declaration on Fast-Track Cities, which outlines a set of commitments to end new cases of HIV by 2030. Since its launch, more than 400 cities and municipalities in approximately 90 countries have joined the global network and endorsed the Paris Declaration.

5.8 The Seville declaration is designed to be a supplement to the Paris Declaration, and commits to putting people, and specifically under-served communities, in the centre of service design.

5.9 Liverpool City Council signed up to this initiative in 2018, to help drive local plans to improve testing, support, identification and treatment related to HIV, and bolster prevention approaches. Some of the benefits included a new galvanised approach to a strategic plan, and the ability to attract even more funding for research and pilots to reach the target of zero new HIV transmissions by 2030.

5.9 The initiative involves aiming for 3 targets, known as the 'triple 95' targets: the ambition is that at least 95% of people living with HIV should be diagnosed, at least 95% of people

living with diagnosed HIV should be on treatment, and at least 95% of people on treatment should be virally suppressed. This is an exciting opportunity for the region to sign up to commit to achieving these goals.

5.10 With this initiative we can work as a collective to formulate a series of strategic actions to help us be one of the first regions to achieve elimination by 2030.

5.11 Our sexual health service is funded via the Public Health Grant and is provided by Axess and it plays a crucial role in combating HIV. They have a comprehensive care approach, including education, medication adherence support, and routine monitoring. The 'triple 95' targets from the FTC initiative align with ongoing work in Cheshire East to better find and support those at risk of HIV infection, engage marginalised/underrepresented communities, and remove the stigma of this topic to better serve those in need.

5.12 During 23/24, the service exceeded the KPI (80%) for the number of service users with needs relating to STIs who have a record of having a HIV test at first attendance. They also saw that the attendance of men who have sex with men to the Cheshire East service increased markedly by more than 40% on the previous year (every patient was offered a HIV test at first attendance and 91.92% accepted, exceeding the KPI of 85%). Additionally, they have increased seen an increased proportion of ethnic minority patients accepting an HIV test at first attendance, reaching and exceeding the KPI of 85%.

5.13 All patients at risk of HIV were assessed for eligibility to access PrEP. The PrEP Express initiative provides quick and easy access to repeat PrEP medication for registered PrEP users.

5.14 Since March 2024, the Axess Outreach Team has been running the Empowherment campaign, which highlights the eligibility of women to access to PrEP. The service also ran an HIV testing week event/campaign and a World AIDS Day communications campaign, and are also involved in delivering trials (e.g., the ILANA trial: Implementing Long-Acting Novel Antiretrovirals for people living with HIV).

6 Access to Information

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

Name: Dr Matthew Atkinson
Designation: Consultant in Public Health
Email: Matthew.Atkinson@CheshireEast.gov.uk

Appendix 1: The seven objectives of the Paris Declaration

1. End AIDS and new HIV transmissions as a public health threat in cities by 2030. We commit to rapidly reduce new HIV infections and AIDS-related deaths, including from tuberculosis (TB) and comorbid diseases, including viral hepatitis, putting us on the fast-track to ending AIDS as a public health threat by 2030. We commit to provide sustained access to testing, treatment, and prevention services. We will end stigma and discrimination.

2. Put people at the center of everything we do. We will focus, especially on people who are vulnerable and marginalized. We will respect human rights and leave no one behind. We will act locally and in partnership with our communities to galvanize global support for healthy and resilient societies and for sustainable development.

3. Address the causes of risk, vulnerability and transmission. We will use all means including municipal ordinances and other tools to address factors that make people vulnerable to HIV, and other diseases. We will work closely with communities, service providers, law enforcement and other partners, and with marginalised and vulnerable populations including displaced people, young women, sex workers, people who use drugs, migrants, men who have sex with men, and transgender people to build and foster tolerance.

4. Use our AIDS response for positive social transformation. Our leadership will leverage innovative social transformation to build societies that are equitable, inclusive, responsive, resilient, and sustainable. We will integrate health and social programs to improve the delivery of services including HIV, tuberculosis, and other diseases. We will use advances in science, technology, and communication to drive this agenda.

5. Build and accelerate an appropriate response to local needs. We will develop and promote services that are innovative, safe, accessible, equitable, and free of stigma and discrimination. We will encourage and foster community leadership and engagement to build demand and to deliver services responsive to local needs.

6. Mobilise resources for integrated public health and development. Investing in the AIDS response, together with a strong commitment to public health, is a sound investment in the future of our cities that fosters productivity, shared prosperity and well-being. We will adapt our city plans and resources for a fast-tracked response. We will develop innovative funding and mobilise additional resources and strategies to end AIDS epidemic as a public health threat by 2030.

7. Unite as leaders. We commit to develop an action plan and join with a network of cities to make the Paris Declaration a reality. Working in broad consultation with everyone concerned, we will regularly measure our results and adjust our responses to be faster, smarter, and more effective. We will support other cities and share our experiences, knowledge, and data about what works and what can be improved. We will report annually on our progress.