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Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday, 19th November, 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 - 8)

   To approve the minutes of the meeting held on 24 September 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. **Housing and Health** (Pages 9 - 14)

To receive a report outlining the approaches taken by both the Council and Registered Housing Providers in response to poor housing conditions on health.

6. **Cheshire and Merseyside Child Poverty Report** (Pages 15 - 78)

To receive a briefing report on the rapid situational analysis on child and family poverty in Cheshire and Merseyside.

7. **Joint Strategic Needs Assessment (JSNA) update** (Pages 79 - 84)

To receive an update of progress in the JSNA work programme since March 2024.

8. **Cancer Alliance** (Pages 85 - 90)

To receive a presentation on the Cancer Alliance.

9. **Cheshire East Drugs and Alcohol Plan** (Pages 91 - 116)

To receive a report on the new drugs and alcohol plan for Cheshire East.

10. **NHS Ten-Year Plan engagement** (Pages 117 - 132)

To consider a report on the engagement exercise underway to inform the drafting of the new Ten-Year Plan for Health.

11. **The Cheshire East Winter Plan** (Pages 133 - 192)

To receive the Winter Plan 2024 – 2025.

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

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 24th September, 2024 in the Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Board Members
Helen Charlesworth-May, Executive Director Adults, Health, and Integration
Councillor Janet Clowes, representing the main opposition group, Cheshire East Council
Sam Corcoran (Chair), Cheshire East Council
Councillor Carol Bulman, Chair of Children & Families, Cheshire East Council
Councillor Jill Rhodes, Chair of Adults & Health, Cheshire East Council
Louise Barry, Chief Executive, Healthwatch Cheshire
Ian Moston, Chief Executive, Mid Cheshire Hospitals NHS Foundation Trust
Peter Skates, Acting Executive Director of Place, Cheshire East Council
Theresa Leavy, Interim Executive Director of Children's Services, Cheshire East Council
Kathryn Sullivan, Chief Executive, CVS Cheshire East
Mark Wilkinson, Place Director, NHS Cheshire, and Merseyside Integrated Care Board
Superintendent Claire Jesson, Area Commander, Cheshire East (Joined remotely via Microsoft Teams)

Cheshire East Officers and Others
Hayley Antipas, Public Health Development Officer
Dr Matthew Atkinson, Public Health Consultant
Lucy Baker, Wellbeing Engagement Officer for Green Spaces for Wellbeing
Annie Britton, Participation Lead, Youth Support Service
Alex Jones, Better Care Fund Programme Manager
Guy Kilminster, Corporate Manager Health Improvement
Dr Susie Roberts, Public Health Consultant
Josie Lloyd, Democratic Services Officer
Ruth Morgan, Parks and Recreation Manager and Programme Manager for Green Spaces for Wellbeing
Anna Moreton, Cheshire East Youth Council
Angela Murney, Participation Worker, Youth Support Service
Rachael Nicholls, Project Worker, Health Improvement Team
Rachel Zammit, Health Promotion, and Improvement Manager

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

14 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Dr Paul Bishop (NHS Cheshire and Merseyside Integrated Care Board), Michelle Davis (Guinness Housing), Claire Williamson (Children's Services - CEC), Charlotte Wright

(Cheshire Fire and Rescue Service) and Isla Wilson (Cheshire East Health and Care Place Partnership).

Ian Moston attended as a substitute for Isla Wilson.

15 **DECLARATIONS OF INTEREST**

In the interests of openness and transparency Councillor S Corcoran declared an interest by virtue of his wife being a GP.

16 **MINUTES OF PREVIOUS MEETING**

RESOLVED:

That the minutes of the meeting held on 2 July 2024 be confirmed as a correct record.

17 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no registered public speakers.

18 **LIFESTYLE PRESCRIPTION UPDATE**

The Board received an update relating to the Cheshire East Lifestyle Prescription resource which had been developed over 2022-23. The resource was developed through partnership working to support the prioritisation of prevention and to help residents think about acting upon lifestyle changes, so they avoid, where possible, the development of long-term conditions.

The update included simplifying the language used, changing the title, translated versions of the adult resource, and designing a children and young people's version of the Lifestyle Prescription resource.

In respect of a question raised about evaluation of the resource officers responded that by working with GPs they would be able to see if it made the process easier for them (the GP) and it was hoped that there would be a follow up with patients to discover if it had encouraged them to make a lifestyle change.

Members offered support in respect of the challenges faced around engaging pharmacies and the Waiting Well programme.

In respect of evaluating how well the resource was working for the adult population it was noted that although the number of times the resource had been viewed or downloaded could be identified from the site, it was more challenging to evaluate the outcomes post download and work was ongoing with partners around this.

RESOLVED:

That the Health and Wellbeing Board

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

19 **CHILDREN AND YOUNG PEOPLE 'MAKE YOUR MARK' BALLOT RESULTS**

The Board received a presentation from the Cheshire East Youth Council, The Youth Council was made up of a group of young people who campaign on and create positive change for others. They help to make services and the support that children and young people receive better.

Board members heard about what young people thought leaders could do to help support their Health and Wellbeing, what the outcome of the national Make Your Mark campaign was and what the Youth Council had been involved in since the Make You Mark campaign.

Board members provided feedback and comments in relation to

- What they could do to influence getting more mental health professionals in school as well as considering support for those not in school.
- The reporting mechanism in relation to bullying.
- Emphasis on the importance of Family Hubs when providing support to children and adults.
- Recognised challenges in engaging with communities, both co-producing and information sharing.
- How to link initiatives together to ensure people are not working in silos.

RESOLVED:

That the presentation be noted.

20 **ALL TOGETHER SMOKE FREE/TOBACCO CONTROL UPDATE**

The Board received an update on the All Together Smokefree – Cheshire and Merseyside framework. The update outlined the key programme objectives, what work was being undertaken and the opportunities for future developments.

Board members shared their concerns about the rise in the number of those vaping and agreed that there was a need to be explicit about dangers of vaping particularly with younger generations.

Members provided feedback and comments in respect of

- Messaging - There was lots about life expectancy but there was a need to also think about healthy life expectancy.
- Managing expectations – Until there had been a decrease in levels of smoking and people stopping taking it up altogether, it needed to be accepted that it was a slow downwards trajectory. In order to stop people taking up smoking in the first place there was a need to understand the role of home conditions, for example parental role models. It was acknowledged that it was a complex public health issue, and it was not going to happen quickly but everything being done was heading in the right direction and it was about keeping the momentum going.
- The branding of 'Altogether Smoke Free' links with the 'Altogether Fairer' and 'Altogether Active' branding at the Cheshire and Merseyside level demonstrating, a common theme being used by the Integrated Care Board (ICB) towards the branding of programmes of work aimed at reducing health inequalities.
- Trading Standards – There was a need for a campaign to make vaping less appealing e.g. colours/flavours.

RESOLVED:

That the Health and Wellbeing Board

1. Note the update.

21 **GREEN SPACES FOR WELLBEING UPDATE**

The Board received an update on the Greenspaces for Wellbeing project from April 2023 - March 2024 which included how the Green Spaces for Wellbeing programme was designed, the delivery models, the referral and lifestyle outcomes, the approach to marketing and the priorities for 2024/25.

Although the project had been undertaken without any national funding there was evidence nationally that schemes such as this worked.

Members welcomed the project and noted that although there were a number of people who dropped out before completing the course, it was a new service and there were several factors which affected attendance. Those factors included people having a range of health conditions, those with mental health conditions could sometimes struggle with motivation, older people drop out to help with childcare, and other conflicting appointments. It had been recognised that the 12-week model may not be best for everyone and following the model being adapted there had been an increase in numbers in the second year.

Priorities for 2024/25 included increasing taster sessions, targeted cohort sessions, continued development of the marketing strategy, developing volunteering and exploring new funding avenues.

RESOLVED:

That the Health and Wellbeing Board

1. note the progress made with the project.

22 **BETTER CARE FUND END OF YEAR ANALYSIS 2023-2024 AND PLAN FOR 2024-2025**

The Board received a report which provided an end of year overview of the Cheshire East Better Care Fund plan for the period 2023-24. In addition, the report outlined the plan for 2024-25 which was a continuation of the plan agreed for 2023-25.

11 new schemes had been added for 2024-25 and Changeology had been commissioned to help understand the barriers and identify opportunities to improve capacity and demand planning capability to enhance overall system resilience.

Members welcomed the fact those schemes that were not working had been cancelled and were encouraged by the additional investment for care communities.

RESOLVED:

That the Health and Wellbeing Board

1. Notes the performance for 2023-24 and approves the plan for 2024-25.

23 **HIV FAST TRACK CITIES**

The Board considered a report which sought support for Cheshire East to become part of the Cheshire and Merseyside work to end new HIV transmission in the sub-region by 2030.

Joining the Cheshire and Merseyside approach would 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.

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).

In relation to a question raised in respect of what happens when people choose not to go to places in Cheshire and Merseyside, would there be the same reciprocal arrangements with neighbouring areas, officers reported that there was no intention to change commissioning arrangements or people's choices if they wanted to go elsewhere, and at present that would still be done under the current arrangements.

RESOLVED:

That the Health and Wellbeing Board

1. Support the sign up to the HIV Fast Track Cities agenda, and therefore commit to the Paris and Sevilla declarations.
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.
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.
4. That members/councillors support the planning and delivery of an HIV Fast Track launch event for Cheshire and Merseyside

The meeting commenced at 2.00 pm and concluded at 3.40 pm

Councillor S Corcoran (Chair)

Agenda Item 5

Cheshire East Council

NHS
Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Housing and Health
Report Reference Number	HWB50
Date of meeting:	19th November 2024
Written by:	Karen Carsberg and Michelle Davis
Contact details:	Karen.carsberg@cheshireeast.gov.uk Michelle.davis@guinness.org.uk
Health & Wellbeing Board Lead:	Guy Kilminster

Executive Summary

Is this report for:	Information ☐	Discussion ☐ X	Decision ☐
Why is the report being brought to the board?	Board Members highlighted the issues of poor housing conditions on health and wished to ascertain the approaches taken by both the Council and Registered Housing Providers in response to this.		
Please detail which, if any, of the Health & Wellbeing Strategic Outcomes this report relates to?	1. Cheshire East is a place that supports good health and wellbeing for everyone ☐ 2. Our children and young people experience good physical and emotional health and wellbeing ☐ 3. The mental health and wellbeing of people living and working in Cheshire East is improved ☐ 4. That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place ☐ All of the above ☐ X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above ☐ X		

Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	To note the actions been taken by both the Council and Registered Housing Providers.
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	No
Has public, service user, patient feedback/consultation informed the recommendations of this report?	No
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	The quality of a person's housing has an impact on their health and wellbeing. Improved housing can benefit the quality of life and the health and wellbeing of the individual / family living with in it.

1 Report Summary

1.1 There are clear links between poor housing conditions and Health, this report outlines the evidence and findings of a number of reports and sets out how Government are responding and also the measures which Cheshire East Council and Registered Housing Providers have put in place.

2 Recommendations

2.1 To note the report and current work being undertaken by both Cheshire East Council and Registered Housing Providers and discuss how the Board might support work to further improve housing conditions in Cheshire East.

3 Reasons for Recommendations

3.1 Members of the Health and Well Board outlined their concerns in relation to the impact that poor housing conditions could have on health conditions and wished to understand the actions that both the Council and Registered Housing Providers are taking to tackle this.

4 Impact on Health and Wellbeing Strategic Outcomes

4.1 Good quality, affordable housing is an essential contributor to good health and wellbeing. There will be positive impacts on all four of the Health and Wellbeing Strategic Outcomes if people are living in decent accommodation.

5 Background and Options

5.1 There has been extensive research conducted on the effects of exposure to poor housing conditions, e.g. cold, damp and mould etc, and the significant impact it has on poor health, both physical and mental, particularly for households living on the lowest incomes or in the least energy efficient homes.

5.2 In 2022, 21.1% (970,000) people in the private rented sector in England and 10.4% (416,000) of people in the social rented sector still lived in non-decent housing **(1. English Housing Survey 2022-2023).**

5.3 One of the biggest housing condition problems facing the UK is excess cold (properties that are below the NHS recommended room temperature of between 18°C and 21°C) which can then lead to damp and mould issues within the property **(2. Public Health England: Minimum home temperature thresholds for health in winter Oct 2014).**

5.4 A significant contributing factor to this issue is the rate of fuel poverty due to the current cost of energy. In 2022 on average 11.2%, (20,163 residents) in the Cheshire East area were in fuel poverty **(3. Cheshire East Council open data portal: Fuel Poverty).** Many of the worst hit groups, were the elderly, vulnerable adults, households with dependent children and poorer families, whose heating needs are generally higher, as they spend more time in their homes and require heating all day rather than for short periods of time but are more likely to be unable to pay the costs of heating their properties or carrying out energy efficiency improvements. This leads to many people facing the option of whether to heat their homes or eat.

5.5 Children exposed to poor housing environments, are also more likely to experience long term health issues and disabilities, slower physical growth, delayed cognitive development, and mental health issues, e.g. anxiety and depression.

All these health issues can have potential ripple effects as a child exposed to environments that affect their health, are more likely to take days off sick from school, than those in comfortable living environments. Since these children spend more time away from the school environment, they also become more likely to experience other issues relating to social interaction and lack of employment opportunities later in life.

5.6 Damp is also a major contributing factor to ill health causing various respiratory problems, infections, and allergies. The English Housing Survey found that 9% of privately rented and 5.4% of social rented homes had problems with damp in 2022/23, with older properties more likely to be at greater risk of damp **(4. English Housing Survey 2022-2023).** The effects of damp on people were highlighted by the tragic death of 2-year-old Awaab Ishak in 2020 who died, because of a respiratory infection caused by exposure to mould in his home.

5.7 There is also evidence to show the relationship between higher mortality rates in winter and cold temperatures **(5 & 6 Institute of Health Equity: Health Equity in England and Public Health England: Local Action on health inequalities report).** A study in 2011 by the Marmot review team estimated that 21.5% of excess winter deaths could be prevented **(7. Institute of Health Equity: The Health Impacts of Cold Homes and Fuel Poverty),** an estimated 2,881 of the 13,400 excess winter deaths (December 2021 to March 2022), if adequate heating had been provided in properties during the winter months, as many of the preventable deaths were related to respiratory or circulatory diseases, illnesses that are made worse in cold conditions **(8. Office of National Statistics: Winter mortality in England).** Each year, the National Health Service spends an estimated £1.4 billion treating people living in cold,

damp, or unsafe housing **(9. Gov.uk – Building Research Establishment briefing paper – The cost of poor housing to the NHS).**

5.8 This emphasises the need to improve the quality of accommodation within both social rented and the private rented sectors to ensure that all tenants, irrespective of the tenure of their homes, are guaranteed access to safe and comfortable living environments.

In recent years, previous Governments have introduced several new policies and initiatives to help improve the quality of housing in England, these included:

- A Decent Homes Standard which was first introduced in 2000 to help regulate and improve homes in the social housing sector. The standard was last reviewed in Autumn 2021 and requires that social housing meets the legal minimum standards, are in a reasonable state of repair, have modern facilities, e.g. bathrooms and kitchens and provide safe and secure homes for residents **(10. Gov.uk – A decent home standard: definition and guidance for implementation).**

- The Social Housing (Regulation) Act 2023 also received Royal Assent in July 2023**.** The legislation aims to improve the standards, safety, and operation of social housing in the UK. Key changes introduced by the Act include:

  - strengthening the Regulator of Social Housing.
  - granting additional powers to the Housing Ombudsman.

  and it also enforces `Awaab's Law' and requires landlords to respond to reported health and safety hazards, e.g. damp and mould within strict time limits **(11. Gov.uk – guidance: update on the Governments work to improve the quality of social housing).**

- In June 2022, the previous Government also published `A Fairer Private Rented Sector' white paper, which highlighted the need to improve the quality of housing within the Private Rented Sector **(12. Department for Levelling Up Housing & Communities: A Fairer Private Rented Sector white paper).**

5.9 The new Labour Government also set out their plans in the Kings Speech (July 2024) to overhaul the private rented sector in England and introduce the Renter's Rights Bill to give renters much greater security and stability, including:

- Abolishing Section 21 'no fault' evictions.
- Introducing new clear and expanded possession grounds, so landlords can reclaim their properties when they need to.
- Strengthening tenants' rights and protections, for example empowering tenants to challenge rent increases designed to force them out of their properties and introducing new laws to end the practice of rental bidding wars by landlords and letting agents.
- Introducing a Decent Homes Standard to the private rented sector to ensure homes are safe, secure and hazard free.
- Applying 'Awaab's Law' to the sector, setting clear legal expectations about the time frames within which landlords in the private rented sector must make homes safe where they contain serious hazards.
- Creating a new online private rented sector digital database to bring together key information for landlords, tenants, and councils. Councils will be able to use the database to target enforcement where it is needed.

- Introducing a new ombudsman service for the private rented sector that will provide fair, impartial, and binding resolution, to both landlords and tenants, thereby reducing the need to go to court.
- Making it illegal for landlords to discriminate against tenants in receipt of benefits or with children when choosing to let their property.
- Strengthening local councils' enforcement powers to make it easier for council to identify poor quality properties and fine unscrupulous landlords **(13 Gov.uk The Kings speech 2024).**

5.10 **Cheshire East Council has introduced some key measures to improve housing standards in the Cheshire East area, including**:

- Employing a team of Housing Standards Officers to inspect and regulate housing in the private rented sector, including taking enforcement action. The team respond to complaints from tenants and acts on intelligence from other agencies, including the Home Office immigration enforcement team, Police, and the Fire Service.
- Delivering £6.21 million of Government Home Upgrade Grant programme funding which offers free energy saving improvements, e.g. wall, loft and underfloor insulation, air source heat pumps or electric radiators to eligible residents in the private sector (homeowners and private rented) to help them make energy efficiency upgrades to their homes and improve thermal comfort.
- Developed advice guides relating to damp, mould, and condensation in 2022. The Housing Standards team give these to residents at every first contact; provides face to face advice on preventing/treating damp and mould and takes enforcement action, if required.
- Licensing of Houses in Multiple Occupation (where they are occupied by five or more people). The licence conditions and HMO management regulations inherently drive-up housing standards in HMOs.
- The introduction of Planning Article 4 Directions in parts of Crewe requiring that any property being converted to a HMO must have planning permission. This regulation will bring the property onto the Council's radar and result in a housing condition and HMO management regulation inspection which improves housing conditions.

5.11 **Housing Provider perspective**

The Housing Ombudsman produced a "spotlight" report on damp and mould in 2021 **(14 Housing Ombudsman: Spotlight on Damp and mould, October 2021)** highlighting the impact to health, and to which most housing providers self-assessed and produced internal action plans. In consultation with tenants, policies and procedures were updated, with an emphasis put on the importance of treating residents with empathy and respect, alongside a commitment to dealing with the causes and symptoms of damp and mould, promptly and effectively.

Housing Providers carried out significant analysis of damp related repairs history data, based on property types or locations, to identify any patterns or trends at property level. This then led to proactive campaigns, contacting customers in those homes to identify any previously unreported, recurring since previous repairs, or still unresolved damp issues.

Depending upon the size of the Housing Provider this proactive work ran into thousands of outbound calls, followed up by home visits. Damp and mould repairs were prioritised for visits and rectification, given the associated health risks. In some cases where serious damp and mould was identified, customers were offered alternative accommodation on a temporary basis whilst work was carried out in their homes. As an example, at Guinness in 2023-24 we completed 188,415 responsive repairs – of which 10,569 (nationally) related to damp and mould (5.6%).

Extensive additional training has been given to staff within housing providers both at a technical level for repairs teams to identify the root cause of damp and mould and also front line housing teams on risk management and the importance of recording and reporting all incidences of damp and/or mould. All housing providers have also reviewed and updated the information available to customers about damp and mould in the home (example leaflet at **(15).**

Alongside reporting and repairing damp and mould and ensuring all teams understand what to look for in customer homes, Housing Providers remain concerned and continue to support customers in the cost of living crisis where high energy costs have a significant impact. Each organisation take a slightly different approach, but in relation to heating and energy these include:

- Energy advice to give support on both tariffs and consumption
- Financial support to those experiencing hardship relating to fuel
- Advice and support around income maximisation

Reports of damp and mould do continue to happen, but the procedures and processes within Housing Providers are now swift and responsive to these reports.

Like both doctors and schools – Housing Providers are often the one constant in a customer's life, as it is a long term relationship and it gives us the opportunity to build those valuable relationships. The challenge we all face currently, is particularly around mental health and support for those with mental health conditions (diagnosed or undiagnosed) and ensuring that they are both signposted to, and receive support, in order to successfully maintain their tenancies.

Good quality housing, which we as Housing Providers all seek to provide, is a big part of health and wellbeing, but it is also only a part of the wider picture for residents that links to education, public health, access to services and transport.

6 Access to Information

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

Name:	Michelle Davis	Karen Carsberg
Designation:	Regional Head of Customer Service (North West)	Head of Housing
Tel No:	07872044890	07710975438
Email:	Michelle.Davis@guinness.org.uk	Karen.carsberg@cheshireeast.gov.uk

Title of Report:	Briefing paper: A rapid situational analysis on child and family poverty in Cheshire and Merseyside
Date of meeting:	19 November 2024
Written by:	Dr Susan Roberts
Contact details:	susan.roberts@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Theresa Leavy

Executive Summary

Is this report for:	Information x	Discussion ☐	Decision
Why is the report being brought to the board?	The brief the Board regarding a rent Cheshire and Merseyside level rapid situational analysis.		
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 findings and recommendations within the recently published rapid situational analysis paper. • Consider the role of, and implications for, the Board of the recommendations provided.		
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, it has also been shared specifically with the Director of Public Health and the Executive Director for Adults, Health and Integration.		
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.	Adopting the paper recommendations aims to help to reduce inequalities and enhance existing work to improve overall health and wellbeing in Cheshire East.

1. Report Summary

1.1. The purpose of this report is to update the Health and Wellbeing Board of a recent analysis of child poverty across Cheshire and Merseyside undertaken on behalf of the CHAMPs Public Health Collaborative and published in August 2024 (Appendix 1).

1.2. Key findings from the report include:

- At a sub-regional level there is an absence of a clearly articulated mission on family poverty that brings stakeholders together to maximise synergies and impact, although there is much activity at local and sub-regional levels that contributes to poverty relief and prevention.
- The Cheshire and Merseyside Health Care Partnership's (HCP) recent commitment on poverty presents a significant opportunity to address this alongside other programmes, as does the commissioning of this report by Cheshire and Merseyside's Directors of Public Health and Population Health.
- In 2024/25 the C&M ICB will be allocating additional investment on preventionto the nine local authorities as well as investment at a C&M level, which provides an opportunity for targeted work on child poverty as a prevention to poor health.
- Opportunities to maximise the impact on poverty by inter-related interventions/programmes/policies may be missed by not having a strategic and coordinating approach.
- All areas are engaged directly with families in poverty, seeking their views on access to services, identifying needs and supporting advocacy with the VCS
- The sharing of research and evidence, best practice, innovation and knowledge mobilisation is not done systematically and therefore opportunities to effect change at scale may be missed.
- Any anti-poverty work should support families who are on the edge of poverty, often described as just about managing.
- There are differences in what data is being used as well as gaps in what data is available. Some of this can be addressed through development of a dashboard, as well as working with government departments on data gap.

1.3. Across Cheshire East, work on supporting residents with poverty has been guided by the Poverty JSNA and engagement with residents such as the People's Panel. This work has fallen into the following areas:

- An urgent response with support from local Voluntary Community Faith and Social Enterprise Sector organisations via bids for national funding

Community Grants (cheshireeast.gov.uk). However, this sector is increasingly challenge by the ongoing wider financial climate.

- Utilising available national funds such as the Household Support Fund (cheshireeast.gov.uk).
- Awareness raising through communication channels on resources available to residents locally and nationally Cost of living support (cheshireeast.gov.uk).
- Longer term strategic developments to address inequality including: the Living Well in Crewe strategy; Family hubs; the Crewe Youth Zone; Cheshire and Merseyside All Together Fairer work; Core20PLUS5 developments and promotion of a universally proportionate approach to allocation of resources through tools such as the JSNA and Combined Intelligence for Population Health Action (CIPHA).

1.4 There is a recognition that reducing inequalities and improving the experience of our residents experiencing poverty will take sustained focus, advocacy and resource over many years.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to:

- Note the findings and recommendations within the recently published rapid situational analysis paper.
- Consider the role of, and implications for, the Board of the recommendations provided.

Reasons for Recommendations

2.2. Many of the findings and recommendations in this Cheshire and Merseyside report align well with the poverty JSNA findings, findings within other JSNA reviews and ongoing urgent action to support residents experiencing poverty. However, it highlights the need for sustained attention regarding this key issue for Cheshire East in the coming months and years, as well as a need to work together with partners across Cheshire and Merseyside.

3. Impact on Health and Wellbeing Strategy Priorities

3.1. The recommendations from this report align well with the four outcomes from the Health and Wellbeing Strategy 2023-28, and mark another call to action:

- 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. Child poverty is a core focus both locally and nationally[1].

4.2. Cheshire and Merseyside's Directors of Public Health and Population Health, who work together as the CHAMPS Public Health Collaborative, commissioned a report into child and family poverty in the subregion. The report was steered via a lead Director of Public Health, a Director of Chidlren's Services, an analyst, a representative from the voluntary and community sector, two leading academics, the director of the CHAMPS Support Team, an NHSE management trainee and the author of the report, Eustace de Sousa, a Public Health Honorary Fellow of the Royal Colleague of Paediatrics and Child Health.

4.3. The report was published in August 2024 and represented a rapid situational analysis rather than a detailed examination of child and family poverty. It found that child poverty levels in England, and across Cheshire and Merseyside, are a serious issue of social injustice. It also acknowledged that child and family poverty were not inevitable. Key findings included:

- At a sub-regional level there is an absence of a clearly articulated mission on family poverty that brings stakeholders together to maximise synergies and impact, although there is much activity at local and sub-regional levels that contributes to poverty relief and prevention.
- The Cheshire and Merseyside Health Care Partnership's (HCP) recent commitment on poverty presents a significant opportunity to address this alongside other programmes, as does the commissioning of this report by Cheshire and Merseyside's Directors of Public Health and Population Health.
- In 2024/25 the C&M ICB will be allocating additional investment on preventionto the nine local authorities as well as investment at a C&M level, which provides an opportunity for targeted work on child poverty as a prevention to poor health.
- Opportunities to maximise the impact on poverty by inter-related interventions/programmes/policies may be missed by not having a strategic and coordinating approach.
- All areas are engaged directly with families in poverty, seeking their views on access to services, identifying needs and supporting advocacy with the VCS

[1] Cabinet Office (2024) Tackling Child Poverty: Developing Our Strategy. 23 October 2024. Available: https://www.gov.uk/government/publications/tackling-child-poverty-developing-our-strategy/tackling-child-poverty-developing-our-strategy-html#focus-and-approach-to-the-child-poverty-strategy (Accessed 5 November 2024).

- The sharing of research and evidence, best practice, innovation and knowledge mobilisation is not done systematically and therefore opportunities to effect change at scale may be missed.
- Any anti-poverty work should support families who are on the edge of poverty, often described as just about managing.
- There are differences in what data is being used as well as gaps in what data is available. Some of this can be addressed through development of a dashboard, as well as working with government departments on data gap.

4.4. Key recommendations included:

- Set an ambition on child poverty and articulate this widely.
- Agree a governance and oversight system.
- Set a plan and have the capacity to implement it.
- Adopt a Framework to set, monitor and drive action.

4.5. A Cheshire East specific version of the report highlighted:

- 10,476 (14.7%) of children (under 16s) were in relative low income families in 2022/23.
- Of these children, 6,959 (66.4%) were in working families.
- There has been a significant trend upwards in the percentage of children in relative low income families since 2018/19 (when the rate was 12.3%).
- 16 (6.8%) of lower super output areas (LSOAs) are among the most deprived 20% in England according to the Income Deprivation Affecting Children Index (IDACI) 2019.

4.6. The report asks Local authority Directors of Public Health to consider:

- Is there a clear articulation of the local state of child and family poverty, including general rates, trends, groups and local areas experiencing higher rates (data sources include Fingertips, Stat-Xplore and the Income Domain Affecting Children Index)?
- How are the lived experiences of children and families shaping anti-poverty work?
- Is there local agreement across stakeholders of an ambition and a plan, who leads on what, is this covered in for example the Health and Wellbeing Strategy?
- How can your area use the Framework’s proposed local actions across the following priority themes?: Leadership and advocacy; maximising household income; supporting children, young people and families from pre-conception through to adulthood; and building inclusive places.

4.7. Another useful tool in understanding child poverty in Cheshire East is the Social Mobility Commission's *Conditions of Childhood* tool[2]. This outlines variation in local authority conditions of childhood from least favourable to most favourable. According to the data within this tool, Cheshire East is in the middle of the five groups for: conditions of childhood (based on Households below average income (HBAI) statistics and Labour Force Survey statistics) and labour opportunities for young people. Cheshire East is in the second most favourable of the five groups in terms of innovation and growth (based on broadband speed, business spending on research and development and postgraduate education). The tool also highlights that Cheshire (as a whole) has higher proportions of parents with higher education qualifications and in higher professional occupations than the England average. Cheshire also has lower than average rates of unemployment in people aged 16 to 24 years old than the national average.

4.8. The findings from the *Conditions of Childhood* tool[1] need to be balanced against further insights relating to pupils experiencing disadvantage across Cheshire East. These data clearly demonstrate substantially lower rates of educational attainment in our more disadvantaged pupils[3]. Cheshire East has some of the lowest rates of attainment in the entire country with regards to school readiness and the proportion of disadvantaged pupils obtaining a grade 5-9 in both English and Maths (see table below).

	Pupils with free school meals (%)	**Pupils without free school meals (%)**	**National rank for attainment in pupils with free school meals (1 best to 152 worst)**
Achieving a good level of development at the end of reception	46	72	132
Achieiving the expected (or better) standard of phonics in year 1	64	84	98
	Disadvantaged (%)	**Not disadvantaged (%)**	**National rank out of 152 local authorities for attainment in disadvantaged pupils**
Achieving expected standards of reading, writing and maths at the end of Key Stage 2.	42	68	95
Achieving 9-5 grades in English and Maths at the end of Key Stage 4	16	52	149

[2] Social Mobility Commission (2024) Conditions of childhood. Published: 11 September 2024. Available from: https://social-mobility.data.gov.uk/drivers_of_social_mobility/composite_indices/conditions_of_childhood/latest (Accessed 25 October 2024).
[3] Education dashboard version 2 (2024) based on Department for Education statistical releases and The Local Authority Interactive Tool (LAIT) https://www.gov.uk/government/publications/local-authority-interactive-tool-lait

4.9. The report recommendations also align well with the findings and recommendations of the wider Poverty Joint Strategic Needs Assessment (JSNA). Across Cheshire East, work on supporting residents with poverty has been guided by this JSNA review, as well as other JSNA reviews that articulate variation in aspects by deprivation. Locally, responses have also been guided by engagement with residents such as via the People's Panel. Work has fallen into the following areas:

- An urgent response with support from local Voluntary Community Faith and Social Enterprise Sector organisations via bids for national funding Community Grants (cheshireeast.gov.uk). However, this sector is increasingly challenge by the ongoing wider financial climate.
- Utilising available national funds such as the Household Support Fund (cheshireeast.gov.uk).
- Awareness raising through communication channels on resources available to residents locally and nationally Cost of living support (cheshireeast.gov.uk).
- Longer term strategic developments to address inequality including: the Living Well in Crewe strategy; Family hubs; the Crewe Youth Zone; Cheshire and Merseyside All Together Fairer work; Core20PLUS5 developments and promotion of a universally proportionate approach to allocation of resources through tools such as the JSNA and Combined Intelligence for Population Health Action. The challenge of overcoming stigma associated with the experience of poverty and reaching help has also been highlighted.

There is also an acknowledgement that improvements to support people experiencing poverty will require sustained focus, advocacy and resource over many years. Ongoing monitoring of the issue has been recognised to be key. Currently, this is facilitated to a certain extent through the Joint Outcomes Framework. However, there is potential to build upon this initial monitoring as part of Phase Two of the Joint Outcomes Framework development, and also through changes to monitoring frameworks within the Council as part of transformation activity. A key consideration will be to articulate variation in child and family poverty by geographical area given that the Poverty JSNA highlights the extent of variation across the local area.

Access to Information

4.10. 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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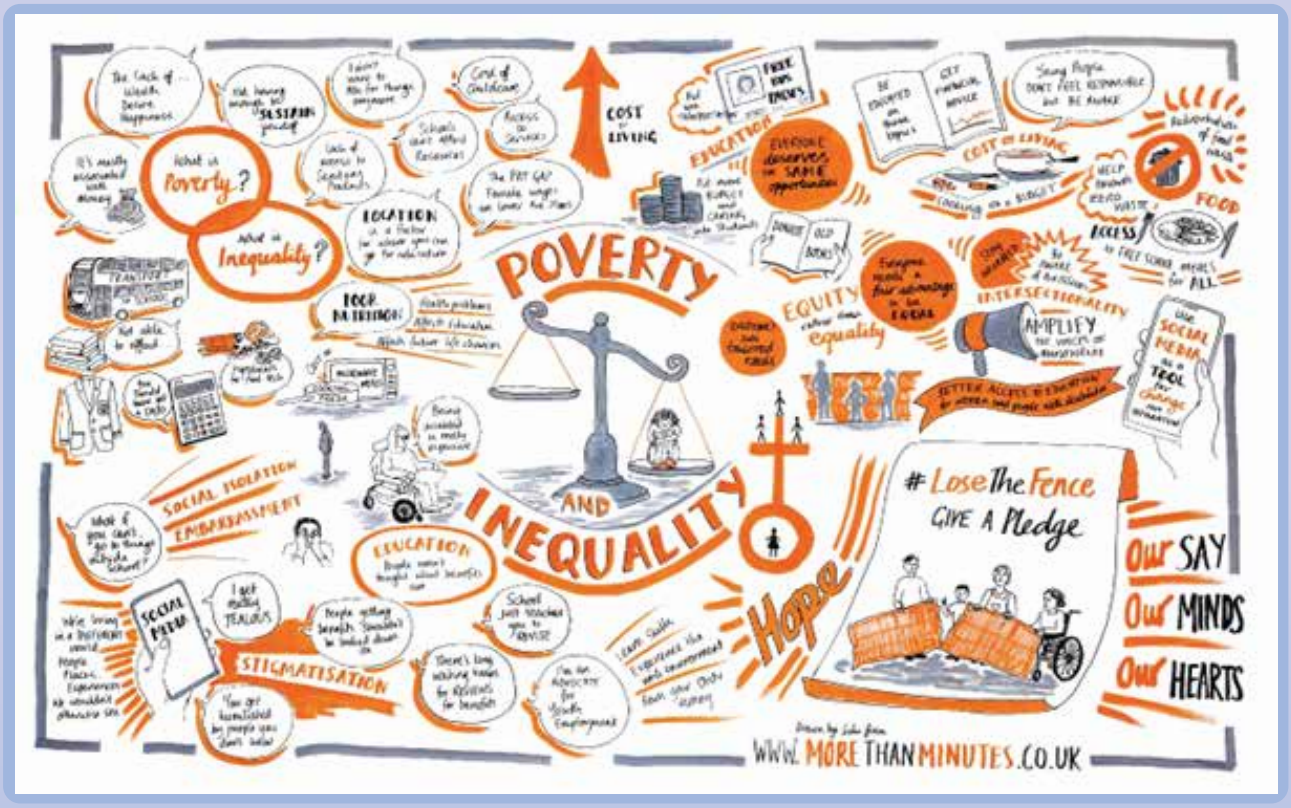
Champs Public Health Collaborative

COLLABORATING SINCE 2003

A RAPID SITUATIONAL ANALYSIS ON CHILD AND FAMILY POVERTY IN CHESHIRE AND MERSEYSIDE

August 2024



Eustace de Sousa

Independent Consultant
in Public Health
Hon. Fellow RCPCH

Analysis by Lynn Deacon

Principal Public Health
Intelligence Analyst
OHID North West

CONTENTS

EXECUTIVE SUMMARY

"Overcoming poverty is not a gesture of charity. It is an act of justice. It is the protection of a fundamental human right, the right to dignity and a decent life."

Nelson Mandela

INTRODUCTION

Cheshire and Merseyside's Directors of Public Health and Population Health, who work together as the Champs Public Health Collaborative, commissioned a report into child and family poverty in the subregion. The report, published in August 2024, found that child poverty levels in England, and across Cheshire and Merseyside (C&M), are a serious issue of social injustice. Poverty can harm children before they are born, throughout their childhood and into adulthood. It can persist when they have their own children. The consequences impact on every part of an individual's life, and have a negative impact on society, including the economy, potentially creating an inter-generational cycle of inequalities.

But child and family poverty are not inevitable. Many people do exit poverty, although generally this requires a range of government and local interventions and support. Across Cheshire and Merseyside organisations are taking action to address both the symptoms and the causes of poverty, including for example a C&M Health Care Partnership commitment to prioritise poverty, as well as a sub-regional commitment to being a Marmot community. Some of this has been intensified because of the cost-of-living crisis and the post-pandemic effects.

This report, and others, show that national government policies have been a dominant factor for the rise in child poverty through changes to the welfare system, cuts in funding to local government, and arguably the absence of a cross-government strategy on child poverty. The new government's ministerial taskforce to work on a Child Poverty Strategy will be seen as a major first step in using "*all available levers … across government to create an ambitious strategy".*[a]

Notwithstanding the influence of national policies, there is a great deal that can be done at a local and sub-regional level, which this report sets out. And there is more that can be done to advocate for action at sub-regional and national levels, drawing on the positive experience of Cheshire and Merseyside's Directors of Public Health and Population Health speaking with one voice as the Champs Public Health Collaborative on issues such as COVID-19 policies and smoking cessation.

[a] Ministerial taskforce launched to kickstart work on child poverty strategy - GOV.UK (www.gov.uk)

STATE OF CHILD POVERTY IN C&M: MAIN FINDINGS

- There are 100,300 children aged under 16 years in Cheshire and Merseyside living in relative low-income families.
- Between 2021/22 and 2022/23, Cheshire and Merseyside's position for this measure moved from being significantly better than the England average to significantly worse.
- Local authority-level averages mask very much higher rates of child poverty in smaller local areas within each local authority.
- The distribution of poverty is uneven, with some groups and households having higher than average rates including lone parent families and black and ethnic minority families.
- 6 out of 10 children in C&M in low-income households were in a working household

The association of poverty on virtually all aspects of a child or young person's life is well documented and includes:

- Greater likelihood of low birthweight and risk of dying in the first year of life
- In C&M higher than England averages in the percentage of 5 year olds with visually obvious dental decay.
- 24.0% of year 6 children in C&M were obese compared with the England average of 22.7%, with one area in the sub-region as high as 30.7%.
- In C&M there are higher than England averages for teenage conceptions and hospital admissions for asthma and mental health conditions among under 18s.
- Fewer children eligible for free school meals achieve a good level of development (48.8% in C&M, 51.6% across England) compared with all children at the end of Reception (65.4% and 67.2% respectively).
- Attainment 8 scores for pupils eligible for free school meals are lower than scores for all pupils across C&M, with six C&M local authorities among the worst quintile in England.

Main drivers of policy

The drivers of poverty are complex, interact, and operate at different levels (individual, family, community and national). The drivers include:

- Previous government policies in respect of welfare benefits, tax credits and policies on wages has been a major influence on poverty rates.
- Complex, and sometimes stigmatised, benefits systems that lead to significant levels of unclaimed benefits.
- Long term worklessness in households, level of parental education, low earnings, family instability and family size.

- Cost of living crisis, with 13.8% of C&M households in fuel poverty, and Covid-19 legacy.

Stakeholder Analysis

The main findings

- At a sub-regional level there is an absence of a clearly articulated mission on family poverty that brings stakeholders together to maximise synergies and impact, although there is much activity at local and sub-regional levels that contributes to poverty relief and prevention.
- The Cheshire and Merseyside Health Care Partnership's (HCP) recent commitment on poverty presents a significant opportunity to address this alongside other programmes, as does the commissioning of this report by Cheshire and Merseyside's Directors of Public Health and Population Health.
- In 2024/25 the C&M ICB will be allocating additional investment on prevention to the nine local authorities as well as investment at a C&M level, which provides an opportunity for targeted work on child poverty as a prevention to poor health.
- Opportunities to maximise the impact on poverty by inter-related interventions/programmes/policies may be missed by not having a strategic and coordinating approach.
- All areas are engaged directly with families in poverty, seeking their views on access to services, identifying needs and supporting advocacy with the VCS
- The sharing of research and evidence, best practice, innovation and knowledge mobilisation is not done systematically and therefore opportunities to effect change at scale may be missed.
- Any anti-poverty work should support families who are on the edge of poverty, often described as just about managing.
- There are differences in what data is being used as well as gaps in what data is available. Some of this can be addressed through development of a dashboard, as well as working with government departments on data gaps.

Recommendations

To build on the significant assets in the sub-region and in the North West, as well as the support of other areas and national organisations, this report proposes four recommendations. It should be stressed that the voices of the lived experience of children, young people and families should shape, and challenge, priorities and actions.

Recommendation 1: Set an ambition on child poverty and articulate this widely.

Rationale: Stakeholder feedback highlighted the need for a more concerted voice about child and family poverty at a Cheshire and Merseyside (C&M) level. The co-production of an ambition and a narrative on child poverty provides a very public way

for partners to commit to tackling the causes and symptoms of poverty. The ambition would obviously need to be agreed through the relevant partnerships, but should aim to be aspirational: **to set an ambition that no child in Cheshire and Merseyside lives in poverty.** Central to the shaping of the ambition, and to all the priorities set out in this report, are the views and experiences of children and their families with lived experience of poverty.

Recommendation 2: Agree a governance and oversight system

Rationale: There is a significant amount of work underway in Cheshire and Merseyside that contributes to alleviating and/or preventing child poverty. Generally, these are badged under specific programmes (such as Best Start in Life, cost-of-living crisis programmes, etc). This fragmentation can mean that the opportunity for synergies and greater collaboration and advocacy on child and family poverty is missed. A governance and oversight system could be part of an existing structure (for example in the HCP, with leadership from the All Together Fairer Programme, and aligned to the ICB's work on population health, its Children and Young People's Committee, the Women's Health and Maternity programme, and the Beyond Programme).

Oversight would need to be inclusive of the full range of policy makers and stakeholders that collectively can drive action on poverty. Consideration should be given to the merits of having Champion type roles which can be part of the public facing anti-poverty work at a sub-regional level.

Recommendation 3. Set a plan and have the capacity to implement it

Rationale: Having a shared ambition requires a plan that is owned by the anti-poverty partnership, that sets out the focused areas of work where greatest impact could be made in a timely way. It is evidence from the stakeholder interviews that there is limited capacity to facilitate this and therefore additional resources would need to be quantified and secured. This could be part of an existing programme of work as described above but would need increased capacity to make things happen at pace.

Recommendation 4. Adopt a Framework to set, monitor and drive action.

Rationale: Evidence shows that a Framework can give clarity and structure to a complex programme involving a wide range of stakeholders. The draft Child and Family Anti-Poverty Framework sets out high-level priorities and actions. These will require testing with stakeholders and can then be jointly owned and monitored.

The detail of the Framework is set out in the Appendix; the three priority pillars are based on the areas which evidence shows provide greater protection for people in poverty, as well as building prevention for children now and in the future. Many of these actions are underway to some extent in C&M, but are not shared consistently, and the synergies with other programmes are not always fully exploited.

The list of interventions is intended to set a prioritised set of actions. Finally, it is important to remember that the evidence indicates that whilst individual interventions can be beneficial for children and families, in the context of poverty reduction they generally work most effectively alongside complementary interventions addressing economic and social needs.

Led by evidence and the views of children, young people and families

System leadership and advocacy

- There is a shared and articulated C&M ambition on child and family poverty
- There is a C&M-wide plan and capacity to work towards the ambition

Pillar 1 Priorities

Maximising household income

- Families have more income and other support

- Employers adopt best practices to reduce poverty

- Families have affordable and quality housing, childcare and transport Households receive help with the cost-of-living crisis

Pillar 2 Priorities

Supporting children, young people and families

- There is targeted support in preconception, early years and school readiness – Best Start in Life

- There is extra support across school-age particularly attainment and wellbeing

- There is additional support on transition from school to adult life (work/learning)

Pillar 3 Priorities

Building inclusive places

- Families in poverty do not face barriers to access services

- Organisations make full use of Social Value and Anchor capabilities

- The unique role of the voluntary and community sector is supported

Aligned to the C&M HCP/HEC/All Together Fairer and BEYOND priorities

PURPOSE OF THE REPORT, METHODOLOGY AND DEFINITIONS

This report was commissioned by Cheshire and Merseyside's Directors of Public Health and Population Health, who work together as the Champs Public Health Collaborative, because of concerns about the extent of child and family poverty.[b] The C&M Health and Care Partnership (HCP) has identified poverty as a priority issue and this is reflected in the work of the integrated care board (ICB), local authorities and the voluntary and community sector.[1]

The report

- Summarises the current data and trends across C&M and where appropriate national data
- summarises key evidence on the causes and consequences of child poverty
- captures some of the work being undertaken across C&M to address child poverty through a stocktake exercise
- concludes with a set of four recommendations and a proposed framework by which Directors of Public Health and Population Health, working with partners, can set a mission on child poverty through a strategic approach across C&M and three broad pillars on which to organise and coordinate action. Priority interventions are identified in the three pillars which aim to:
  - meet the current needs of families in poverty
  - reduce exposure to, and the impact of, poverty across childhood
  - build places that use the power of public service to address causes and symptoms of power.

Time constraints did not allow for consultation with people with lived experience, but the report draws from the work of local areas. It is important when considering future actions that these views are fully considered and kept under review.

Limitations

This is a rapid situational analysis and not a detailed examination of child and family poverty nor a full account of all anti-poverty work taking place across the sub-region.

Methodology

A steering group provided expert advice and met three times. It included a lead Director of Public Health, a Director of Children's Services, an analyst, a representative from the voluntary and community sector, two leading academics in the field of child health and poverty, the director of the Champs Support Team, an NHSE management trainee and the author.

[b] Wherever the term child poverty is used this should be seen in the context of family poverty

Discussions were held with key stakeholders (see Acknowledgements) A stocktake through public health leads collated examples of family poverty work.

STATE OF CHILD AND FAMILY POVERTY IN CHESHIRE AND MERSEYSIDE

MAIN POINTS

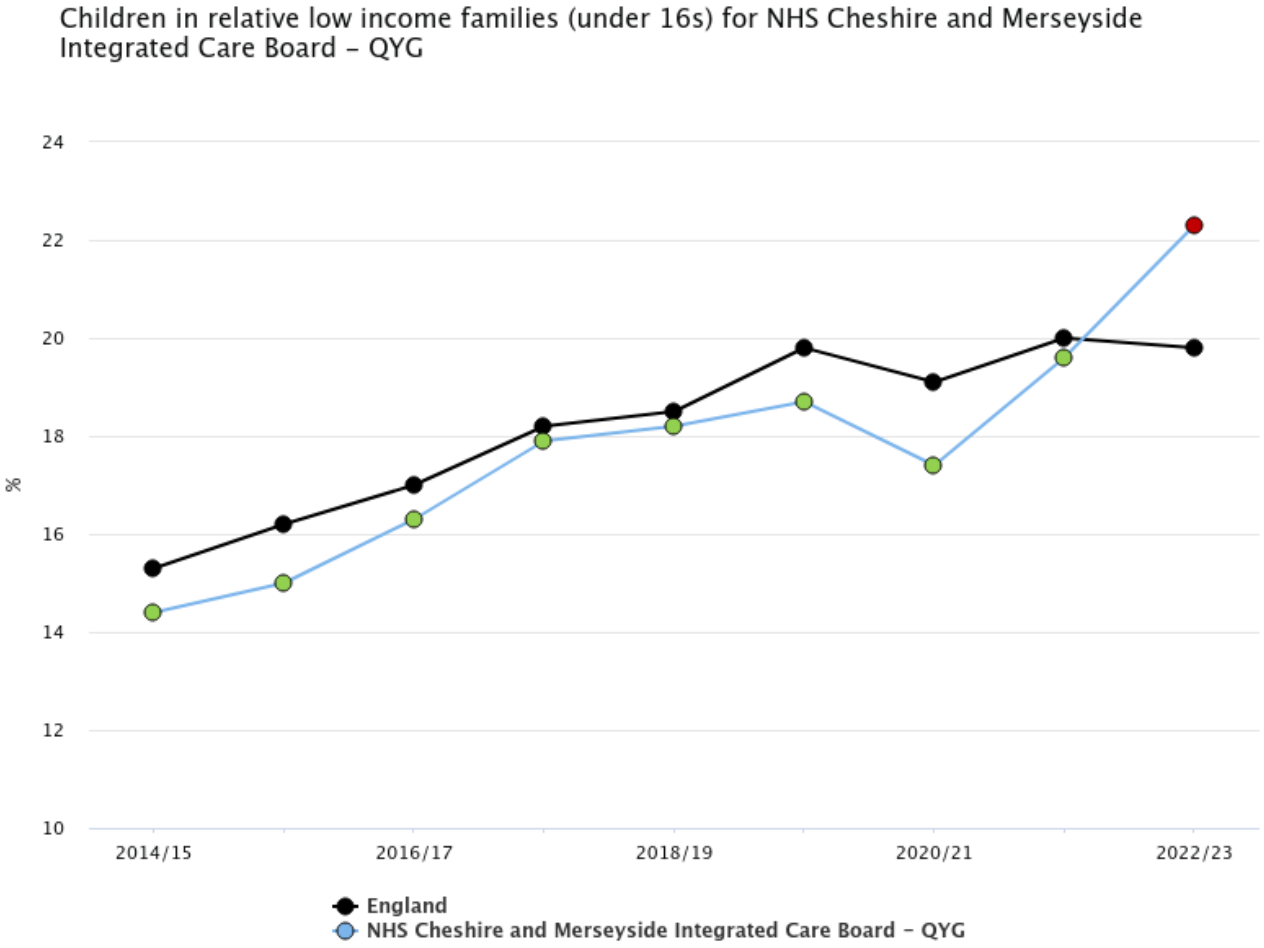
100,300 children aged under 16 years in C&M are living in relative low-income families, 22.3% of all children of this age.

Between 2021/22 and 2022/23, C&M's position for this measure moved from being significantly better than the England average to significantly worse. Local authority-level averages mask higher rates of child poverty in smaller areas.

There are a range of indicators that help us understand and quantify the level of child poverty in an area. Definitions of published measures that are often titled 'child poverty' vary, and so it is important that we fully explain any figures that we use to assess child poverty. The stocktake also identified that there are some differences in what indicators are used across the local authorities in the area. However, there were some excellent pieces of work within areas that drew together both local figures from national data combined with locally held data to help assess and tell the story of child poverty in a locality.

One measure that is widely used is the number and percentage of children aged under 16 years who are in relative low income families. Relative low income is defined as a family in low income (with a threshold of 60% of the UK median) before housing costs (BHC) in the reference year, with the full definition of the indicator published on Fingertips. A summary of child poverty definitions is given in Appendix A. At a UK level, children are more likely to live in low income households compared with the overall population.[2]

In 2022/23, 22.3% of children in C&M were in relative low income families. This was significantly worse than the England average of 19.8%, although it was significantly better than the North West region average of 26.7%. Between 2021/22 and 2022/23 the percentage of children living in relative low income families in C&M had increased by 13.8% (from 19.6% to 22.3%) and this also shifted C&M's position from being significantly better than the England average to significantly worse in one year.



Source: Fingertips

Of the 100,300 children living in relative low income families in C&M, 29.2% were aged 0 to 4 years, 37.4% were 5 to 10 years and 33.4% were 11 to 15 years.

By local authority area, the percentage of children living in relative low income families varied from 14.7% in Cheshire East to 32.3% in Liverpool. Liverpool, Knowsley, Halton, Wirral and Sefton's rates were significantly higher than the England average, while Warrington, Cheshire West and Chester and Cheshire East's rates were significantly lower. In every local authority area, in recent years the percentage had grown.

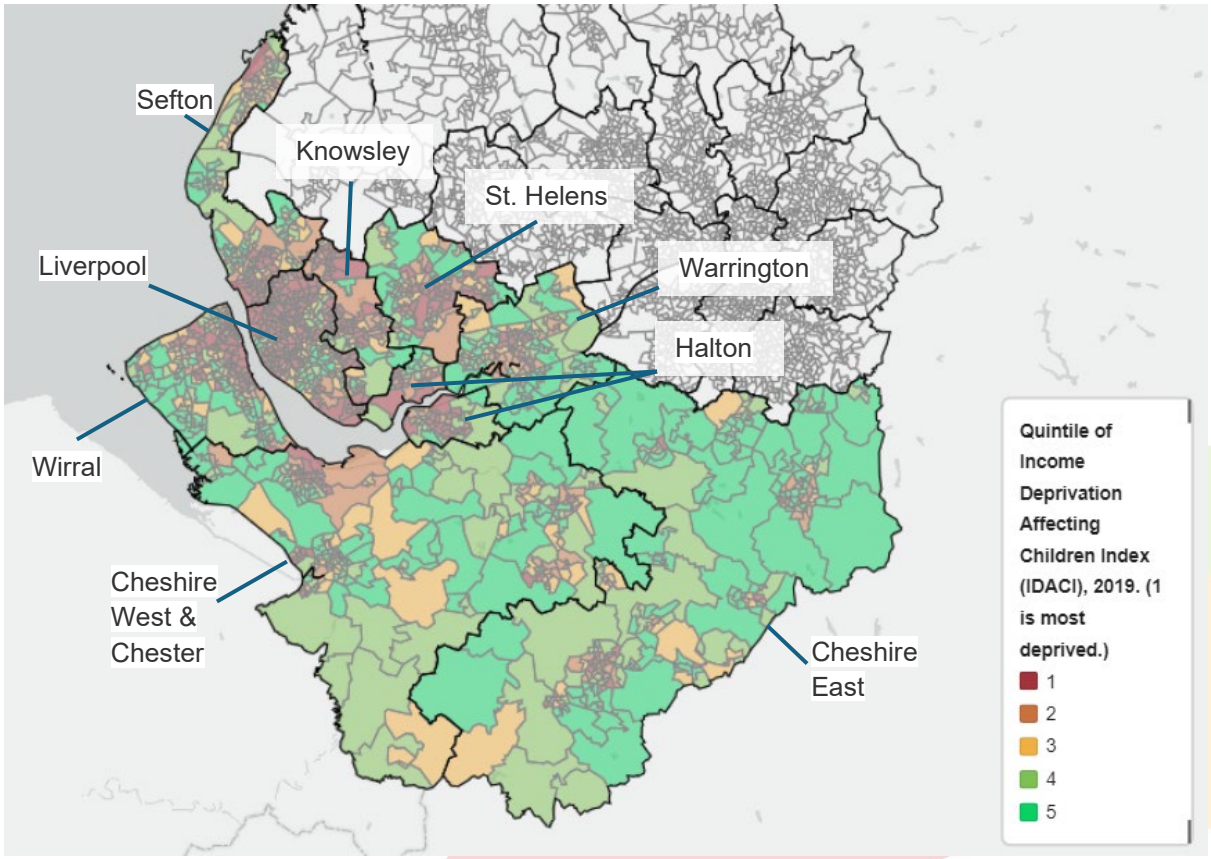
Children in relative low income families (under 16s) 2022/23

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	19.8	19.8	19.8
Cheshire and Merseyside	–	-	-	-	-
Liverpool	↑	-	32.3	31.9	32.8
Knowsley	↑	-	27.8	27.1	28.5
Halton	↑	-	24.1	23.4	24.9
St. Helens	→	-	23.0	22.4	23.7
Wirral	↑	-	22.2	21.8	22.7
Sefton	↑	-	21.0	20.5	21.5
Warrington	↑	-	17.4	16.8	17.9
Cheshire West and Chester	↑	-	17.3	16.9	17.7
Cheshire East	↑	-	14.7	14.4	15.1

Source: Fingertips

Although three local authority areas appear to have lower levels of child poverty than the national average, these averages mask high levels of child poverty concentrated in particular areas of the authority. One way of identifying those areas is by using the Income Deprivation Affecting Children Index (IDACI, 2019) which ranks each lower super output area (LSOA, an average of about 1,500 households) in England. This shows that within Cheshire East there are 16 LSOAs that are among the most deprived quintile in England for this measure, in Cheshire West and Chester there are 32, and in Warrington, 16. The map below illustrates this for C&M.



It is well understood that poverty affects different groups of people disproportionately.

Across C&M in 2022/23, 60.4% of children living in relative low income households were living in a lone parent family, while 39.6% were in a couple family (source: Stat-Xplore, DWP). By contrast, the Annual Population Survey 2022 estimates that 20.8% of all children aged under 16 years in C&M live in a lone parent household, while 77.6% live in a couple household.

In total, 60.1% of C&M children living in relative low income households were living in a working household in 2022/23, while 39.8% were not in a working family (source: Stat-Xplore, DWP). Once again, by contrast the Annual Population Survey 2022 estimates that 20.8% of all children aged under 16 years in C&M live in a working or mixed (one adult working and one unemployed/inactive) household, while 8.1% live in a workless household.

Information for the sub-region for certain groups was not available, but drawing on other data:[3]

- Poverty rates are higher for children in Pakistani and Bangladeshi households, with rates of 61% and 62% respectively.

- 53% of children in households headed by someone from Black African backgrounds and 50% of children in households from Asian backgrounds other than Indian, Pakistani, Bangladeshi or Chinese were in poverty.

- They were therefore all twice as likely as children in white households to be in poverty (the figure for the latter was 25%). Children in Black Caribbean households also had a higher risk of living in poverty (45%).

- 30% of children in Bangladeshi households lived in very deep poverty, compared with 9% of children in white households. Other ethnic groups also have higher rates

- Whilst higher average family size for some minority ethnic groups increases their risk of poverty, rates tend to be lower in white families than in families from minority ethnic groups.

- In 2021/22, the poverty rate for children in families with three or more children was almost twice as high as the poverty rate for children in one- or two-child families (43% compared with 23% and 22% respectively).

- A new poverty measurement by the Department for Work and Pensions found almost half of all individuals in families with at least one disabled child and one disabled adult in the UK were living in poverty by 2021-22.[4]

- In 2022 half of children in single parent households were living in relative poverty compared with 25% for children in two-parent households.[5]

The challenges in obtaining current and trend data on key metrics at a C&M level, that would help inform our understanding of the extent of child poverty, is a concern. Further consideration needs to be given to the development of a data set that provides a more rounded view of child poverty, that enables longitudinal studies, and that highlights gaps which local and sub-regional agencies can work with national government on. Such data should enable population level analysis by local authority and sub-local authority levels, as well as support targeting of interventions.

WHY CHILD POVERTY MATTERS: THE EVIDENCE BASE OF IMPACT

Main points

1. Child poverty impacts both children and their families across all aspects of life and is associated with poor outcomes in adulthood.

2. Certain groups of families experience both higher rates of poverty as well as longer (deeper) periods of poverty, that can continue into adulthood.

3. Poverty has significant consequences on local economies

"I don't want to just exist, I want to live. I want to live a happy life"

From young person participant in *West Cheshire Poverty Truth Commission*
Community Inspirers

The impact of poverty on the health and wellbeing of children and families has recently led to the Faculty of Public Health, the Royal College of GPs, the Association of Directors of Children's Services, a coalition of national voluntary organisations, and the Royal College of Paediatric and Child Health calling for government action on child poverty.[6] [7] [8] [9] [10]

High levels of child poverty are explicitly seen as an issue of social injustice by the Scottish and Welsh governments, in their respective child poverty strategies and plans. The new government's ministerial taskforce on a Child Poverty Strategy will be seen as a major first step in using "*all available levers… across government to create an ambitious strategy".*

Children experience poverty differently. The size of the family they live in, their ethnicity, age, disability, and where they live are just some of the factors that shape this experience and their capacity to deal with the consequences.[11] Strategies and plans to address poverty need to consider this complexity. Amid these challenges, families and individuals also have assets (individually, families and communities), and interventions are more effective when built on these assets.[12] A "poverty premium" can also impact on low-income families compared to families on higher incomes by having to pay more for the same essential goods and services (such as energy, insurance, groceries, and so on).[13]

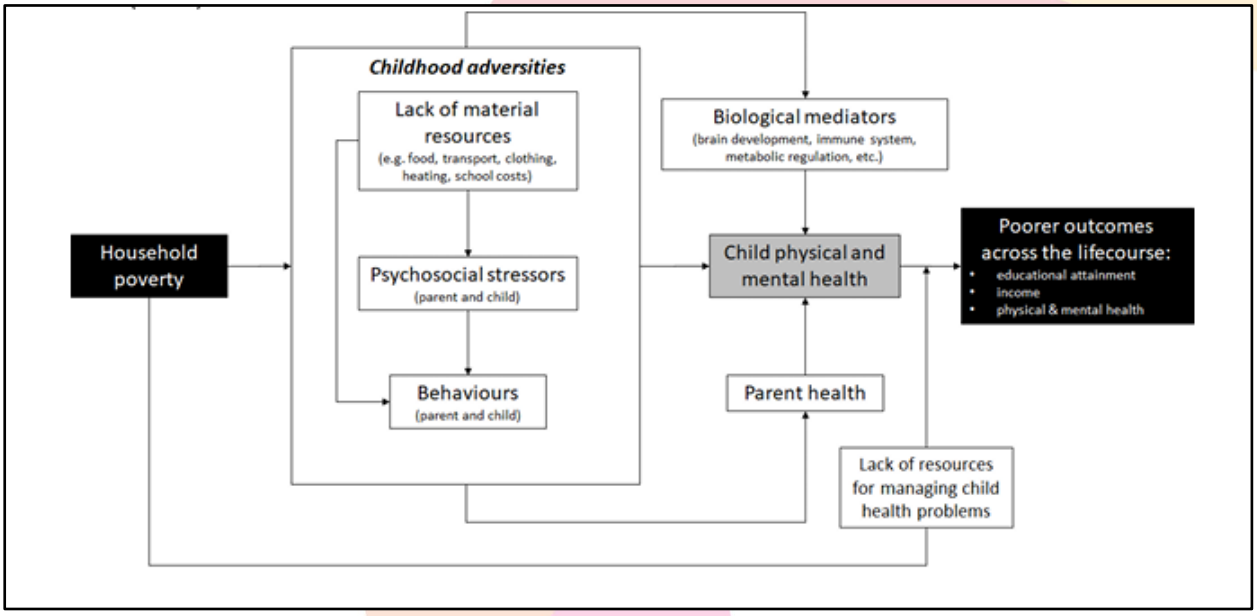
From stakeholder engagement, it was clear that the COVID-19 pandemic continues to have an impact on families living in poverty. Pre-existing financial pressures are exacerbated alongside the emotional and mental health impact on adults and children, which may be present today. Modelling suggests that this will persist for some time for children and families.[14]

Childhood poverty is associated with poor outcomes across virtually every aspect of a child's life.[15] [16] [17]For many children the consequences continue into adulthood and can impact on subsequent generations.[18] [19] Children in lower socio-economic groups have a greater risk of experiencing an adverse childhood experience (ACE) and contributes to a significant burden of adverse health developmental outcomes in adolescence.[20] [21] Living in persistent poverty is estimated to triple children's likelihood of having mental health problems in adolescence.[22]

At an individual level the experience of poverty harms children's friendships as well as their opportunities to enjoy childhood free from *"shame, sadness and the fear of social difference and marginalisation"*.[23]

Some of the ways in which money impacts on children's outcomes include parental stress, anxiety and material deprivation, and the longer children live in poverty the more severe the outcomes.[24] In short, the unequal distribution of resources that would otherwise give children the best start in life helps to drive and perpetuate health inequalities.[25]

The diagram below gives a simplified model to show how poverty impacts children's health and development.[26]



Pathways from household poverty

Poverty is not just a lack of financial resources, important though that is. It is also about not having the resources to have good living conditions, amenities and access to things like healthy food and places to live and grow up in.[27]

Some poor outcomes for children living in households in poverty are summarised below.

HEALTH

The impact of poverty (all age) on the NHS alone is estimated at £34 billion at current prices.[28] Some health outcomes particularly affected by child and family poverty include:

- Greater likelihood of low birthweight infants and greater risk of dying in the first year of life.73F[29] Across C&M in 2021, 525 term babies were born with a low birthweight, a rate of 2.3%. And between 2020 and 2022, there were 291 infant deaths in C&M (an average of 97 a year), equating to a rate of 4.0 infant deaths per 1,000 live births. Liverpool's rate of 5.2 infant deaths per 1,000 live births was significantly above the England average of 3.9. A rise in infant mortality was seen across England between 2014 and 2017, which affected the poorest areas of the country the most, with an estimated 572 excess infant deaths across England.[30]

- A&E attendances: in 2022/23 there were 133,245 Accident and Emergency department attendances among children aged 0 to 4 years in C&M, a rate of 1,016.7 per 1,000 population, 27.5% higher than the England rate of 797.3. Halton, Knowsley, Liverpool, St Helens, Sefton and Warrington had rates that were significantly higher than the England average, with Halton having a rate 2.2 times higher than the national rate.

- Oral health: the percentage of 5 year olds with experience of visually obvious dental decay is higher in C&M than England. Liverpool, Halton, Sefton, St Helens, Knowsley, Warrington and Wirral have rates that are significantly higher than the England average of 23.7%; Liverpool's rate of 43.5% being one of the highest in the country.

- Child obesity: in 2022/23, 10.4% of Reception year children in C&M were obese (including severely obese), compared with the England average of 9.2%. Knowsley (with the highest rate in C&M at 14.1%), Liverpool, Halton, St Helens and Sefton had rates that were significantly higher than the England average. While Cheshire East's rate was not significantly different to the England average, over the last five data points the rate has increased. In the same year, 24.0% of year 6 children in C&M were obese compared with the England average of 22.7%. Knowsley (with the highest rate of 30.7%), Liverpool, St Helens and Halton had rates that were significantly higher than the England average, and five local authorities – Knowsley, Liverpool, St Helens, Warrington and Cheshire East – had seen an increase in their rates over the last five data points.

- Respiratory illness: in 2022/23, there were 670 hospital admissions for asthma among children in C&M, a rate of 125.2 per 100,000 population of this age, compared with the England average of 122.2. At 163.9 per 100,000, Liverpool's rate was over a third, and significantly, higher than the England average.

- Teenage conceptions: in 2021, there were 675 teenage conceptions in C&M, a rate of 16.6 per 1,000 females aged 15 to 17 years compared with the England rate of 13.1. St Helens (with the highest rate of 25.9 per 1,000), Halton, Knowsley, Liverpool and Wirral had rates that were significantly higher than the England average – the first four over 50% higher than the national rate.

- Mental health: in 2022/23, there were 505 hospital admissions for mental health among the under 18 population in C&M, equating to a rate of 99.6 per 100,000 population of this age, compared with the England average of 80.8. Wirral (144.6) and Cheshire East (106.0) had rates that were significantly higher than the England average. Children and adults in households in the lowest 20% income bracket in Great Britain are two to three times more likely to develop mental health problems than those in the highest[31]; a survey in 2022 of 11-year-olds reported that money worries led to them experiencing stress, anxiety, anger or unhappiness.[32]. Living in poverty for long stretches of time can intensify mental health issues in the family.[33] In a longitudinal analysis of the UK Millenium Cohort Study, transitioning into poverty for the first time was associated with an increase in the risk of child and maternal mental health problems.[34]

- A national retrospective study indicated that children from the lowest income households are four times more likely to be regular smokers by the age of 17 years.[35] The Smoking, drinking and drug use among young people 2021 report revealed that 3% of pupils in years 7 to 11 in the North West were current smokers, the same as the national average. The survey does not disaggregate the data to a lower geographical level. However, we know that adult smoking rates in Liverpool (17.4%, 2022/23) and Knowsley (16.8%) are significantly higher than the England average (13.6%).

Although data is not routinely published or calculable for the above health indicators by level of child poverty within C&M, national data demonstrates inequalities for these measures by overall deprivation level of local areas in England using the Index of Multiple Deprivation (IMD, 2019). The charts hyper-linked below use the smallest and/or most recent geographic boundaries and data available at the time of writing. They provide evidence that these health outcomes have a relationship with area deprivation.

Indicator	Inequalities for England using IMD 2019
Low birthweight of term babies	In 2021, term babies in the most deprived decile of districts and unitary authorities (UAs) in England were 1.5 times more likely to be born with a low birthweight than term babies in the least deprived decile.
Infant mortality	In 2020-22, infants in the most deprived decile of districts and UAs in England were 2.1 times more likely to die within their first year of life than infants in the least deprived decile.
A&E attendances (0 to 4 years)	In 2022/23, the rate of attendance at A&E for children aged 0 to 4 years in the most deprived decile of districts and UAs in England were 1.5 times higher than for children aged 0 to 4 years in the least deprived decile.
Percentage of 5 year olds with experience of visually obvious dental decay	In 2021/22, 5-year-olds in the most deprived decile of lower super output areas (LSOAs) in England were 3.1 times more likely to have visually obvious dental decay than 5-year-olds in the least deprived decile.
Reception prevalence of obesity (including severe obesity)	In 2022/23, Reception year children in the most deprived decile of LSOAs in England were 2.1 times more likely to be obese than Reception year children in the least deprived decile.
Year 6 prevalence of obesity (including severe obesity)	In 2022/23, year 6 children in the most deprived decile of LSOAs in England were 2.3 times more likely to be obese than year 6 children in the least deprived decile.
Hospital admissions for asthma (under 19 years)	In 2022/23, the rate of hospital admissions for asthma for children under 19 years in most deprived decile of counties and UAs in England was 2.5 times higher than for children under 19 years in the least deprived decile.
Under 18 conception rate	In 2021, teenage girls in the most deprived decile of districts and UAs in England were 2.7 times more likely to conceive than teenage girls in the least deprived decile.

HOUSING

Poor quality housing has been identified as a major concern for young people, impacting on their physical and mental health. [36]

"Bed poverty I think is fairly widespread from what we are hearing with very little resources and young people are really feeling the effects of this"

Youth Focus North West

It is well established that poor housing contributes to physical and mental health harms: [37]

- Babies, children, older people and those with pre-existing health problems are at greatest risk of health problems because of living in cold homes.[38]
- Poor mental health amongst children and young people, with the greatest incidence amongst teenagers, and linked to greater social isolation and exclusion because of lower school attendance and attainment.[39] [40]

EDUCATION

School readiness

- In 2022/23, 65.4% of all children in C&M achieved a good level of development at the end of Reception, compared with the England average of 67.2%. Liverpool, Halton, Sefton, Knowsley, St Helens and Wirral had significantly lower percentages of children achieving a good level of development than the national average.

- At all geographical areas for the same year, the percentage of children achieving a good level of development at the end of Reception is significantly lower for children eligible for free school meals (FSM) than for all children.

- At a C&M level, 48.8% of FSM-eligible children were achieving a good level of development, and at an England level, 51.6%. Within C&M, St Helens, Cheshire East, Liverpool and Sefton's rates were significantly lower than the England average. Some respondents to the stocktake noted the financial pressure on schools in relation to provision of healthy school meals.

- The Attainment 8 score for all pupils at the end of key stage 4 is generally lower in C&M than the England average (46.2), with Knowsley, Liverpool, Halton, Sefton and St Helens having scores that are in the worst quintile of local authorities nationally. Attainment 8 scores for pupils eligible for free school meals are lower than scores for all pupils across all C&M local authorities as well as England. Knowsley, Sefton, St. Helens, Cheshire West and Chester, Liverpool and Cheshire East have Attainment 8 scores for pupils eligible for free school meals that are among the worst quintile of local authorities in England.

- Nationally against key educational milestones, disadvantaged pupils[c] consistently have worse outcomes than their peers including:
  - By age 5, they were 4.8 months behind their peers in 2022, a level not seen since 2014 (when it was 4.9 months).
  - by the end of primary school (key stage 2), the disadvantage gap was 10.3 months which reverses a period of decreasing inequalities between 2011 and 2018.

[c] The Education Policy Institute define a pupil as disadvantaged if they have been eligible for free school meals (FSM) at any point in the preceding six years, and non-disadvantaged if they have not, using the same definition as the DfE Covid-19 and disadvantage gaps in England 2021 - Education Policy Institute (epi.org.uk)

- by the end of secondary school (key stage 4), disadvantaged pupils were over 18.8 months behind their peers. This gap is at its highest level since 2012. The figures for children who were persistently disadvantaged were worse and no progress in closing the gap for this group has been made over the last decade.[41] The pressure on school staff (not just teachers) was described in a recent report where 79% of staff said they or a colleague have less time for some of their role because of the effects of child poverty.[42]

"Young people would like to see budgeting on their curriculum or sessions within the community that educates them to deal with money matters. They would like to see increased funding for all students to access activities outside of school, personal annual budget for school trips, sports memberships etc."

St Helens, REACH engagement (Raising Aspirations)

THE ECONOMY

Poverty damages the economy, and the lack of sufficient investment in measures to prevent poverty impacts on areas such as productivity and unemployment through ill health. The wider societal costs to the UK of poverty have been estimated to be over £39 billion a year.[43]

The extent of insecure work – both in terms of lower wages and poorer working conditions - is also a source of concern in parts of C&M. A report for Liverpool City Region found that 18.8% of workers are in insecure work a rate slightly lower than the England average but the city region has higher rates of second jobs, low paid jobs and temporary work.[44]

The development of business and employer models that incorporate principles of Anchor Institutions and have a stronger community focus can begin to help address some of these issues.[45]

A recent report for the Royal Foundation estimated that by more effective investment in early childhood across the UK, £45.5 billion in value added could be generated for the economy per annum including £27.5 billion in earnings for UK's workforce.

MAIN DRIVERS OF CHILD POVERTY

Main points

Previous government policies in respect of welfare benefits, tax credits and policies on wages has been a major influence on poverty rates. The drivers of poverty are wide-ranging and interact, leading to worse outcomes for affected families, requiring cross-government, cross-sector responses. In-work poverty and the cost-of-living crisis are significant drivers of family poverty.

Several factors are known to drive poverty. These include household long-term worklessness and low earnings, level of parental education, family instability, family size, risks factors such as drug and alcohol dependency, and mental health.[46]

Other factors that have an impact include government policies on welfare benefits, the impact of funding cuts to local government and organisations they support which compromise efforts to prevent poverty and address its consequences. The most deprived areas in England were most affected by cuts to local government spending.[47]In this section we briefly consider some of these factors.

HOUSEHOLD INCOME AND POVERTY: STATE BENEFITS

There are three main child-related benefits that families can claim[48]: Universal Credit (UC) for low-income families paid via an additional Child Element in the UC payment; Child Tax Credits to support families with the costs of raising a child, but to be replaced with UC; and Child Benefit, paid to parents or carers responsible for a child until they are 16 (or older in some circumstances), but whose real value has fallen by 20% since 2010 and an estimated 800,000 children in the UK do not receive.[d] It is estimated that claims for over 800,000 children worth more than £1.6 billion a year have not been made by eligible families.

In 2017 the previous government introduced a two-child limit on a parent being able to claim additional support for a third or subsequent child through child tax credit or universal credit. The changes are estimated to impact on 1.1 million children living in poverty, with these families losing up to £3,235 per annum.[49] It is estimated that by increasing the child element of UC by at least £15pw and abolishing the Benefit Cap would lift nearly 320,000 children in the UK out of poverty.[50]

Independent bodies, such as the Joseph Rowntree Foundation, describe the consequences of the cuts to benefits in real terms over recent years *means that for too many people* the basic rates do not cover the cost of essentials.[51] It is estimated

[d] Either parent can earn up to £60,000 a year before Child Benefit is repaid in full through a tax charge.

that £22.7 billion a year is unclaimed in all income related benefits and social tariffs.[52]

Eligible families can also access benefits or schemes towards costs of supporting a child including:

- £500 Sure Start Maternity Grant
- Healthy Start vouchers in the form of digital payment card and free vitamins
- Childcare costs support
- Free school meals and the Holiday Food and Activities Programme
- Support with school transport and uniform costs.

Research indicates that free school meals (FSM) make an important financial relief to families on low incomes, contributing £1,400 pa, a gateway to some other benefits, and a route for schools to claim a Pupil Premium.[53] Across the country some £231 million in FSM is unclaimed each year with some areas such as Sheffield and Lewisham successfully developing auto-enrolment so that eligible parents (and schools) do not lose out.

In addition, an estimated 37,500 pupils living in poverty across C&M are not entitled to a free school meal as set out in the table below.[54] [e]

LA	In poverty but don't qualify for any FSM		In poverty but don't qualify for any means tested FSM
Cheshire East	3,500		4,500
Cheshire West and Chester	3,500		4,500
Halton	1,500		2,000
Knowsley	2,000		3,000
Liverpool	6,500		9,000
Sefton	3,000		4,000
St Helens	2,000		3,000
Warrington	2,000		2,500
Wirral	3,500		5,000
Totals	**27,500**		**37,500**
Figures taken from CPAG, GMPAG, Hogan Lovells (2024) Free School Meals in the North West			

[e] Means-tested FSM, which are available to families who meet certain eligibility criteria and universal FSM, which are available to all children in Reception, Year 1 and Year 2. From GMPAG (2024)

Evaluations of the Healthy Start voucher demonstrate its value in helping families access healthy food, although issues around stigmatisation and take-up remain a concern in some areas. The value of the voucher has not kept up with food inflation and consequently has less impact than it would otherwise.[55] Take up campaigns, in the North West and elsewhere, can increase take-up rates, but should be accompanied with a support programme for registration.[56]

In May 2024, there were 24,335 eligible beneficiaries of the Healthy Start scheme in Cheshire and Merseyside. Of these, 16,439 were on the digital scheme – an uptake of 68%. Cheshire East (61%) and Warrington (62%) had the lowest uptakes.

It is worth noting that although not a direct payment to parents, schools eligible for the national school breakfast programme provide free breakfasts. Schools are eligible if 40% of more pupils in bands A-F of the Income Deprivation Affecting Children Index (IDACI).[57] Beyond the financial benefits to families, evidence indicates that a healthy breakfast can contribute to increased concentration, improved wellbeing and behaviour.

"We have seen a huge demand in parents needing help with school uniforms and food. School uniforms and PE kits are expensive. Many families can't afford them – we have been inundated with requests for help with school uniforms over the last 3 years. Poverty is definitely worse than 5 years ago."

Sefton support agency worker

IN WORK POVERTY

As previously mentioned, in 2022/23 60.1% of C&M children living in relative low income households were living in a working household.

Parents on low income who work full-time are more likely to be in the caring, leisure and other service occupations, and 23% are employed in the health and social care sectors. It is estimated that these families would need an extra £8,736 a year to exit poverty, whilst the average family would need to work 19 hours a week extra.[58] These figures mask further inequalities for ethnic minority households and where at least one adult is disabled.

The rising cost of childcare and transport contribute disproportionately on those on low wages and can be a barrier to moving from part-time to full-time work. Similarly poor health has a significant impact on the ability to work at all, or part-time.

Parental worklessness and low educational status are also associated with child poverty, and the persistence of poverty for children into adult life.[59] As we shall see in the stocktake section, the work of local areas with the Department for Work and Pensions including the Job Centre, is important in supporting this group into work and qualifications. Similarly work with health services, particularly primary care, are important measures to reduce unemployment rates.

COST OF LIVING, HOUSING, DEBT AND FUEL POVERTY

The cost-of-living crisis continues to have a major impact. At a UK level:

- 2.8 million of the poorest fifth of households (47%) were in arrears with household bills or behind scheduled repayments
- 4.2 million households (72%) were going without essentials, and
- 3.4 million households (58%) reported not having enough money for food[60]

Across Cheshire and Merseyside in 2021, 13.8% of households were in fuel poverty, compared with the England average of 13.1%. Liverpool had the highest rate of 18.0% (which fell into the worst quintile of local authority rates in England), followed by Wirral (at 15.3%, the rate was within the second worst quintile of local authority rates nationwide).

The scale of poor housing conditions and fuel poverty has worsened over the last decade. Some key data includes:

- In 2023 1.17 million households with children in England were in fuel poverty, up from 1.15 million in 2022[61]
- 20% of households with children in the UK reported food insecurity, including 3 million children[62]
- Families living in privately rented accommodation were more likely to experience problems with damp, compared with socially rented accommodation.
- Compared with better-off households, those with the least disposable income spend more of this on heating and fuel. Lone parent households, who are at higher-than-average risk of being in relative poverty, are consequently more exposed to experiencing fuel poverty.[63]

Evidence shows that there is a link between interparental conflict in the context poverty and economic pressure which has consequences for children and young people's outcomes including emotional, behavioural, and academic.[64]

"I got my first own bed at the age of 8 and it made such a difference to my mood, my social engagement and my schoolwork. I was genuinely a happier and healthier child."

Young person, Merseyside Youth Association

GOVERNMENT POLICIES

Government policies significantly determine the extent of child poverty through measures such as welfare benefits, housing and employment policies, investment in education and funding of local government.

In 2016 the abolition of the Child Poverty Act with the Welfare Reform and Work Act removed the requirement for UK and local authorities to have child poverty strategies. In England, unlike Wales[65] and Scotland[66], the socio-economic duty (Section 1 of the Equality Act 2010) requiring public services to have due regard to how their decisions increase or decrease inequalities has never been brought into force, although many local authorities do so as part of committee governance. Unlike Wales and Scotland, England also does not currently have a national child poverty strategy, although the new government has prioritised this through a cross-government ministerial Taskforce.[f]

The Association of Directors of Children's Services has recently highlighted that whilst diagnosis of the *systemic challenges faced by children* are well set out, across nine different government departments is leading to an 'implementation gap'.[67]

Between 2010-11 and 2020-21 central government funding for local authorities fell in real terms by over 50%, whilst resources available to deliver services fell by 26% in real terms over ten years.[68] LGA analysis estimated that by 2024/25 cost and demand pressures to deliver council services will have grown by £15 billion (almost 29 per cent) since 2021/22.[69] The impact of these cuts at a local level translate to less ability to invest in meeting local need and prevention.

In 1999 the then government set a target to halve child poverty by 2010 as part of a wider English Health Inequalities Strategy – although this target wasn't quite achieved, through a mixture of child benefit rises, child tax credits and policies on low unemployment and the minimum wage contributed to 1.4 million children moving out of poverty in ten years.[70]

[f] This places a legal requirement on public bodies to consider how their decisions increase or decrease inequalities that result from socio-economic disadvantage.

CHESHIRE AND MERSEYSIDE STAKEHOLDER ANALYSIS

Main points

- At a sub-regional level there is an absence of a clearly articulated mission on family poverty that brings stakeholders together, although there is much activity at local and sub-regional levels that contributes to poverty relief and prevention. The HCP's recent commitment on poverty presents a significant opportunity to address this alongside other programmes.

- Opportunities to maximise the impact on poverty by inter-related interventions/programmes/policies may be missed by not having a strategic and coordinating approach. The sharing of best practice, innovation and knowledge mobilisation is not done systematically and therefore opportunities to effect change at scale may be missed.

Notwithstanding the absence of a national strategy to tackle child poverty, C&M local authorities, Directors of Public Health and Population Health, the ICB/ICS, NHS trusts, ATF, HEC, the Beyond Programme, the voluntary, community and faith sector, businesses, and academic institutions (to name just a few), are taking action to relieve the impact of poverty on local communities alongside action to prevent poverty.

As part of this rapid review public health teams were asked to summarise work on child and family poverty including definitions, use of data, policies/strategies and plans. The returns should include the broad spectrum of local work and not just that of the local authority.

Some general themes from the stakeholder analysis included:

- There is not sufficient 'noise' at a system level about child poverty, so the work commissioned by Directors of Public Health and Population Health was welcomed.
- Whilst there is much work underway sub-regionally and locally to address child poverty, there was limited structured opportunity for areas to collaborate and share learning through an anti-poverty lens.
- The use of data varied between areas, there was a general view that a consistent approach could help locally as well as with developing sub-regional work.
- Respondents stressed the importance of drilling down to very local levels because local authority level averages hide small areas of (often) long standing poverty.
- Anti-poverty work needs to be more than just surviving, we should consider those on the margins of poverty such as families just about managing.

In the following section, the main findings are summarised on the themes of:

- Strategic approaches
- Use of data and intelligence
- Support to families and prevention work

STRATEGIC APPROACHES ON CHILD AND FAMILY POVERTY

Local areas

All areas describe child poverty specifically, but generally this is seen in the context of family poverty because of the impact of carer/parental poverty. Some areas expressed concern about the number of households that were 'just about managing' where a relatively minor setback could push the family into poverty and stress. There was a consistent message that the narrative around poverty should be more ambitious than just surviving, but to be one of flourishing.

All councils had references and commitments to addressing symptoms and causes of child and family poverty across different committees/departments, as well as in corporate plans and strategies – this reflects the need for a multi-departmental approach. Health and wellbeing boards, council committees covering children/social care/education, planning/business and economy, and health, alongside cabinet/portfolio leads were often identified as having different leadership and governance roles relevant to the authority.

Partnership working across a local authority area is seen as essential and each area had examples of this, whilst recognising the resource constraints on funding for example for the local VCS as well as essential front-line council services. The VCS's role in advocacy and reaching lived experience was valued and critical to shaping local responses. The work of Greater Manchester Poverty Action (now called Resolve Poverty)[g] and the C&M-based Poverty Research and Advocacy Network were cited as helpful resources. GMPA have been commissioned by NMS Greater Manchester to support development of a poverty strategy, poverty proofing, data and delivery of poverty awareness training to over 600 frontline staff, the latter which has been well received.[h] Costs per head of such training is in the region of £55 dependent on delivery format and numbers being trained. PRAN is a relatively new independent advocacy group bringing organisations and individuals together for collective action against poverty.[i]

Examples of specific child poverty strategies include Sefton's Child Poverty Strategy[j] and its accountability process through the health and wellbeing board; Warrington is

[g] Greater Manchester Poverty Action - Greater Manchester Poverty Action (gmpovertyaction.org)
[h] Optimizing the Role of the NHS in Tackling Poverty.pdf (greatermanchester-ca.gov.uk)
[i] Poverty, Research & Advocacy Network (pran.org.uk)
[j] childhood-poverty-strategy-2022.pdf (sefton.gov.uk)

in the process of establishing a poverty truth commission[k] which will shape a borough wide approach; Cheshire West and Chester's Fairer Future Strategy sets an aim of halving child poverty by 2032[l]; and St Helens' Children's Plan which has reducing child poverty and inequalities as a priority.[m]

Alongside the use of Marmot Principles and Place model, some areas are using (or planning to use) international frameworks, such as Child Friendly Cities[n], and national models such as Health in all Policies[o] and Health Equity Assessment Tool[p] to frame approaches that will address underlying causes of poverty. Sefton are working with the LGA to develop a system wide approach using HiaP.

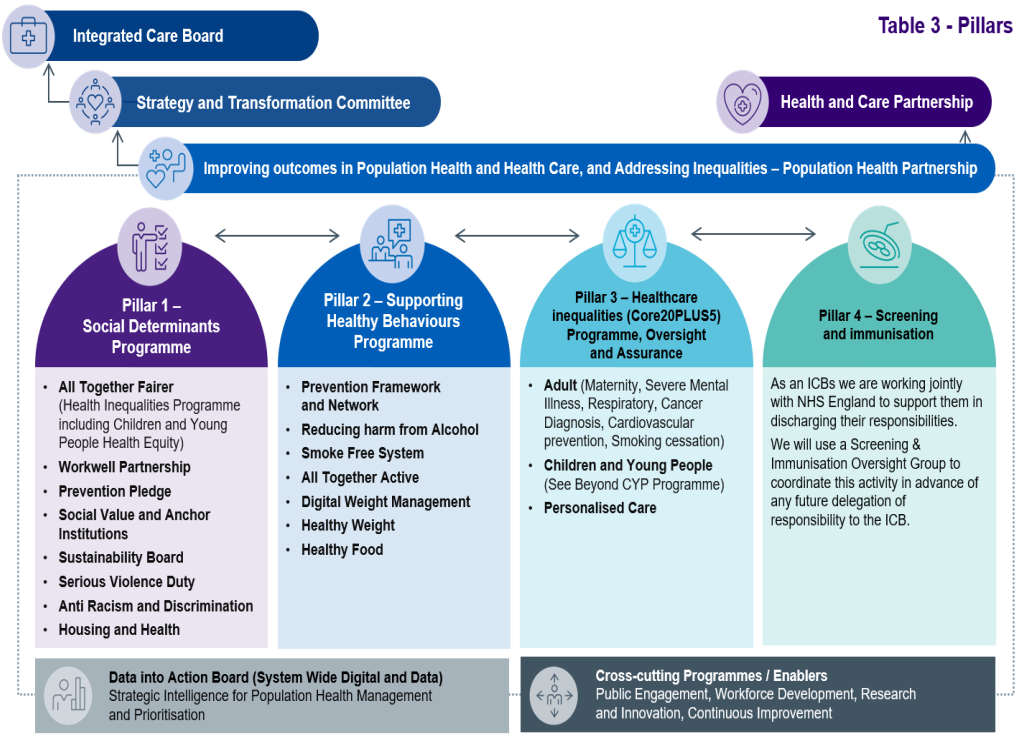
REGIONAL AND SUB-REGIONAL

Discussions with stakeholders often raised the issue of an 'absence' of a strategic, and focussed, anti-poverty strategy whilst recognising that there are significant regional and sub-regional assets (networks, programmes, resources, and so on) engaged in anti-poverty related work. Activities referenced included the NHS C&M's work on health inequalities, Liverpool City Region's Fair Employment Charter, the NHS Prevention Pledge, the C&M NHS Anchors programme, and the work of C&M Directors of Children's Services on vulnerable children and families. The point being made was that these could sometimes be seen as stand-alone programmes of work rather than maximising synergies between them through an anti-poverty lens.

The ICB/ICS leadership and prioritisation of population health and health inequalities was seen as critical and is summarised in the graphic on the next page.

[k] What is a Poverty Truth Commission? | Poverty Truth Network
[l] fairer-future-strategy-final.pdf (cheshirewestandchester.gov.uk)
[m] Plan puts children's priorities first - St Helens Borough Council
[n] www.childfriendlycities.org
[o] Local wellbeing, local growth: adopting Health in All Policies - GOV.UK (www.gov.uk)
[p] Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)

Our Core Strategies – Population Health and Addressing Inequalities



Pillar 1: This describes how we will deliver All Together Fairer: Our Health and Care Partnership Delivery Plan

Pillar 2: supports healthy behaviours is built around a number of priority prevention programmes.

Pillar 3: Outlines our Core20PLUS5 priorities and Personalised Care approach for Adults and Children and Young People. We have a dedicated Children and Young People Committee with a structured delivery plan.

Pillar 4: this programme will support the NHS England delegation expected by April 2025

C&M ICB Slide Presentation January 2024

The C&M HCP has set poverty as one of its three priorities:

- The All Together Fairer programme - which has joint accountability to Directors of Public Health alongside the ICB/ICS has in development 22 beacon indicators around the 8 Marmot themes which are important metrics around poverty and inequalities and a commitment to being a Marmot community.[q]

- The Beyond Programme - delivering workstreams supporting healthy behaviours including emotional health and wellbeing, healthy weight, respiratory and oral health. The Programme is also working on a 3-year Child Health Equity Collaborative alongside Barnardo's and the Institute of Health Equity (UCL) to improve health equity for children and young people. In Cheshire and Merseyside, the intervention will focus on reducing inequalities in school readiness as part of wider work on best start in life.

- Champs Public Health Collaborative - providing public health leadership across C&M but also influencing regionally and nationally on a range of public health and health inequalities issues, and which commissioned this report.

The work of OHID NW office is valued around data/intelligence, areas such as Healthy Start and Early Years, and the interface with other government departments

[q] All Together Fairer | Champs Public Health Collaborative

in the North West. The NW cross-government Children's Partnership consists of OHID NW, Department for Education, Department for Work and Pensions, and Department for Levelling Up, Housing and Communities and is an important route to national policy and local implementation of policy.

The importance of the VCS was stressed throughout the stakeholder engagement, for example the work of Youth Focus NW[r], advice services, food and clothing banks, whilst acknowledging the challenges of under-funding, and short-term funding (usually annual that doesn't allow programmes to embed).

Stakeholders said there are benefits of having a strong academic presence on poverty and adversity through universities and Institute in the sub-region but acknowledged that these are not being fully exploited. Stakeholders described the need to put research and evaluation at the heart of a poverty strategy and plan, including how we translate the evidence into policy and practice. There needs to be a better understanding of the specific pathways through which exposure to adverse childhood socio-economic circumstances, and particularly poverty, affect specific health and social outcomes in particular conditions and contexts. The significant sub-regional academic institutions, civic partnership and data assets (CIPHA, C-GULL etc) provide a unique opportunity to generate evidence to re-orientate systems to act early, on time and together.[s] [t] [u]

There will be other networks critical to anti-poverty work, including around economic development, local authority policy leads, social housing and education, which will need to be included in the development of a C&M anti-poverty programme.

USE OF DATA AND INTELLIGENCE

There is a difference in the use of definitions of child poverty across the sub region. One area used absolute poverty as a benchmark but included relative poverty, whilst most used relative poverty. All areas referenced Government (DWP) definitions and data for both children and households. Sefton have developed a Child Poverty Monitoring Framework which captures in one place some key data, and all areas dynamically used a range of adult and child metrics and platforms (for example social care, education, health, housing, Fingertips, Acorn segmentation tool and Marmot Beacon indicators[v]) to build local profiles. Another important difference is the age range covered in analysis locally, with some areas going up to 20. The latter is important to consider because of monitoring progressing from statutory education/training to adulthood.

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[r] Home | Youth Focus North West (youthfocusnw.org.uk)
[s] CIPHA -
[t] Children Growing up in Liverpool (C-GULL) - Children Growing up in Liverpool (C-GULL) - University of Liverpool
[u] Heseltine Institute for Public Policy, Practice and Place - Heseltine Institute for Public Policy, Practice and Place - University of Liverpool
[v] St-Helens-Marmot-Datapack-FINAL.pdf (Champspublichealth.com)

Joint strategic needs assessments (JSNAs) are used to identify poverty-related issues within a theme such as housing, whilst in Cheshire East there is a poverty-wide JSNA.[w] The reliability of data was generally seen as an issue for some metrics, as were the limitations of being able to drill down to some demographics, and all areas referenced national data in reports. Wirral are developing a detailed suite of data slides that summarise key information on child and family. Although the C-Gull Study's birth cohort study for Liverpool City Region is at an early stage[x], that and CIPHA, the C&M population health management platform will be critical tools in identifying and targeting need.[y]

Within the Beyond Programme, data science is embedded and enables identification of key areas of health inequality to support risk stratification. A consistent approach to measurement has been developed with strong links established with ICB data programmes to ensure interconnectivity. Dashboards ensure that it is easy to access and interrogate, and that data sets are complete, accurate and timely. The data science work of the Beyond Programme aims to influence and enable system change based on insights captured to improve the outcomes for children and young people.

The Paediatric Storyboard has been shared during 2023-24, enabling programme stakeholders to see the consistent information about programme priorities in as real time as possible. This gives stakeholders access to functional and interactive visuals, from over 15 data sources including health and wider data repositories, such as paediatric audits, public health data sets, CENSUS data and patient level insights. Over 174 users have requested access to the dashboard, with 116 users regularly accessing the dashboard. The dashboard continues to be reviewed and updated to ensure that content is up to date and supporting programme delivery.

Outside of C&M some areas have looked at developing poverty dashboards, recognising the above limitations. Greater Manchester Poverty Action (now called Resolve Poverty), working with local authorities and the NHS, has developed a GM Poverty Monitor,[z] and Calderdale have a selected statistics resource for the

[w] JSNA Food and Fuel Poverty: Spotlight review (cheshireeast.gov.uk)
[x] The C-Gull Study (cgullstudy.com)
[y] The C-Gull Study (cgullstudy.com)
[z] Access the Poverty Monitor 2023 - Greater Manchester Poverty Action (gmpovertyaction.org)

borough. The Born in Bradford CYP Outcomes Framework provides a wide-ranging dashboard on key child health outcomes.[aa]

SUPPORT TO FAMILIES AND PREVENTION WORK

There is a vast range of work taking place to address current needs of families and children in poverty, as well as work to address the underlying causes. Throughout, there are examples of lived experience (across the age ranges and demographics) informing policy and shaping services, including for example St Helen's Inequalities Commission looking at all age poverty, through to Cheshire West and Chester's use of drama workshops by young people to produce a series of short films, How We Live on family poverty.[bb]

The role of the VCS is clearly central to delivery in all areas, allied to services such as family hubs, children's centres, housing, social care, education, youth provision, and public health commissioned services.

In this section some areas of support and prevention work are highlighted.

Cost of living

"Some [young people] described a healthy home as one with a cupboard of food."

Barnardo's Child Health Equity Framework engagement[cc]

Nationally funded programmes to relieve some of the impact of the cost-of-living crisis have had some positive impact, but this stakeholder analysis highlighted that the mechanisms for funding generates uncertainty that hampers local planning.

All areas have a blend of direct support such as cash/vouchers/subsidies, furniture and food banks as well as referral to agencies for support, including Citizens Advice and appropriate community organisations. Cash first, rather than vouchers etc, is an issue that a number of areas raised, including Cheshire East as part of their Food Alliance work. Some areas described utilities and food poverty predominate the types of support being given in response to the cost-of-living crisis. Areas are heavily dependent on the Government's Household Support Fund and Holiday Activities Fund to resource much of this, and consistently there was concern over the uncertainty of the future of the Funds with councils not able to plug any gap.

All areas have taken a multi-agency approach for support to families and have galvanised action through strategic leadership alongside a convening role for councils. Wirral for example identified fuel poverty as a 'game changer' in their Health and Wellbeing Strategy. Liverpool public health's part-funding of Feeding Liverpool generates benefits directly to residents in need, as well as an advocacy

[aa] Changing-the-way-we-look-at-data_V5.pdf (borninbradford.nhs.uk)
[bb] West Cheshire Poverty Truth Commission - YouTube
[cc] Children and Young People's Insights Report - Child Health Equity Framework.pdf (barnardos.org.uk)

platform for good food for all and, as with other areas, considers the role of planning policies around schools to build healthy places. Building community capacity through a Community Shop model with outreach in association with the Bread-and-Butter Thing has been supported by Warrington[dd]. Halton have tested placement of CAB welfare advisers at foodbanks for benefit take-up. Some of the many examples of building from local assets and/or building capacity in the VCS to reach communities most in need.

More locally, councils across C&M have a range of programmes to support families and children, partly as a response to the cost-of-living crisis as well as anti-poverty measures. These are summarised in the stocktake section and include support direct to families, support to voluntary and community organisations to signpost and assist households for example via food banks and advice surgeries.

To provide accessible and lower cost credit, many areas across the country have developed community-based credit unions. These can be established at a neighbourhood-level by community organisations but can face challenges in meeting the needs of low-income communities and higher risks of default.[71]

Benefit take-up, and debt support is provided across areas. Both the VCS and council's Revenue and Benefits departments (or equivalent) work with Job Centres/DWP, to support on issues such as health and transport helping people to stay in work or return to work. Stakeholder interviews highlighted the work of Greater Manchester Poverty Action's (now called Resolve Poverty) benefit take up and debt advice campaign, Money Matters (funded by Kellogg's) which since 2022 gained over £300,000 for families in four local authority areas working in and via schools.[ee]

Health

Joint working between local authorities and NHS Place leads has created diverse approaches to addressing urgent health needs as well as longer term investment for prevention. These are captured in the stocktake returns. Work around broader services, such as safeguarding, also enhances protection for children living in disadvantage including families in poverty (for example domestic violence, parental substance misuse). An example of primary care's poverty related work is Liverpool's Citizens Advice on Prescription, which provides a rapid response social prescribing service to modify risk factors relating to poverty and mental health and includes a peri-natal team.

The expansion of the nationally funded Early Support Hub programme[ff] to Warrington, St Helens and Liverpool will contribute to early mental health support for children and young people, whilst all areas have examples of mental health and wellbeing programmes being delivered through education settings and community-based models. Initiatives to increase take-up of vaccinations in areas of low take-up

[dd] The Bread and Butter Thing
[ee] Money Matters Programme - Greater Manchester Poverty Action (gmpovertyaction.org)
[ff] Extra funding for early support hubs - GOV.UK (www.gov.uk)

were also described, often associated with areas of deprivation. The importance of all these programmes to support children's mental health cannot be understated particularly for children living in poverty.

In the sub-region, Alder Hey are using a Family Hub model, and a Poverty Proofing model to remove barriers to access to health care for all families because of finance. The programme also raises awareness across the organisation of how poverty impacts children and families and has strong clinical support. NHSE NW worked with Children North East who own the to run poverty proofing training sessions for those working with children and young people who have long-term conditions (asthma, diabetes and epilepsy as these are part of the Core 20+5). This was open across the North West.

Poverty Proofing can be extended to other services, for example the model developed in the North East for schools, as well as for employers, culture and the arts.[gg] Poverty Proofing model has three core principles covering the Voice of those affected by poverty, the context of Place and how and why decisions are made, and how structural inequalities lie at the heart of the causes of poverty.[hh]

The Beyond Programme supports sub-regional delivery of the children and young people's commitments in the NHS Long Term Plan, but also takes a wider population health approach in health outcomes including healthy weight, respiratory, emotional wellbeing and mental health, learning difficulties, disabilities and autism, diabetes, epilepsy and oral health. The targeting of funding and interventions in some of the most deprived areas, for example for diabetes technology, will contribute to improving outcomes for these communities. The Programme's engagement with children is strong and an important asset for the area.

Housing

Poor housing conditions, rent levels and debt, and in some areas growing numbers of families in temporary accommodation, were cited by a number of areas. Knowsley have an established energy efficiency programme with eligibility for children under 5 with a health condition which aims to alleviate one form of poverty. Work is planned with social housing and Liverpool's healthy homes team using CIPHA fuel poverty dashboards to target work.

Although recognised as an issue, the stocktake returns did not consistently describe specific housing and anti-poverty work. Owing to time constraints contact with housing providers was not possible and warrants further work as part of any future anti-poverty work.

Early years and education

[gg] Nine things you can do to start Poverty Proofing your school - Children North East (children-ne.org.uk)
[hh] Poverty Proofing© Services - Children North East (children-ne.org.uk)

Those areas with family hubs and/or Start for Life programmes described the opportunity to reinvigorate early years partnership working and welcomed the guidance reference to poverty. Similarly, multi-agency work across children's services and health services, for example maternity and health visiting services, were seen as essential for early identification of risks and provision of support, although there was a concern that reduced service capacity and information sharing delays can hinder effective partnership working. The Family Nurse Partnership model was recognised as a valuable intervention. Like others, Halton have family hubs that are working to identify and target vulnerable families with the full range of necessary support. This includes the online platform currently being developed which will incorporate referral pathways for poverty support such as discretionary support, citizens advice and foodbanks.

Agencies need to inform people better and communicate better. One section does not communicate with another, never mind communicate with us.

Sefton parent

Most areas could describe some of the impact of early years interventions on families in poverty and how these yielded benefits to other services. For example, Wirral's Family Toolbox offers free information and advice to families which saw a 27% drop in referrals to Early Help services. Liverpool's 24 Magic Months © user-centred app uses behavioural insight to provide accessible content for parents of under two years olds and recently won the Local Government Chronicle's Campaign of the Year 2024.[ii]

An area of common concern was the take up of Healthy Start vouchers which some areas were tackling through campaigns; Halton's campaign demonstrates the importance of awareness raising as it became amongst the top ten councils for take-up at the time; Healthy Start is an issue which OHID NW is currently working on. Although the value of the vouchers is relatively modest, they do help families in poverty whilst providing a potential route to other advice and support.

Public health investment in the Healthy Child Programme, including mandated checks, was not always explicit in relation to addressing child poverty in the stocktake returns, although the commissioning contracts will certainly require targeting families/children. Some areas described recruitment and retention challenges for health visitors, and stakeholder discussions emphasised significant budget cuts having a major impact on what is being commissioned. Healthy Schools are seen as having an important role on issues such as mental health and healthy weight which can disproportionately impact poorer children.

"It was only when speaking to my health visitor when she asked how I was doing and through her reassuring me - that's what got me the right support, she took her time, and I didn't feel rushed or a tick box."

[ii] 24 Magic Months free app - Liverpool City Council

Halton parent, Consultation on Family Hubs

Education attainment is recognised as an important outcome for children, but for many children additional support may be necessary that extends beyond the classroom. In Warrington for example, qualitative work with schools and headteachers is being aligned with educational attainment data to identify what are the barriers to children from the most disadvantaged areas reaching their potential.

The engagement of school age children in a wide range of participation programmes is frequently cited, including Sefton's work with schools in informing regeneration programmes. The stocktake encouraged a council-wide response, because of the importance of education as a protective factor for current and future life chances for children and young people. Considering this, more examples of work would have been expected and warrants further consideration with the DCS network where a more complete picture will be available and potential gaps and best practice identified. Particular attention should be given to secondary school pupils, and school-leavers, as part of maximising attainment.

Programmes such as Right to Succeed are also being used in areas such as Wirral and Knowsley, to improve educational outcomes through development of place-based, community engagement working with schools (Cradle to Career).[jj]

There were some references to groups of children at heightened risk of poverty, both now and in the future, particularly those in care and on the edge of care. The renewal of Halton's housing strategy will look at specific needs of children leaving care, which other authorities are also doing through support packages that extend across the range of needs of these young people. Areas have strategies that describe levels of need and provision for children with disabilities, although progression to adult life and reducing the risks of living in poverty are generally not explicit.

Economy and regeneration

There are examples of where the impact of disadvantage and poverty on an area's economy are described in corporate plans and strategies, for example in relation to employment and business development, as well as regeneration. There were limited examples of the use of socio-economic and Social Value as a means of reducing poverty alongside addressing economic, financial, other social and environmental outcomes, although this may have been implied in the plans and strategies shared in the stocktake. Sefton's work on regeneration and engaging young people stands out as a positive model.[kk] LCR's Social Value Framework is an important resource aiming to provide a consistent approach across the Combined Authority area.[ll]

[jj] Impact - Right to Succeed
[kk] Sefton Social Value and the Growth and Strategic Investment Programme
[ll] LCRCA-Social-Value-Policy-and-Framework-2022.pdf (liverpoolcityregion-ca.gov.uk)

Further consideration should be given to the use of Social Value and socio-economic duty principles by way of reducing poverty, learning from areas in and outside of C&M. Similarly, considering the impact that low pay has on in-work poverty, the limited references to this warrant further consideration.

A WAY FORWARD FOR CHESHIRE AND MERSEYSIDE - RECOMMENDATIONS

An international evidence review found that effective poverty strategies set out a high-level commitment, a process for accountability, involve and communicate, prioritise, and are able to demonstrate understanding and monitoring of progress.[72] To enable actions, it is recommended that a framework is used.

To build on the significant assets in the sub-region and in the North West, as well as the support of other areas and national organisations, this report proposes four recommendations. It should be stressed that the voices of the lived experience of children, young people and families should shape, and challenge, priorities and actions.

Recommendation 1: Set an ambition on child poverty and articulate this widely.

Rationale: Stakeholder feedback highlighted the need for a more concerted voice about child and family poverty at a Cheshire and Merseyside (C&M) level. The co-production of an ambition and a narrative on child poverty provides a very public way for partners to commit to tackling the causes and symptoms of poverty. The ambition would obviously need to be agreed through the relevant partnerships but should aim to be aspirational: **to set an ambition that no child in Cheshire and Merseyside lives in poverty.** Central to the shaping of the ambition, and to all the priorities set out in this report, are the views and experiences of children and their families with lived experience of poverty.

Recommendation 2: Agree a governance and oversight system.

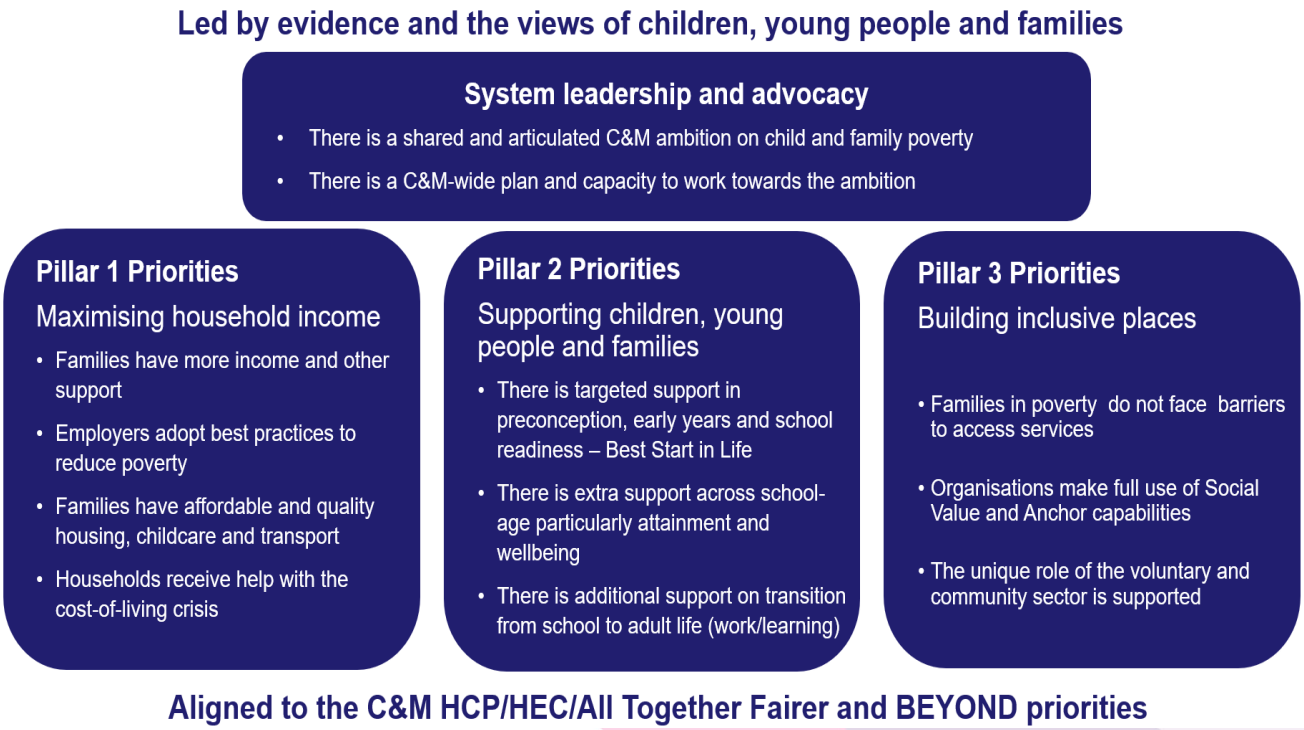
Rationale: There is a significant amount of work underway in Cheshire and Merseyside that contributes to alleviating and/or preventing child poverty. Generally, these are badged under specific programmes (such as Best Start in Life, cost-of-living crisis programmes, etc). This fragmentation can mean that the opportunity for synergies and greater collaboration and advocacy on child and family poverty is missed. A governance and oversight system could be part of an existing structure (for example in the HCP, with leadership from All Together Fairer, and aligned to the ICB's work on population health, its Children and Young People's Committee, the Women's Health and Maternity programme, and Beyond). Oversight would need to be inclusive of the full range of policy makers and stakeholders that collectively can drive action on poverty. Consideration should be given to the merits of having Champion type roles which can be part of the public facing anti-poverty work at a sub-regional level.

Recommendation 3. Set a plan and have the capacity to implement it.

Rationale: Having a shared ambition requires a plan that is owned by the anti-poverty partnership, that sets out the focused areas of work where greatest impact could be made in a timely way. It is evidence from the stakeholder interviews that there is limited capacity to facilitate this and therefore additional resources would need to be quantified and secured. This could be part of an existing programme of work as described above but would need increased capacity to make things happen at pace.

Recommendation 4. Adopt a Framework to set, monitor and drive action.

Rationale: Evidence shows that a Framework can give clarity and structure to a complex programme involving a wide range of stakeholders. The draft Child and Family Anti-Poverty Framework sets out high-level priorities and actions. These will require testing with stakeholders and can then be jointly owned and monitored. The detail of the Framework is set out in the Appendix; the three priority pillars are based on the areas which evidence shows provide greater protection for people in poverty, as well as building prevention for children now and in the future. Many of these actions are underway to some extent in C&M, but are not shared consistently, and the synergies with other programmes are not always fully exploited. The list of interventions is intended to set a prioritised set of actions. Finally, it is important to remember that the evidence indicates that whilst individual interventions can be beneficial for children and families, in the context of poverty reduction they generally work most effectively alongside complementary interventions addressing economic and social needs.



APPENDIX A: DEFINITIONS OF POVERTY

"Individuals, families and groups in the population can be said to be in poverty when they lack resources to obtain the type of diet, participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged and approved, in the societies in which they belong."

Peter Townsend[mm]

There is no single, universally accepted definition of poverty.[nn] However, in general the term refers to when people lack the material resources to meet minimum needs.

The UK government publishes two key measures of poverty based on disposable income, broken down further on a before housing costs (BHC) and after housing costs (AHC) basis.

Relative low income refers to people living in households with income below 60% of the median in a given year. This reflects that standards of living change over time.

Absolute low income refers to people living in households with income below 60% of median income in a base year, usually 2010/11, adjusted for inflation. This measure demonstrates whether the proportion of individuals living in poverty is getting better or worse off in absolute terms and does not account for changes in prosperity in society.

The Department for Work and Pensions (DWP) publishes estimates for the number of children living in low income households each year using these measures. It also published its most recent 'Households below average income' release on 21 March 2024. The estimates within the release were compiled using data from the annual family resources survey for 2022/23.

[mm] What is poverty? | CPAG

[nn] https://lordslibrary.parliament.uk/child-poverty-statistics-causes-and-the-uks-policy-response/

APPENDIX B: CHAMPS CHILDREN AND FAMILY ANTI-POVERTY FRAMEWORK

It is essential that the views of children and families with lived experience of poverty informs and shapes the actions set out here.

System leadership and advocacy		
Priority 1. There is a shared and articulated C&M ambition on child and family poverty		
Actions	**Intended impact**	**Lead/s**
With partners, agree a C&M ambition and narrative on child and family poverty (C&M) Year 1. Consider an advocacy model, for example having figureheads such as Child Poverty Champion/s alongside leadership from HCP, LAs, VCS, businesses, academia, CYP&F (C&M) Year 1. Consider areas for advocacy on urgent government action to take families out of poverty including prioritising a nationally funded child and family poverty strategy (C&M/Local) Year 1. Other areas for national advocacy could look to make the case for C&M for: a) a benefit system that takes children out of poverty; b) long-term targeted support for early years and school age children in poverty; c) establish longer-term funding for programmes such as Household Support Fund; and longer term d) national adoption of Real Living Wage (C&M) Years 1-2. Agree oversight and accountability (C&M) Year 1.	The public and stakeholders are clear about the shared ambition that no child in C&M grows up in poverty. A coalition of support is built over time, maximising distributed leadership. There is strong advocacy with Government departments and national policy. The voices of children, young people and families are central to all that we do.	LAs and ICB. Working with NW Government departments, VCS, Business, Academia and others.

System leadership and advocacy		
Priority 2. There is a C&M-wide plan and capacity to work towards the ambition		
Actions	**Intended impact**	**Lead/s**
Use the framework to set early actions for collaboration across C&M (C&M) Year 1. Develop a child and family poverty dashboard, with metrics set to track progress, consider qualitative measures as well (C&M) Year 1. Establish ways to ensure the diversity of CYP&F voices inform actions, learning from existing networks (C&M with local) Year 1. Establish capacity to drive this at pace, complementing existing resources/networks (C&M) Years 1-2. Collaborate with academic institutions to establish areas for collaboration on research and evidence into policy and practice Years 1-2.	There is a shared set of priorities driving progress to ambition across C&M partners, making effective use of existing resources. There are clear plans between government departments and C&M/local organisations on areas for collaboration. The voices of lived experience inform policy and actions. Resources/tools/knowledge are promoted in a structured way to improve use of resources. Innovation is promoted and shared at pace and scale, influencing policy and practice.	Consider embedding the framework in the strategy of the HCP, and under the ATF programme aligned to the work of the ICB/Beyond including the Child Health Equity Collaborative. Other key networks will involve NW Government Departments including OHID, VCSE and academic partners. Voices of lived experiences will draw from local and sub-regional fora, Beyond and HEC, but may require more specific focus as well as the work progresses. Academic partners across C&M.

Pillar 1: Maximising household income		
Priority 3. Families have more income and other support		
Actions	**Intended impact**	**Lead/s**
Establish campaigns to increase take-up of benefits, including Healthy Start (already underway with Beyond), free childcare vouchers, Universal Credit particularly as it affects families with children, widen eligibility for free school meals to all children in poverty, and promote auto-enrolment to free school means wherever possible (C&M) Years 2-3. Consider advocacy for family benefits that are adequate to meet needs, including maintaining parity with cost of living increases (e.g. Triple Lock type arrangements) (C&M) Years 2-3. Consider the use of credit unions and debt relief schemes where these don't exist (Local) Years 2-3. Provide poverty-awareness training to front-line staff in public services to give brief advice and signposting (C&M with Local) Years 2-3 Money/benefit advice-type services are available and accessible, including online and in-person (Local) Years 2-3. Establish pathways for referrals for benefits, employment etc and ensure practical support is provided with forms etc (C&M with Local) Years 1-2. Consider how the voluntary sector can be supported to respond to demand (C&M with Local) Years 1-2.	There is an increase in household income through benefit take-up and eligibility for other resources (e.g. food/clothing/furniture grants/banks). Schools will benefit from the Pupil Premium via a child claiming FSMs. Lower levels of debt for families in poverty. Practical help to families for financial and other support including through Family Hubs/Sure Start Centres/Children's Centres. There are no 'advice deserts' across C&M and the advice sector is adequately resourced.	Champs/LAs working with DWP and ICB and relevant government departments/agencies. Connect with the work of the LCR CA's Better Off Support Programme, with national organisations such as Save the Children and Policy in Practice who have developed resources around benefit take-up, as well as North West based organisations including CAB, Resolve Poverty (formerly Greater Manchester Poverty Action) 40F[oo] Consideration should be given as to what can be done at scale at C&M level and what is best done locally. It may be that some actions, for example developing training/establishing referral pathways, can be commissioned at a C&M level but delivered locally to add value to other work taking place. In the actions column L indicates Local, C&M is sub-regional.

[oo] Mayor Steve Rotheram launches £2million scheme to support hardest-hit through cost-of-living crisis (liverpoolcityregion-ca.gov.uk)

Pillar 1: Maximising household income		
Priority 4. Employers adopt best practices to reduce poverty		
Actions	**Intended impact**	**Lead/s**
Consider widening the adoption of the fair employment charter (C&M) Years 2-3. Work towards wider adoption of the Real Living Wage (C&M and local) Year 3. Working with employers, establish targeted training and skills development programmes (Local) Years 2-3. Establish with DWP and ICS programmes to support people in and out of work because of ill health, learning from the pilots of the national WorkWell programme.[pp] (C&M) Years1-2.	In-work poverty reduces. The number of workless households reduces through increase take up of employment opportunities. Reduction in people leaving work because of ill health, increase in people returning to work from ill health.	LAs, LCR and ICB. For work and health strand, include relevant government departments including DWP, OHID and DHSC and business networks.

[pp] New £64 million plan to help people stay in work - GOV.UK (www.gov.uk)

Pillar 1: Maximising household income		
Priority 5. Families have affordable and quality housing, childcare and transport		
Actions	**Intended impact**	**Lead/s**
Develop an assessment of how housing is impacting on child poverty and how this can be addressed (C&M) Year 3. Awareness raising for free childcare (see above Priority 3) Years 1-2. Assessment of the impact of public transport costs on adults and children in poverty (C&M) Year 3.	Housing is less of a barrier to exiting poverty. Increased childcare take-up enables adult to return to work and children to benefit from learning and development in quality childcare. There is an increase in the numbers of people living in poverty who can use public transport.	LAs, LCR's childcare guarantee commission).[qq]

Pillar 1: Maximising household income		
Priority 6. Households receive help with the cost of living crisis		
Actions	**Intended impact**	**Lead/s**
Local areas share learning of effectiveness of programmes (C&M) Year 1. Consideration is given to explore if multi-authority commissioning can improve efficiency and reach of Cost of Living interventions (C&M) Years 2-3. At a C&M level advocate for the continuation of government funding for time-limited funding (such as Household Support Fund) (C&M) Year 1-2.	Shared learning leads to use of best practice models. Greater efficiency and reach in delivering programmes. Stability in government support for the longer term.	LAs and ICB.

[qq] Taking-Back-Our-Future-Web.pdf (steverotheram.com)

Pillar 2: Supporting children, young people and families

Context for Pillar 2: The priorities and actions set out here are additional to the services generally provided to children and families through the Healthy Child Programme schedule of interventions and other locally developed plans43F[rr]. The intention is to recognise the *additional burden* that living in poverty has on families on children, to identify *as early as possible* when families in poverty require extra support, and to *maintain an enhanced offer* for as long as that is needed. The use of data will be critical to identifying families that need support as well as monitoring progress. Interventions and support build on the assets of the family/children, considering any risk factors to children and parents/carers. Interventions should be seen alongside other measures to support parents' access to work, training and community resources.

Priority 7. There is targeted support in preconception, early years and school readiness – Best Start in Life

Actions	Intended impact	Lead/s
Maternity services provide advice and support to expectant parents on maternal mental health, benefits and employment rights, support from Family Hubs/Sure Start/Children's Centres. (Local) Years 2-3. Identified families receive enhanced support using all 5 HCP mandated reviews and wherever appropriate the 2 suggested contacts are in-person. Interventions, including having appropriate resources in the home, should especially consider the following protective factors for children in poverty in relation to school readiness.[73] (Local) Timescale to be discussed with LAs/ICB. Sensitive parent-child interactions and availability of home material learning resources Parents feel able to support learning and literacy in the home. Parents recognise and take-up the benefits of children being in affordable/free quality childcare/nursery care. Positive inter-parental relationship.	Expectants parents can prepare positively for parenthood Children and young people's health, educational and social outcomes across CYP life-stages are equivalent to that of their peers Take up of early years childcare/nursery provision increases There is a reduction in higher-level social care interventions because of early intervention and greater agency in families	Beyond, ICB/DsPH and DsCS

Pillar 2: Supporting children, young people and families		
Priority 8. There is extra support across school-age particularly attainment and wellbeing		
Actions	**Intended impact**	**Lead/s**
Pupils living in poverty can fully take part in school and extra-curricular activities through: (Local) Years 1-2. Extra financial support or cost-free activities (using poverty proof © type approach). Additional cost of living in a low-income household is recognised and supported (e.g. IT). Support for healthy eating is provided through free breakfast clubs. Youth services provide support including reducing isolation, building confidence.	School age health, educational and social outcomes are equivalent to that of their peers. There is a reduction in higher-level social care interventions because of early intervention and greater agency in families. Young people report improved wellbeing.	Beyond, ICB/DsPH and DCSs.

[rr] Healthy child programme schedule of interventions - GOV.UK (www.gov.uk)

Pillar 2: Supporting children, young people and families		
Priority 9. There is additional support on transition from school to adult life (work/learning)		
Actions	**Intended impact**	**Lead/s**
There is early identification and targeted support for young people at greater risk of poverty in adult life including those with lower educational attainment, and care experience. Interventions will include: (Local) Years 2-3. Youth Employment and Training support, working with schools, Pupil Referrals Unit and employers/Further Education. Personalised support for children leaving care to live independently, including work/training, housing and life skills. Access to health services to protect and promote health is enhanced by youth friendly health and care services (for example using You're Welcome)[ss] (C&M with Local) Years 2-3.	Reduction in the numbers of young people who start adult life in poverty. Reduction in inter-generational poverty from one family to another. Health outcomes are equivalent to young people not in poverty.	Champs/ATF/ICB?/DsCS? Working closely with Beyond, including CHEC/ICB CYP Partnership, C&M, NW Government Departments including OHID, VCSE, Businesses.

[ss] Establishing youth-friendly health and care services - GOV.UK (www.gov.uk)

Pillar 3: Building inclusive places		
Priority 10. Families in poverty do not face barriers to access services		
Actions	**Intended impact**	**Lead/s**
Test implementation of the model of Poverty Proofing (©) public services, or a relevant adaptation, with a view to wider roll-out (C&M) Year 1-2 subject to learning from current work. Social prescribing/primary care, working with benefit agency and Job Centre, can support adults to remain in employment or return to work (C&M) Years 2-3.	More families in poverty can access services. Services report improved engagement (for example, fewer DNAs) and outcomes (for example in health, education and social care). Reduction in numbers of families in poverty because adults are out of work.	ICB and LAs, NHSE NW, Alder Hey and working closely with Beyond.

Pillar 3: Building inclusive places		
Priority 11. Organisations make full use of Social Value and Anchor capabilities		
Actions	**Intended impact**	**Lead/s**
Use C&M networks for LA Place and Policy Directors to increase the use of models of social value and to share best practice (C&M) Years 1-2. Regeneration programmes include a poverty lens to improve employment/training, housing and environmental conditions for people in poverty (Local) Years 2-3. At C&M level look to move at pace on the opportunities of Anchor institutions in reducing inequalities (C&M) Years 1-3.	There are long-term benefits to residents on low-income through, for example, skills development and employment. Public resources increase benefits to families in poverty through increased employment/training opportunities. Local areas benefit from having a more diverse workforce and engaged communities.	LAs and ICB.

Pillar 3: Building inclusive places		
Priority 12. The unique role of the voluntary and community sector is supported		
Actions	**Intended impact**	**Lead/s**
Consideration is given to how the strengths of the VCS can be supported across C&M through shared learning and collaboration in respect of family poverty reduction (C&M) Years 1-2. At C&M level stability of funding is considered to allow longer-term delivery of interventions (C&M) Years 2-3.	The VCS can demonstrate increased impact on family poverty. There are mechanisms to engage the diverse lived experience of poverty across C&M to inform policy and for advocacy.	LAs and ICB with VCSE.

ACKNOWLEDGEMENTS

The views expressed in the report are solely those of the author.

A Steering Group provided oversight and direction to the report:

Dawn Leicester, Director of Champs Support Team
Alan Higgins, All Together Fairer Strategic Lead
Dave Bradburn, DPH, Wirral BC
Susan Jarvis, Heseltine Institute, University of Liverpool
Lynn Deacon, LKIS, OHID North West and lead analyst for the report
David Taylor-Robinson, University of Liverpool
Melisa Campbell, Liverpool City Council Public Health
Stuart Dunne, Youth Focus NW
Helen Cartwright, Champs Support Team
Lorraine Joy, Champs Support Team
Kathy Buglass, Champs Support Team
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Title of Report:	Joint Strategic Needs Assessment (JSNA) update
Date of meeting:	19 November 2024
Written by:	Dr Susan Roberts
Contact details:	susan.roberts@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Helen Charlesworth May

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 an update of progress in the JSNA work programme since March 2024		
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 progress on the JSNA work programme and current capacity challenges across the system. • To continue to use the JSNA to inform decision making across the system.		
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, it has also been shared specifically with the Director of Public Health and the Executive Director for Adults, Health and Integration.		
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.	Adopting the JSNA recommendations aims to help to reduce inequalities and enhance existing work to improve overall health and wellbeing in Cheshire East.

1. Report Summary

1.1. The purpose of this report is to update the Health and Wellbeing Board on the Joint Strategic Needs Assessment (JSNA) work programme.

1.2. Key updates include:

- The Special Educational Needs and Disability JSNA is nearing completion.
- Social isolation, Macclesfield and Care of Older People JSNAs are progressing with extensive engagement from across the system.
- Planning for the sexual health JSNA has recently commenced and the lifestyle JSNA is due to commence in the near future.
- A programme of JSNA promotion and engagement will be undertaken during Autumn 2024.
- JSNA progress needs to be balanced against duties to complete the pharmaceutical needs assessment during 2024/25.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to:

- Note the progress on the JSNA work programme and current capacity challenges across the system.
- To continue to use the JSNA to inform decision making across the system.

Reasons for Recommendations

2.2. The JSNA recommendations are based on the triangulation and interpretation of data from wide and varied sources through multi-partner engagement and collaboration.

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

3. Impact on Health and Wellbeing Strategy Priorities

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

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

4. Background and Options

4.1. Health and Wellbeing Boards have a duty to produce JSNAs under the Health and Social Care Act 2012. JSNAs are in-depth assessment of the current and future health and social care needs. They are informed from a wide range of sources to produce recommendations for commissioners and partners to use to improve the overall health and wellbeing of residents of Cheshire East whilst looking to reduce inequalities.

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

4.3. Reviews are undertaken through multi-partner working groups and are subsequently approved for publication by the Director of Public Health or Executive Director of Adults Health and Integration through delegated responsibility (further details are provided via: https://moderngov.cheshireeast.gov.uk/ecminutes/documents/s102045/JSNA%20approval%20processes%2021%20March%202023%20Final%20Version.pdf

4.4. The priorities for the JSNA work programme are agreed by the multi-agency, multi-partner JSNA Steering Group.

4.5. 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).

4.6. **Progress in relation to the current work programme**

4.6.1. The *Special Educational Needs and Disability JSNA* analysis has been finalised. Recommendations are currently being agreed through multi-partner collaboration. The target approval date has moved further due to system pressure. The JSNA is aligned with other key SEND workstreams.

4.6.2. *Care of older people*

The scope of this review has been proposed and is currently being finalised. It is likely that this review will take 12-18 months to complete in view of its breadth. However, key elements of the work may be quality assured and finalised prior to completion of the entire review, to ensure timely utilisation by the system.

Loneliness and social isolation

Data collection and analysis is well underway.

Macclesfield

Data collection and analysis is well underway.

Sexual health

Planning for this review has commenced with many key stakeholders now identified and an initial working group meeting scheduled.

Lifestyle JSNA

The Lifestyle JSNA will be summarising the findings of the lifestyle survey (published earlier in 2024). It will triangulate findings from the survey with additional data sources. It will also involve statistical comparison of findings at Care Community level and by different population group.

4.6.3. *Progress in relation to the Joint Outcomes Framework*

Phase two of the Joint Outcomes Framework development continues. Sessions are planned to promote the JSNA with each of the eight Care Communities with the intention of further development and co-production of a local population health/population health management approach across Cheshire East place. This engagement will also further inform phase two of the Joint Outcomes Framework development.

Conversations have also commenced regarding developing an interactive dashboard in Power BI that aligns with other tools produced by the Integrated Care Board. There will be a refresh of the Phase One

Outcomes Framework indicators in the coming months, once this is feasible within the Office for Health Improvement and Disparities tool.

4.6.4. Commencement of future reviews will be deferred until after the draft pharmaceutical needs assessment has been published for formal consultation. This deferral is necessary in view of capacity challenges across the system. The next reviews to commence include:

- Health and wellbeing in the early years of life (0-5 year olds)
- A place-based JSNA focusing on Congleton and Holmes Chapel Care Community.

4.7. **Additional activities**

4.7.1. *Councillor briefing sessions*

Two councillor sessions will be delivered during Autumn 2024. The first session will be delivered to Cheshire East councillors, whilst the second will be delivered to town and parish councillors. The purpose of these sessions is to increase awareness, understanding and application of the JSNA.

Access to Information

4.8. 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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Community & Voluntary Services cheshire east

Cheshire and Merseyside Cancer Alliance

Partnership: Collaboration between Cheshire & Merseyside Cancer Alliance and CVS organizations

Target Area: Focus on Cheshire and Merseyside, where cancer incidence and late diagnosis rates are higher than the national average

Goal: Reduce cancer mortality by raising awareness, promoting early diagnosis, and encouraging participation in NHS cancer screenings

Grassroots Efforts: Social Action Leads empowering community groups to drive early cancer diagnosis

Impact: Helped Cheshire and Merseyside rank joint-top in improved early cancer diagnosis rates in England

Award-Winning Initiative: Named Community Care Initiative of the Year at HSJ Patient Safety Awards 2024

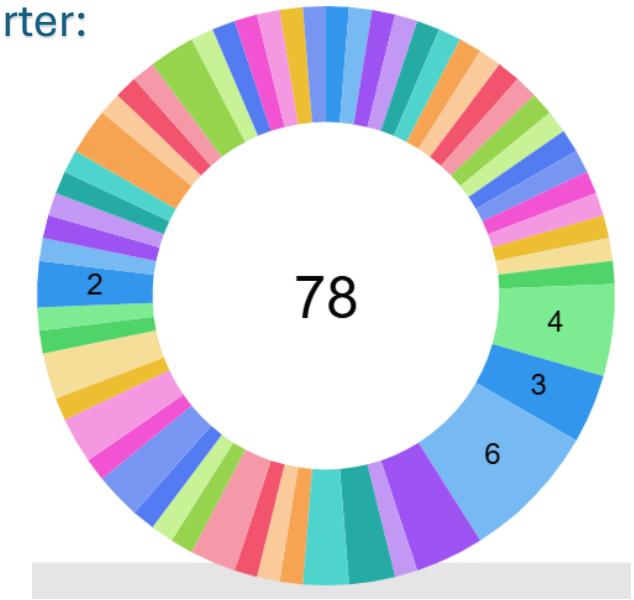
Community & Voluntary Services cheshire east

Cheshire and Merseyside Cancer Alliance

Engagement with Cancer Alliance Organisations

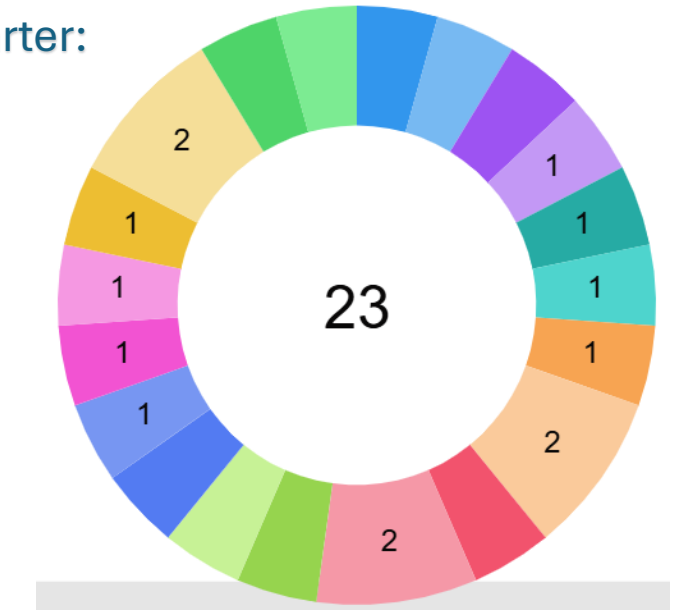
Events and Meetings Last Quarter: 25

Calls and Emails with Organisations Last Quarter:



Events and Meetings This Quarter: 10

Calls and Emails with Organisations This Quarter:



FEEDBACK from community groups who have used funding from the cancer alliance to run projects for their beneficiaries:

"Attending the wellbeing session was a transformative experience for me. The session provided invaluable information on early detection, treatment options, and the importance of regular screenings. It empowered me to take charge of my health and spread awareness within my community. I now feel more confident and equipped to support others in their journey towards better health."

"Before attending the wellbeing session, I didn't realize how crucial early detection is in cancer prevention. The information I received about regular screenings and self-examinations has completely changed my approach to my health."

FEEDBACK from community groups who have used funding from the cancer alliance to run projects for their beneficiaries:

"The wellbeing sessions were a much-needed break. The focus on finding time for self-care was particularly helpful. The speakers shared realistic strategies to minimise the risks of cancer that I could easily incorporate into my daily routine. The educational talks were thorough and easy to understand, making complex medical information accessible."

"The cancer awareness and wellbeing sessions exceeded my expectations. It was a perfect blend of education and practical advice. The focus on finding time for self-care was particularly beneficial, as it's something I struggle with. The information provided was clear and actionable, and the supportive environment made it easy to open up and connect with others."

"The emphasis on lifestyle changes and going for screenings was a great reminder of what we can all do to lower our risks. The positive atmosphere in the room made us feel comfortable and able to ask questions."

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Agenda Item 9

Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Cheshire East Drugs and Alcohol Plan
Report Reference Number	HWB70
Date of meeting:	19th November 2024
Written by:	Hannah Gayle
Contact details:	Hannah.gayle@cheshireeast.gov.uk / 01625 383767
Health & Wellbeing Board Lead:	Guy Kilminster

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision ✓
Why is the report being brought to the board?	To raise awareness of the new drugs and alcohol plan for Cheshire East.		
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.	To note the new drugs and alcohol plan – Reducing drug and alcohol harm in Cheshire East (appendix 1)		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The report is being presented at Adults and Health Committee on 18th November 2024. The plan has been approved by the Cheshire East Combatting Drugs Partnership.
Has public, service user, patient feedback/consultation informed the recommendations of this report?	Yes – further information in report body.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	The drugs and alcohol plan sets out a number of actions which aim to improve services and support for the residents of Cheshire East. The plan also sets out measures of success. A few examples are below: ▪ Joint assessments from mental health and substance misuse services – residents benefit from a more holistic approach and not having to retell their story. ▪ Improved training and education offer – greater understanding and reach of harm reduction advice, services available and information on the risks of drugs and alcohol harm. ▪ Targeted support for those most in need – providing early intervention to at risk groups and specialist support where needed.

1 Report Summary

1.1 The Government's 10-year plan: 'From Harm to Hope', mandates a local drugs and alcohol plan that reflects national priorities at a local level.

1.2 This report details the engagement and coproduction that underpins this plan and discusses evidence of population need relating to drugs and alcohol.

2 Recommendations

2.1 To note the new drugs and alcohol plan – 'Reducing drug and alcohol harm in Cheshire East'.

3 Reasons for Recommendations

3.1 The plan provides a clear set of actions to address recommendations outlined in the Drugs and Alcohol JSNA, contributing to the reduction of poor mental and physical health and reducing inequalities across Cheshire East.

3.2 Development of a local plan is also mandated within the government's 10-year strategy and will be monitored through key Office for Health Improvement and Disparities indicators.

4 Impact on Health and Wellbeing Strategic Outcomes

4.1 The drugs and alcohol plan supports the following outcomes of the Joint Health and Wellbeing Strategy 2023-2028 by:

- Creating a place that supports wellbeing for everyone living in Cheshire East.
- Improving the mental health and wellbeing of people living and working in Cheshire East.
- Enabling more people to live well for longer.

5. Background and Options

5.1 Around 1 in every 27 people in Cheshire East regularly drink above the recommended levels of alcohol, and almost 1 in every 100 people are dependant drinkers. Among young people in Cheshire East, a survey showed that about half feel that drinking is normal, fun, and not a risk to health, with about 1 in 14 claiming that they binge drink.

5.2 It is estimated that 1 in 18 adult Cheshire East residents have used illicit drugs in the past year, with cannabis being the most used drug. For crack cocaine and opiates (including drugs like heroin), about 1 in 270 people in Cheshire East have misuse issues. About 2 in every 5 of this group are not currently accessing treatment for this.

5.3 In Cheshire East, there are higher levels of drug and alcohol related admissions to hospitals among both young people and adults than the England average. For treatment, Cheshire East is similar to the England average for substance remissions.

- In 2021, the Government published its 10-year drug strategy – 'From harm to hope' which centres on prevention, enforcement, treatment, and recovery. The national strategy emphasises the need for co-ordinated action across a range of organisations to deliver on three strategic priorities:
- Break drug supply chains
- Deliver a world-class treatment and recovery system
- Achieve a shift in demand for drugs.

5.4 Local responsibilities highlighted in the Governments 10-year strategy are:

- Produce a local Drugs and Alcohol Joint Strategic Needs Analysis.
- Form a local Combatting Drugs Partnership.
- Produce a local drugs and alcohol plan.

5.5 In September 2023, Public Health colleagues produced a local JSNA which provided a comprehensive account of local challenges and priorities relating to drug and alcohol addiction.

5.6 In August 2022, Cheshire East Combatting Drugs Partnership (CDP) was established, providing a multi-agency approach to reducing drug related harms in the local setting. This collaborative approach includes public health, the police, commissioning, community safety, housing, drug and alcohol treatment services, commissioners and providers, service users, NHS, Cheshire Wirral Partnership, probation, and youth justice.

5.7 The CDP reports to the Safer Cheshire East Partnership (SCEP) on a quarterly basis, is closely linked to the Cheshire East Health and Wellbeing Board, and monitors progress on the measures outlined in the National Combating Drugs Outcomes Framework. Links will also be made with other relevant groups such as the Cheshire East Safeguarding Children's Partnership to reduce risk of duplication.

5.8 The Cheshire East plan: "Reducing drug and alcohol harm in Cheshire East", incorporates the actions laid out in the national strategy and builds on the learning and recommendations from the substance misuse JSNA to ensure it meets local need and addresses local priorities. It also takes account of discussions within the Combatting Drugs Partnership.

5.9 The plan incorporates a set of actions developed through the coproduction process. The following paragraphs summarise our intentions for the next five years.

5.10 **Training and Education** - We aim to enhance the reach and impact of drug and alcohol education, to upskill the local workforce and provide targeted sessions where needed most as part of an early intervention approach. This includes developing a modular training package for professionals to raise awareness and build confidence in viewing addiction as an illness, offering basic harm reduction advice, understanding available treatment services, and clearly communicating pathways and referral processes. This is part of a 'Making Every Contact Count' approach.

5.11 **Communication and relationships** - We aim to create a platform for regular inter-agency communication to ensure a coordinated approach to promoting substance use services. We aim to build connections with ethnic minority groups to address cultural and language barriers and provide accessible information in various formats.

5.12 **Targeted approach** - Targeted interventions will focus on high-risk groups, such as children in care and those living with substance-misusing family members. This will help to protect against risk of ill-harm including domestic violence or child abuse. It will also encompass the targeting of homeless families and prison leavers. Additionally, intensive outreach will take place in collaboration with homelessness services supporting individuals with complex needs. Working closely with the eight care communities, we will work towards a hub and spoke model ensuring that people have access to services where they need them.

5.13 **Refine pathways** – We aim to streamline transitions between services, ensuring individuals receive appropriate support without repeatedly sharing their stories.

5.14 **Dual diagnosis** - We aim to enhance collaboration between mental health and substance misuse services, adopting a holistic approach. This includes creating opportunities for co-location, joint assessments, and developing bespoke recovery support pathways for both adults and young people with dual diagnoses.

5.15 **Stigma and lived experience** - To reduce stigma around substance misuse, we aim to change attitudes and encourage people to seek help without fear of shame. Additionally, we will celebrate and utilise the knowledge of those with lived experience, supporting them throughout recovery and facilitating opportunities for Lived Experience Recovery Organisations to thrive.

5.16 **Reducing supply and demand** - This includes targeting areas for drug and alcohol related crimes and disrupting drug supply (including county lines) through sharing of intelligence related to enforcement.

5.17 Outcomes will be measured in line with the metrics set out in the National Combatting Drugs Outcomes Framework and will be monitored locally by the local Combatting Drugs Partnership (CDP).

5.18 The feedback from the coproduction process and the plan will inform the design of the new Substance Misuse Service.

5.19 The proposed new plan has been coproduced with a large range of stakeholders:

- Young people (Youth council, JIGSAW, Youth service)
- Service users
- Service user family and friends
- Police
- Probation
- CWP
- People from ethnic minorities
- Health (0-19, GP's)
- Lived Experience Recovery organisations.

- Integrated Care Board
- Substance misuse provider forum
- Substance misuse providers, commissioned and non- commissioned (AA/NA)
- LGBTQ+
- VCFSE Sector
- Headteachers / Education
- All eight Care Communities
- Family Hubs
- Hospital trusts
- Housing
- Elected members.

5.20 Between March 2023 and August 2024, 43 focus groups and 33 one-to-one interviews were held with a total of **434** participants.

5.21 The action plan was presented to members of the Combatting Drugs Partnership and elected members in July, discussing intelligence gathered from engagement and allowing the opportunity to inform the approach.

5.22 Several task and finish groups have been held involving key stakeholders and those with lived experience with the aim to design a Cheshire East wide action plan which will inform the aims of new Substance Misuse Service model.

5.23 The alternative option of not publishing the plan would mean that Cheshire East are not adhering to the recommendations made within the national 10-year plan. This would also mean that key transformational and partnership work would not take place to improve the wider treatment and recovery network.

6 Access to Information

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

Name: Hannah Gayle
Designation: Project Manager – Thriving and Prevention
Tel No: 01625 383767
Email: hannah.gayle@cheshireeast.gov.uk

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Appendix 1

Reducing drug and alcohol harm in Cheshire East

2024-2029

An integrated 5-year plan to improve treatment outcomes, address unmet need and build recovery capital

Produced on behalf of the Cheshire East Combating Drugs Partnership by:

- Katy Ellison, Project Manager, Cheshire East Council
- Hannah Gayle, Project Manager, Cheshire East Council
- Dr Gisèle Spencer, Specialty Registrar in Public Health, Cheshire East Council
- Dr Andrew Turner, Consultant in Public Health, Cheshire East Council

Contents

1. Background

1.1. From harm to hope: A 10-year drugs plan to cut crime and save lives

Illegal drugs cause far-reaching and devastating harm. Drug misuse currently costs society over £19 billion a year. Drug use drives crime, damages people's health, puts children and families at risk and reduces productivity. It impacts the whole country, with the most deprived areas facing the greatest burden.

Combating illegal drugs and the harm they cause is an issue which needs action from a range of local partners. At a local level, success is reliant on these partners working together to understand their population and how drugs are causing harm in their area, any challenges in their local system and the changes that are needed to address them.

The Government's drugs strategy, *From harm to hope: A 10-year drugs plan to cut crime and save lives*, relies on co- ordinated action across a range of local partners including enforcement, treatment, recovery and prevention. The ten-year drug strategy requires a partnership approach to delivering the following strategic priorities:

- Break drug supply chains
- Deliver a world-class treatment and recovery system
- Achieve a shift in demand for drugs

As part of the national strategy, every local area has formed a Combating Drugs Partnership (CDP). These partnerships bring together a range of local partners working across enforcement, treatment, recovery, and prevention, to work together to deliver the national strategy's priorities.

As drug and alcohol use are so closely linked, local partnerships also focus on addressing alcohol dependence and wider alcohol-related harms alongside their focus on reducing the use, supply, and harms of illegal drugs.

1.1. Cheshire East Combating Drugs Partnership

What is the Cheshire East Combating Drugs Partnership?

The Cheshire East Combating Drugs Partnership (CECDP) provides a single setting for understanding and addressing shared challenges related to drug-related harm, based on our local context and need. On its formation in January 2023, the Cheshire East CDP collectively agreed a further local priority to, "understand and explicitly address the co-occurrence of substance misuse with mental illness and other complex issues", alongside the stated national priorities. In addition, the CDP has adopted a more explicitly "public health approach" than the national strategy, with a greater focus on harm reduction.

The functions of the Cheshire East Combating Drugs Partnership are:

- To bring together the NHS and Local Authority leaders across Cheshire East area, including representatives of both commissioners and providers of services.
- To bring together and co-ordinate other major agencies, organisations, sectors and interests that can contribute towards improving the strategic priorities of the Combating Drugs Partnership.
- To provide oversight of the development, implementation, performance and review of the associated action plan of the Combating Drugs Partnership and additional actions associated with the developing Cheshire East Substance Misuse Strategy.

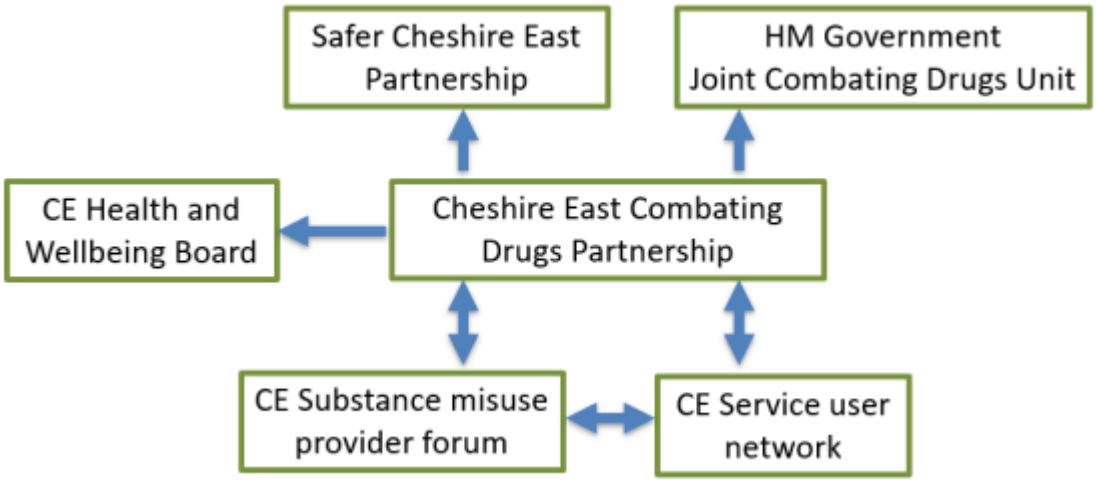
- To provide oversight of the development, implementation, performance and review of the drug and alcohol misuse Joint Strategic Needs Assessments (JSNAs).
- To ensure that the action plan and JSNA are used as the basis for strategic decisions and the identification of priorities for the commissioning and delivery of services relating to substance misuse.
- To ensure a common approach to effective communication and the provision of information about drugs is developed across the partnership.

Who sits on the Cheshire East Combating Drugs Partnership?

The membership of the Partnership is broad to reflect the breadth and complexity of the factors that influence drug and alcohol harm. Members include representatives from: public health; the police; commissioning; community safety; housing; safeguarding; drug and alcohol treatment service commissioners and providers; service users; NHS; mental health services; probation; and youth justice.

Who does the Cheshire East Combating Drugs Partnership report to?

The governance structure of the CDP is summarised below:



- The Combating Drugs Partnership is a subgroup of – and reports on a quarterly basis to - the Safer Cheshire East Partnership (SCEP).
- The Partnership is one of the specialist bodies linked to the Cheshire East Health and Wellbeing Board and may report as necessary to the Board, or as requested by the Board.
- The Partnership will report annually to the national Joint Combating Drugs Unit (JCDU)
- The Combating Drugs Partnership works in collaboration with the Cheshire East substance misuse provider and service user networks.

2. Drug and alcohol harm in Cheshire East

A Cheshire East substance misuse joint strategic needs assessment (JSNA) was published in September 2023, which reviewed the use of and harm caused by drugs and alcohol across Cheshire East. The purpose of the JSNA was to understand the current situation in Cheshire East, identify gaps in current services, and make recommendations on how these can be addressed. A summary of the findings and recommendations follows below.

2.1. Risk factors for substance misuse

A number of risk factors for drug and alcohol use in Cheshire East have been identified, which are similar to those elsewhere. These include:

- Family history of substance dependence
    - In 2019/20 30% of new presentations were in parents who did not live with children.
    - 24.1% of alcohol users and 8.5% of opiate users In Cheshire East were living with children.
    - It is estimated that 81% of parents with alcohol dependence in Cheshire East are not known to services.
- Socio-economic deprivation
- Homelessness
    - A slightly smaller percentage of service users have unmet housing needs at the start of treatment in Cheshire East than nationally.
- Unemployment and precarious employment
    - People in Cheshire East who are not in work are more likely to be a user of the drug and alcohol service, with approximately half of all service users being economically inactive at the start of treatment.
- Poor mental health
    - 79% of service users in Cheshire East had a mental health need at the start of treatment, which is higher than for England generally.
- Male gender
    - Overall, 69% of service users in Cheshire East are male
    - 55% of alcohol treatment service users are male
    - 69% of non-opiate treatment service users are male
    - 71% of opiate treatment service users are male
    - The majority of hospital admissions related to substance misuse is among males
    - Most substance misuse related deaths are of males
- Ethnicity
    - In Cheshire East new presentations to drug and alcohol services were more likely to be among white British, White Irish or Other White ethnicities in 2021-2022. However, nationally it has been identified the Black people are more susceptible to substance misuse than other ethnicity groups.
- Age at initiation
    - In 2017/18 all young people who presented to services began using their primary substance before their 15th birthday.
    - Age also affects which types of product you use

- The substance used, experiences related to that use, and polysubstance use
- Exposure to preventative environments and intervention
    - Drug and alcohol use is more taboo in some sectors of society, for example in religious groups.
- The influence of the risks and protective factors.

2.2. Prevalence of substance misuse

It is estimated that there are around 14,000 higher risk drinkers and 3,500 dependent drinkers in Cheshire East. However, just under a quarter of these are engaged with treatment.

A survey of 14-17 year olds in Cheshire East by Trading Standards found that around half of respondents considered drinking alcohol as normal, fun and did not perceive any health risks. 7% claimed to binge drink, 6% drank alcohol multiple times a week, and a further 6% drank alcohol weekly. The survey also found that young people most commonly drank in the home and there had been an increase in young people who bought alcohol for themselves since 2020. For crack cocaine and opiates there are an estimated 1,400 residents who have misuse issues. 62% (860) of these are engaged with treatment. These figures point to significant levels of unmet need in both areas. Cannabis is the most widely used illicit drug in Cheshire East, and a predicted 21,000 people in the area aged 16 to 74 years old have used one or more illicit drugs in the past year.

Among young people, approximately 1,100 boys and 1,200 girls aged 11 to 15 years old are thought to have used illicit drugs in the past year in Cheshire East. The most used drug by this group was cannabis, followed by nitrous oxide and ketamine.

2.3. Substance related harm in Cheshire East

Cheshire East has higher rates of alcohol specific hospital admissions than England in both adults and paediatrics. These rates were highest in residents of the most deprived wards including the 'Crewe 6', and wards in Macclesfield, Middlewich and Nantwich. Alcohol related deaths in Cheshire East are similar to national levels, with the highest rates in Nantwich and Rural, SMASH, and Crewe care communities.

Among children and young people (aged 15-24), the rates of hospital admissions due to substance misuse is worse than the England average and has been rising. Hospital admissions for drug poisoning is also worse than the England average. Between April 2019 and March 2022 there were 38 drug related deaths in Cheshire East of people in treatment. Whilst this figure is below the England average overall, this conceals local variations within Cheshire East.

The highest rates of drug offences between September 2019 and August 2022 were in areas of Crewe, Macclesfield, Wilmslow and Knutsford Rural. However, drug offenses only make up a small proportion of drug associated crimes. It is thought that there are nine organised crime gangs active in Cheshire East and 17 county lines gangs impacting the area. Nine of these county lines gangs are believed to have associations with child exploitation.

2.4. Treatment

Change Grow Live (CGL) delivers a comprehensive drug and alcohol service in Cheshire East. This is in addition to digital support via NHS UK, the One You Cheshire East service and the Live Well offer.

Reach Out and Recover (ROAR) provides an inpatient rehabilitation service based in Macclesfield including for those with substance dependency issues. However, the numbers who access this service has typically been low.

Treatment success rates in Cheshire East are currently similar to the England average. However, both locally and nationally success rates were lower among more complex cases. Many of those who access the drug and alcohol service are also heavy smokers but stop smoking services are not routinely offered.

During 2021/24, 34 (35.8%) adults identified as having a substance misuse problem had successfully engaged with treatment on release from prison. Of service users in contact with the criminal justice system, 13% successfully completed treatment in 2021/22. Probation services have set substance misuse and mental health as priorities and were working with 179 people whose case was related to drugs or alcohol as of April 2023. There are higher rates of both drug and alcohol related hospital admissions in Cheshire East than the national average for both adults and under-18s.

2.5. JSNA recommendations

Key recommendations from the JSNA are summarised below. Some of these are explicitly addressed within this action plan (see next section), while others are being addressed within existing workstreams and strategies of members of the Cheshire East Combating Drugs Partnership (see Appendix 1).

Recommendations relating to drug use

- Understand the distribution of risk factors and use across Cheshire East to identify more susceptible groups and geographies.
- Understand the barriers to seeking and accepting treatment. Explore learning from people with lived experience to improve treatment pathways and support.
- Provide tailored outreach treatment options for our homeless population.
- Ensure that clear pathways are in place to optimise the services available.
- Reach our young people in appropriate settings with timely advice regarding substance misuse, protective factors, support with wider social issues, and support with treatment where needed. Advice on drugs should include highlighting the dangers of nitrous oxide.
- Raise awareness of county lines activity and how to stay safe or seek advice with concerns is particularly important amongst our vulnerable children and adults.
- Better understand our rates of drug-related crimes and in those areas with the highest rates, develop a comprehensive evidence-based approach to reduce rates.
- For those in treatment:
    - We need to provide holistic support to their families where children live within their households
    - We need to continue to support people back into employment, housing and to quit smoking.

- Improve response to misuse of emerging types of drugs and help people addicted to prescription medicines.
- Regularly monitor a small group of indicators in the longer term.

Recommendations relating to alcohol misuse

- Understand the distribution of risk factors, alcohol consumption, accessibility and pricing across Cheshire East to identify more susceptible groups and geographies.
- Reach children and families to promote protective factors and address risk factors early (before age 15) through universal and targeted services:
    - Ensure they can reach support on both wider issues through schools/family hubs/ GPs/social prescribers and other family settings
    - Ensure those that have disclosed a problem receive prompt, holistic advice through a variety of media.
- Consider more intensive prevention approaches in parts of Crewe, Macclesfield, Nantwich and Rural, and SMASH (Sandbach, Middlewich, Alsager, Scholar Green and Haslington) Care Communities. Alcohol attributable hospital admissions data suggests that the Crewe 6 wards are of particular concern (also identified in the Crewe JSNA).
- Understand the barriers to seeking and accepting treatment. Explore learning from people with lived experience to improve treatment pathways and support.
- Work on breaking down the stigma in seeking help for alcohol. Synergise with regional Cheshire and Merseyside Public Health Collaborative (CHAMPs) campaigns.
- Ensure that clear pathways are in place and signposted to optimise the services available, including brief intervention and discharge from hospital.
- For those in treatment, we need to continue to support people back into employment, housing and to quit smoking.
- Provide tailored outreach treatment options for our homeless population.
- Further explore the impact of alcohol attributable hospital admissions on the NHS and wider community including economic impact.
- Regularly monitor a small group of indicators in the longer term

3. Action plan

The action plan that follows over the next few pages was co-produced over 12 months of extensive engagement with partners across Cheshire East. This engagement included multiple workshops, surveys, feedback sessions and individual interviews with a broad range of professionals, services, and those with lived experience of drug and/or alcohol misuse.

The five-year plan includes actions across five broad themes identified as priorities:

1. Early intervention and prevention
2. Pathways and unmet need
3. Dual diagnosis
4. Stigma and lived experience
5. Reducing supply and demand

3.1. Monitoring of progress

The key metrics for measuring the overall success of the national strategy are outlined in the National Combating Drugs Outcomes Framework, summarised in Appendix II. A local dashboard will be produced to monitor these metrics at a local level, against which progress will be evaluated annually. Working groups based around each priority theme in the action plan will be responsible for delivery of relevant actions as well as reporting back every quarter on progress to the wider Cheshire East Combating Drugs Partnership and other boards as appropriate (see governance section above).

Reducing Drug and Alcohol Harm in Cheshire East: an integrated 5-year plan to improve treatment outcomes, address unmet need and build recovery capital

Priority theme 1: Early Intervention and Prevention				
What do we want to achieve?	**How are we going to do it?**	**Measures of success**	**When?**	**Who?**
A consistent and accessible training and education offer: *Widen our education offer to increase the reach and impact of drug and alcohol information, upskilling our workforce and providing targeted sessions where the need is greatest.*	Create a modular training package for professionals across the system, which raises awareness and builds confidence to: • View addiction as an illness and empower workforce to instigate exploratory conversations with customers/clients/patients/service users • Provide basic harm reduction advice • Understand treatment services available and provide support to access • Clearly communicate pathways, eligibility and referral processes	Less young people A&E admissions over time Number of schools / pupils engaged. Number of referrals to YP services Look at targeted cohorts and impact that we have made on this. Geographic targeting and results Increase number of sessions delivered in partnership with other agencies.	Year 1	Substance use service provider. Cheshire East Family Hubs
	Create a consistent age-appropriate training and education offer for all schools, which can be easily incorporated into the PHSE curriculum		Year 1	Substance use service provider Schools Cheshire East Council Education
	Work with partner agencies (e.g. Police, sexual health service) to deliver shared education sessions in schools		Year 2	Substance use service provider. Police youth engagement. Sexual health service

Priority theme 2: Pathways and Unmet Need				
What do we want to achieve?	**How are we going to do it?**	**Measures of success**	**When?**	**Who?**
Improving communication and building relationships: *Create new, and reinforce existing communication networks to make sure key messages around drugs and alcohol use are communicated, utilising existing expertise to help people work smarter together to achieve the best for those in need of support.*	Create a platform for regular communications across agencies to facilitate a coordinated approach to promoting substance use services.	Improved referral rates from partners.	Year 2	Combatting drugs partnership
	Embed Making Every Contact Count across the system, ensuring all assessment opportunities include a question around drug & alcohol use	Improved referral rates from partners.	Year 2 – 5	Primary care
	Improve communication and links with Primary Care to achieve more effective signposting to substance use services and capture referral rates	Improved referral rates from partners	Year 1	Substance use service / primary care.
	Build links with ethnic minority groups to understand and consider cultural and language barriers to accessing substance use services.	Improved links with ethnic minority groups. Improved understanding of cultural and language barriers.	Year 2	CEC Commissioning
	Provide accessible information in a variety of formats (easy read, alternate languages etc) when required (paper and online)	Information available on request in a variety of different formats	Year 2	Substance use provider
Take a targeted approach to engaging cohorts who are at risk of unmet need: *Identify key groups and develop a bespoke offer to support those who are unlikely to engage in mainstream services. Working in partnership with key*	Provide targeted early intervention to cohorts identified as potentially high risk: • Children in care • Children living with family members experiencing substance misuse • Homeless families in temporary accommodation • Victims of domestic abuse • Children excluded from school • Children at risk of child sexual exploitation • SEND / mental health	Further work required to consensus build around this area.	Year 2 – 3	Healthy young minds providers Substance use provider Housing Social care Family hubs 0-19 service Youth Support service

services to ensure we target the right people in the right way.	Provide an intensive outreach offer in collaboration with homelessness services to support individuals with complex and multiple needs.	Outreach support being delivered to those with complex and multiple needs.	Year 1	Substance use provider Housing
	Engage with existing forums (such as SMI, physical health checks, talking therapies, GP) to offer bespoke targeted packages of support.	Further work required to consensus build around this area.	Year 2 – 3	Primary care Substance use service
	Improve take-up of community sentence treatment requirements (ATR / DRR / MHTR)	Increase in numbers of ATR / DRR / MHTR.	Year 1	Probation Magistrate Substance use provider
	Place-based approach	Services available in all 8 care communities.		Care communities Substance use provider
Refine pathways to improve continuity of care and access to services: *Work together to make sure transitions between services are streamlined, reducing the number of times people have to tell their story and making sure people get the most appropriate support, when and where they need it.*	Provide clarity on pathways in, out and between services, including: • Prisons • Hospitals • Police custody • Mental Health • Housing / Hostels	Clear pathways produced, agreed, and followed by all partners.	Year 2	Substance use provider CWP MCHT ECHT Police Housing Primary care
	Improve continuity of care between hospital trusts and community substance misuse service by creating multi-agency Alcohol Care Teams	Alcohol care teams in MCHT and ECHT	Year 2	Substance use provider MCHT ECHT
	Provide a bespoke recovery support pathway for those who have coexisting mental health and substance misuse support needs (adults and young people)	Clear pathway in place with no gaps in service	Year 2	Healthy young minds providers Substance use provider Housing Social care Family hubs 0-19 service

Priority theme 3: Dual Diagnosis				
What do we want to achieve?	**How are we going to do it?**	**Measures of success**	**When?**	**Who?**
Provide collaborative support to those with coexisting substance misuse and mental health issues: *Improve the way in which mental health and substance misuse services work together, developing a more holistic approach to supporting those with a dual diagnosis.*	Create opportunities for co-location and joint assessments between substance misuse and mental health services.	Services are co-located. Clear pathway in place with no gaps in service.	Year 1	CWP Substance use provider Social work MH teams

Priority theme 4: Stigma and Lived Experience				
What do we want to achieve?	**How are we going to do it?**	**Measures of success**	**When?**	**Who?**
Reducing stigma: *Change attitudes so that people view substance misuse as an illness and feel confident to approach services without fear of shame or judgement.*	Create an insights-led health promotion campaign to: • Normalise access to substance use services and educate the public that it is a health condition that can be treated. • Paint a picture of what does a substance misuser look like, include drugs and alcohol • Put materials where people will see them • Promote risk awareness and harm reduction	Further work required to consensus build around this area.	Year 1	CEC public health / commissioning
	Increase visibility of substance misuse service and normalise conversation – more events, public-facing	Further work required to consensus build around this area.		
	Create a non-stigmatised culture surrounding access to substance use support and demonstrate a marked improvement on unmet need	Further work required to consensus build around this area.	Year 3 – 5	All partners
	Refine volunteer recruitment journey	Further work required to consensus build around this area.	Year 1 – 2	Substance use provider
Capitalise on and celebrate lived experience: *Utilise the wealth of knowledge of those who have lived experience, providing support throughout the recovery journey, showing those in treatment that recovery is possible.*	Facilitate opportunities for Lived Experience Recovery Organisations to develop and flourish with support to embed sustainability	Increase in number of LERO in Cheshire East.	Year 1 – 5	Substance use provider

Priority theme 5: Reducing supply and demand				
What do we want to achieve?	**How are we going to do it?**	**Measures of success**	**When?**	**Who?**
Enforcement and Regulation	• Combat sales to underage drinkers. • Targeted operations to 'hot spot' areas for crime drug and alcohol, including licenced premises. • Effective communication of successful police operations. • Disrupt supply of drugs through effective sharing of intelligence and enforcement.	Existing monitoring via SCEP and Police	As per SCEP plan	SCEP Police

Appendix I – Key related strategies and plans

The alcohol component of this strategy replaces the 2017 Cheshire East alcohol strategy. In that strategy five key areas were focused on: prevention, protection, treatment, recovery, and enforcement & control. These overlap with the key priorities in this update considerably as there is still progress to be made in these areas.

This new strategy places a greater emphasis on dual diagnosis of substance misuse and mental health conditions. This complements the Cheshire East Place Mental Health Plan 2024-2029, which focuses on six areas spanning from preventative measures to crisis support and wider community change. The Cheshire and Merseyside Public Health Collaborative (CHAMPs), has also developed a pan-Cheshire and Merseyside suicide prevention strategy 2022-2027 and notes that substance addictions as a risk factor. CHAMPs has been engaging in diverse alcohol harm reduction work, including research, prevention, early detection, and a focus on both physical and mental health.

Many of the factors which contribute to individuals developing a drug or alcohol problem sit outside out the purview of the Cheshire East Combating Drugs Partnership but are covered by work done elsewhere. For example:

- The Safer Cheshire East Partnership Annual Strategic Assessment outlines plans to disrupt county lines and reduce other substance related crimes
- The Cheshire Serious Violence Strategy 2024-2029 includes measures such as drug awareness sessions in schools, reducing harms from drug and alcohol use, and disrupting drug markets.
- Cheshire East Council's Homelessness and Rough Sleeping Strategy 2021-2025 includes establishing links with our drug and alcohol services as an action, to enable more people to be able to stay in their home following homelessness and in those at risk of becoming homeless. In turn being homeless and sleeping rough are risk factors for substance misuse and reducing this problem would reduce a driver of substance misuse.

The Cheshire East Combating Drugs Partnership will continue to be a place where partners involved in all the above strategies can meet regularly to discuss progress, challenges, and collaboration.

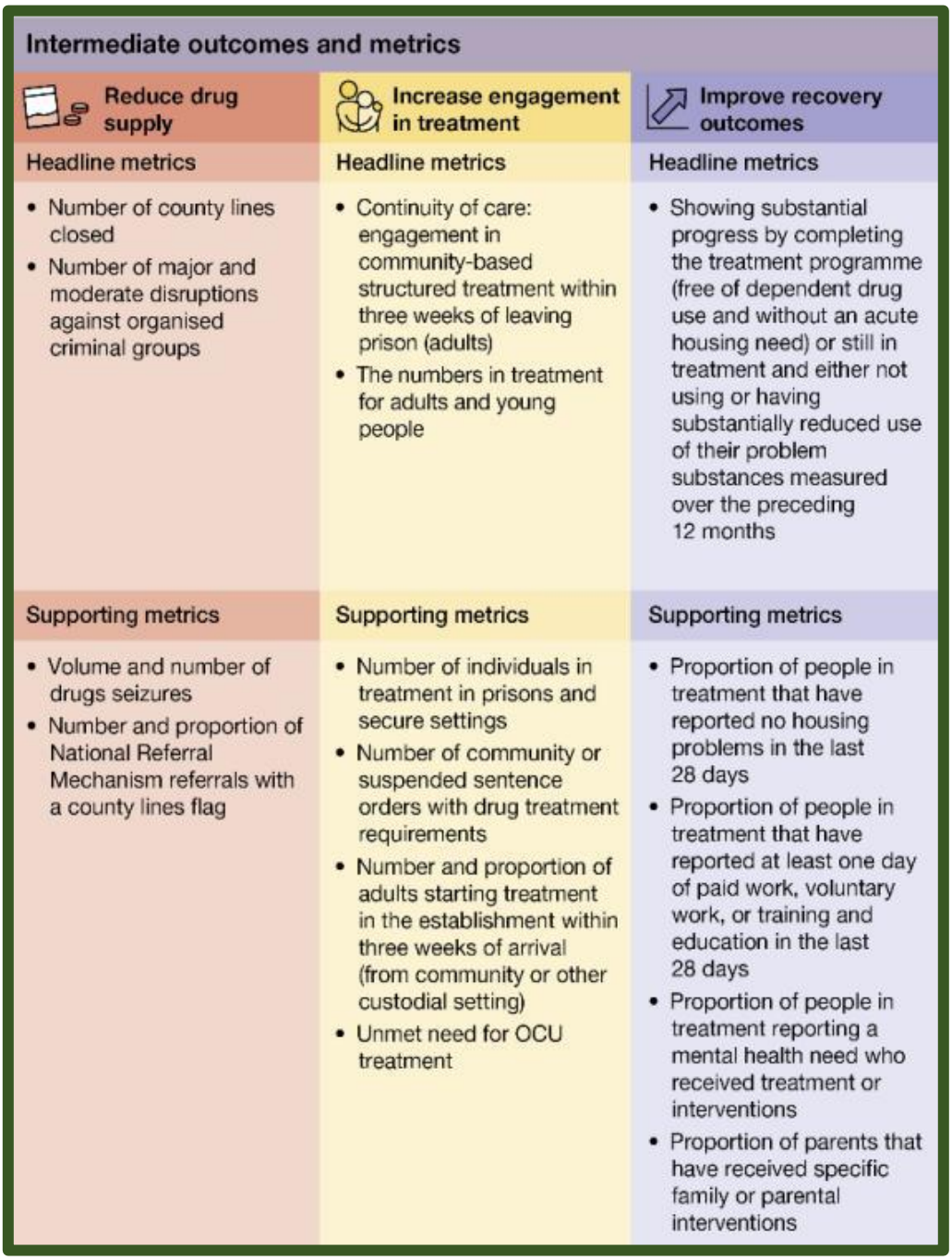
Appendix II – National Combating Drugs Outcomes Framework

Key strategic outcomes and supporting metrics

The framework sets out the Government's three strategic outcomes of reducing drug use, reducing drug-related crime, and reducing drug-related deaths and harm, delivered through the intermediate outcomes of reducing drug supply, increasing engagement in treatment and improving recovery outcomes.

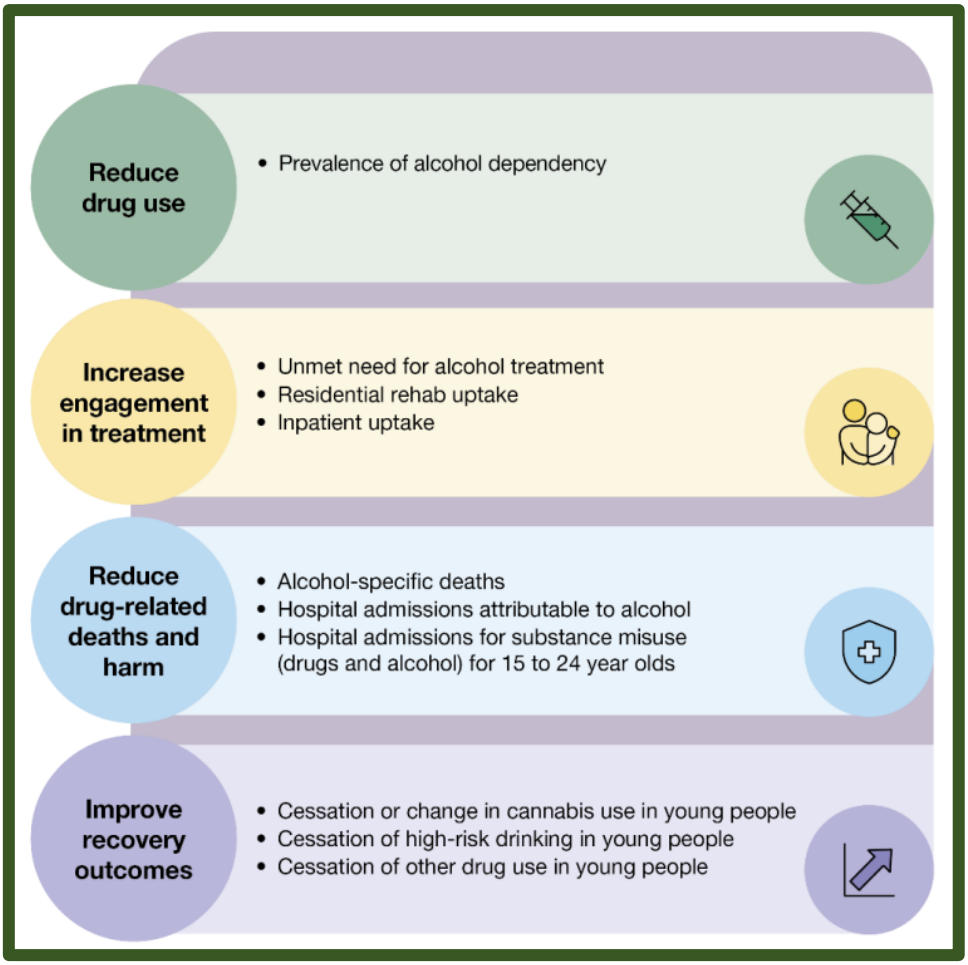
Strategic outcomes and metrics

Reduce drug use	Reduce drug-related crime	Reduce drug-related deaths and harm
Headline metrics	**Headline metrics**	**Headline metrics**
• Proportion of individuals reporting use of drugs in the last year • Estimated prevalence of opiate and/or crack cocaine use (OCU)	• The number of neighbourhood crimes; domestic burglary, personal robbery, vehicle offences and theft from the person • The number of homicides that involve drug users or dealers, or have been related to drugs in any way	• Deaths related to drug misuse • Hospital admissions for drug poisoning and drug-related mental health and behavioural disorders (primary diagnosis of selected drug)
Supporting metrics	**Supporting metrics**	**Supporting metrics**
• Number and proportion of households owed a homelessness duty with a drug dependency need • Rate per population of children of referral and assessments by social services with drugs as a factor • Number of permanent exclusions and suspensions and the proportion that are drug and alcohol related • Proportion of 11 to 15 year olds who think it is OK to take drugs to see what it is like, and think it is OK to take drugs once a week	• Proven reoffending within 12 months • Police recorded trafficking of drugs and possession of drugs offences • Hospital admissions for assault by a sharp object	• Hepatitis C prevalence (chronic infection) in people who inject drugs • Number and percentage of people in treatment that have died during their time in contact with the treatment system



Additional National Drug Treatment Monitoring System local metrics

In addition to the key metrics above that will be used for monitoring the overall performance of the strategy nationally and locally across central Government, the Office for Health Improvement and Disparities (OHID) will be monitoring the treatment and recovery system both nationally and locally in greater detail with the additional outcomes metrics outlined below. These metrics are also important for use by CDPs to monitor local treatment and recovery systems and will be included in local-facing reports produced by OHID.


Reduce drug use
• Prevalence of alcohol dependency
Increase engagement in treatment
• Unmet need for alcohol treatment
• Residential rehab uptake
• Inpatient uptake
Reduce drug-related deaths and harm
• Alcohol-specific deaths
• Hospital admissions attributable to alcohol
• Hospital admissions for substance misuse (drugs and alcohol) for 15 to 24 year olds
Improve recovery outcomes
• Cessation or change in cannabis use in young people
• Cessation of high-risk drinking in young people
• Cessation of other drug use in young people

Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	The Ten-Year Plan for Health
Report Reference Number	HWB71
Date of meeting:	19th November 2024
Written by:	Guy Kilminster
Contact details:	Guy.kilminster@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Councillor Jill Rhodes and Helen Charlesworth-May

Executive Summary

Is this report for:	Information ☐	Discussion X	Decision ☐
Why is the report being brought to the board?	To brief the Board about the engagement exercise underway to inform the drafting of the new Ten-Year Plan for Health and to consider and comment upon the draft Cheshire East Council response.		
Please detail which, if any, of the Health & Wellbeing Strategic Outcomes this report relates to?	1. Cheshire East is a place that supports good health and wellbeing for everyone ☐ 2. Our children and young people experience good physical and emotional health and wellbeing ☐ 3. The mental health and wellbeing of people living and working in Cheshire East is improved ☐ 4. That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place ☐ All of the above X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above X		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The Board are asked to review the draft response to the engagement and suggest additions or edits that might be required.		

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 October the Government and NHS England launched their engagement exercise to inform the new Ten-Year Plan for Health. The details of this are available at Change NHS

1.2 A Cheshire East Council organisational response has been drafted (see Appendix One) and is shared with the Board for comment, prior to internal sign off and submission to meet the closing deadline of 2nd December.

2 Recommendations

2.1 That the Board consider and comment upon the draft Cheshire East Council response to the Ten-Year Plan engagement exercise.

3 Reasons for Recommendations

3.1 To ensure that the Board are aware of the Ten-Year Plan engagement exercise and have an opportunity to comment upon the Cheshire East Council draft response.

4 Impact on Health and Wellbeing Strategic Outcomes

4.1 The Government has set out three priorities that the Ten-Year Plan will be focussed upon:

- moving care from hospitals to the community
- embracing digital transformation
- shifting from treatment to prevention.

These are all reflected within the Joint Local Health and Wellbeing Strategy 2023-2028 and also align with the aspirations of the Cheshire East ‘Blueprint 2030’.

5 Background and Options

5.1 The Secretary of State for Health and Social Care and the Chief Executive of NHS England launched 'Change NHS: help build a health service fit for the future: a national conversation to develop the 10-Year Health Plan' on 21st October 2024 NHS England » Change NHS: help build a health service fit for the future

5.2 Members of the public, those working across the health and care system and organisations are all invited to submit ideas and thoughts regarding the challenges facing the health and care system, and the nation's health more generally and on what the focus of the Ten-Year Plan for Health should be. The Organisational response template sets out a series of questions:

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?
Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?
Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?
Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?
Q5. Please share any specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in.

5.3 Cheshire East Council is responding to the engagement exercise and a draft response to these questions has been prepared with input from different services across the Council. This is attached as Appendix One.

5.4 All partner organisations have the opportunity to respond individually, but it was thought it would be helpful to share the draft Council response with the Board for information and comment.

6 Access to Information

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

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

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Cheshire East DRAFT Response

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

- Recognition that this needs to be a plan for health and wellbeing and health and social care services, not just the NHS. It needs to begin with an emphasis on individuals being empowered (and supported in being more health literate) allowing them to take responsibility for their own and their family's health and wellbeing and enabling families through a 'healthy household' approach and a 'healthy neighbourhoods' model (asset / strength-based utilising the community, voluntary, faith and social enterprise sector that will support Neighbourhood Health Services). The importance of prevention and early intervention must be emphasised and the recognition of the importance of addressing the wider determinants of health that impact upon individuals and communities as well as addressing all of the challenges facing the NHS **and** social care services. A systematic approach is required, rather than piecemeal improvement that fails to recognise the interdependencies within a very complex health and care system.

- Importantly, a 'neighbourhood health service' and 'shifting care into the community' must not mean shifting a medical model into communities. It requires a new proactive model of care that works more effectively with communities and wider partners.

- Underpinning the Plan should be a 'strength-based' practice approach across the health and care system, that recognises what positive steps are already being taken and advises/coaches about the next steps that need to be taken, rather than focusing on the deficits and providing paternalistic solutions that can generate further demand.

- We would like to see improved and extended (at least three years) financial settlements for local authorities (including the Public Health grant). These should take account of projected demand pressures and inflationary pressures, noting for Social Care services that, as opposed to RPI, the main driver of rising prices is in relation to increases in the national living wage. Most externally commissioned care costs are driven by this. Using the current financial year (2024-2025) as an example, the national living wage increased by close to 10% whereas councils were restricted to raising Council Tax by 5% - immediately creating a financial pressure and in turn, restricting the council's ability to respond in this area.

  The negative impacts of the wider determinants of health and health inequalities have increased as council budgets have reduced the services and resources available to support those in most need. This includes amongst other things housing, anti-social behaviour, provision of library and youth

services, employment support, benefits availability, community services, accessibility of green spaces etc.

If the NHS and Local Authorities have security of funding for at least a 3-year rolling base this will further enable them to commission services from the community, voluntary and social enterprise sector on a longer term basis rather than on a year-to-year basis, broadening the availability of services, strengthening the neighbourhood service provision and creating a more sustainable sector.

- A commitment to investment in Public Health to make up for the 25% reduction in the Public Health Grant since 2015. The reduction in the grant over the last 9 years and the internal financial pressures of local authorities have impacted upon the level of preventative work that Public Health teams have been able to commission or instigate. Similarly, there needs to be a move away from time limited grants (for example in relation to substance misuse) as these make it very difficult to plan in the long term.

- A recognition of and commitment to the 'Marmot principles' as set out in *Fair Society, Healthy Lives (The Marmot Review) (2010)* and *Health Equity in England: The Marmot Review 10 Years On (2020):*

  - giving every child the best start in life
  - enabling all people to maximise their capabilities and have control over their lives
  - ensuring a healthy standard of living for all
  - creating fair employment and good work for all
  - creating and developing healthy and sustainable places and communities.

  Inequalities should be considered in every decision and funding provided to areas that reflects inequality challenges (recognising that rural areas face particular challenges in relation to inequality and access to services).

- We recognise the immense challenges facing all parts of the NHS and social care providers in relation to the recruitment and retention of a skilled, qualified and experienced workforce. Addressing these issues will need to be a key part of the 10-year plan.

- Restore the grants to undergraduate health courses to reduce student debt as a measure to improve recruitment and retention. This could be linked to the individual agreeing a minimum period of service to the NHS or an accredited social care service, e.g. a hospice.

- A commitment to moving care closer to home and out of acute settings wherever possible, and that the care should be holistic, person centred (not condition focussed) that considers physical, psychological and social wellbeing and that engages the household whenever feasible, the patient and their relatives.

- A commitment to address funding and capacity issues in Primary Care. Many people are now turning to social care and secondary care (A&E departments) due to primary care limitations.

- Delegation of powers and resources from the centralised Cheshire and Merseyside Integrated Care Board to Place-based ICB teams and the neighbourhood partnerships that are delivering on-the-ground transformation (but are hampered by lack of capacity and access to finance).

- Standardisation of community services offers to address variance across the Place, to provide good access and equity for all Residents.

- A recognition of the need to stop major re-organisations of the NHS and enable the service to focus on service improvement. This would include reducing the bureaucracy of NHS England, Integrated Care Boards and the Department of Health and Social Care, including freezing recruitment in the civil service whilst similar restrictions are placed on NHS Trusts.

- Mitigate the pressures placed on NHS providers by reviewing the requirements of CQC inspections. Enable Trust Non-Executive Directors to have a greater role in improving services within their Trusts.

- Reduce the regulations on NHS trusts and their use of financial resources to enable them to invest in their local services and play their full role as anchor institutions. This would enable the NHS and Local Authorities to invest in the neighbourhood hubs favoured by the government.

- A commitment to making every health and care contact count (MECC) in terms of lifestyle and social support to enable every contact between a health and care professional and a patient/service user to have benefits in relation to the ‘whole person’s’ health and wellbeing, not just the condition being treated.

- Recognition of and a plan to address the crisis in SEND, both in terms of local authority funding and capacity to meet the increasing demands. In particular there needs to be more weight given to education’s role in preparing for adulthood and holistic wellbeing (in childhood and adulthood). This should be driven by the department for Education who should recognise the importance of more balance between these outcomes and those relating to education.

- Children and Young People with SEND should be provided with more information at a much earlier stage regarding opportunities in adulthood. This should include provision of adult role models and celebration of successes, rather than system and national focus on crisis. In addition, newly diagnosed young people should be adequately supported with appropriate information about their condition, support available locally, how to thrive with their condition and opportunities to connect with others with similar diagnosis. There also needs to be more recognition of the psychological adjustments and support required for both children and families when diagnosed with a neuro-divergent condition and/or disability.

- Recognition of and a plan to address the crisis in mental health services, in particular the lack of specialist acute mental health service provision for people with serious mental ill health who find themselves in unsuitable settings in hospital A&E or Police cells.

- Crisis support for acute mental health problems and the impact on A&E due to the lack of beds in mental health hospitals, as well as the difficulty of discharging in-patients into the community due to lack of supportive living accommodation.

- Access to different forms of supported living for people with physical and/or mental health problems. Colleagues in the social housing sector are considering stepping away from some forms of housing because of the challenges of providing it.

- A review of the thresholds into secondary mental health care and a clear pathway for those with dual diagnosis - i.e. substance misuse and mental disorders

- Recognition of and a plan to address the issue of Deprivation of Liberty Safeguards. Too many people are waiting too long for a Deprivation of Liberty Safeguards (DoLS) authorisation, despite multiple examples of local authorities trying their best to reduce backlogs and ensure sustainable improvement.

- A population health system that measures wellbeing rather than only illness and considers impact of professional interactions on overall levels of wellbeing (for example, the ONS4).

- A new approach to tackling stigma - raise awareness of the prevalence of issues and that people are not alone. Key areas of stigma are: disability, death, poverty, mental health and obesity.

- The use of all national policy levers and all Government Departments to maximise public health (for example across planning, housing, transport,

environment etc). For example, we are supportive of introducing highway infrastructure that promotes active travel, but whilst it is accepted that the Department for Transport may wish to make proportionately more of the capital funding from government reliant on demonstrably encouraging active travel, there needs to be an acceptance that there are significant practical limits to the extent to which additional infrastructure can be introduced within the course of routine capital maintenance. Without providing revenue funding to support capital measures introduced, financial prudence and common sense would suggest that councils can't commit to accepting capital funding to create assets they cannot afford to maintain.

- Transport has an important role to play in the Ten-Year Health Plan to improve health and wellbeing and as a tool to support prevention and early intervention. Transport provides access to amenities, services and employment, and it promotes socialisation. Mobility is an essential part of a place. The way we move affects our health as individuals and as a community, depending on the mode of transport we use.

  There are three key areas which link transport and health and wellbeing:
  - o Transport and access: Transport plays a key role in improving access to services (i.e. health, education, employment), particularly for vulnerable groups like older people.
  - o Mode of transport: Mode of transport affects physical and mental health, including physical activity and commuting time.
  - o Wider effects of transport and infrastructure: Transport can facilitate social interactions and promote social inclusion.

- The health benefits of active travel are clearly established with a wealth of evidence to demonstrate the benefits. There are opportunities for health workers to be supported to prescribe walking and cycling for health, wellbeing and to promote active travel for everyday journeys.

- It is important that the plan recognises the role of local bus services in providing accessibility and therefore supporting health and wellbeing. There were 2.8 million bus passenger journeys made between 2022 and 2023 and a significant proportion are older and more vulnerable people. Provision of bus services support people to remain independent in their own home for longer. In addition, young people rely on bus services to access school and further education, training, apprenticeships and opportunities which would not otherwise be possible – all of which relate to wider health outcomes.

- Community transport has significant benefits to local communities by providing access to health care, shopping and opportunities for social interaction. Many good neighbour schemes and community car schemes are provided specifically for access to hospital. Recognising and valuing the role of these services as part of the Ten-Year Health Plan will be important.

- Recognition that for some local authorities that border other Integrated Care systems, that there is a need for connectivity with those neighbouring systems that our residents may access services within and a mechanism to ensure inclusive conversations with the ICB that we are a part of (so for Cheshire East a part of Cheshire and Merseyside, that includes Greater Manchester, Derbyshire and Staffordshire ICBs)

Useful links

The state of health care and adult social care in England 2023/24 - Care Quality Commission

The case for neighbourhood health and care | NHS Confederation

https://www.nhsconfed.org/publications/working-better-together-neighbourhoods

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Challenges

- Critically, the neighbourhood health services need to be co-produced in partnership with commissioners, providers, the local authority, the local voluntary, community and social enterprise sector, residents etc involved in the design. An imposed 'top-down' solution will not create the local buy-in and ownership that is required.

- The double running costs of the transition phase have prevented this happening for the last 15 years. Investment (capital and revenue) is needed in community and primary care services to create the infrastructure and staffing to take on these services, whilst at the same time continuing to run them in the hospitals until the community provision is ready to receive patients. At that point the costs will transfer from the hospital to the community. The recent cost of living / inflation crisis has exacerbated the issue as resources have become even tighter.

- Many GP surgeries lack capacity and infrastructure to provide additional services and struggle to provide the services they currently do. Revenue and capital investment will be required to facilitate Neighbourhood Health Services.

- The concept of 'integrated care' has not yet delivered what it was supposed to deliver (based on the concept of 'Accountable Care organisations'. Acute Trusts are not responsible for their catchment area's population health, only their own service provision. They continue to deliver the care they have always delivered and to be financed and performance measured in the same

way. This prevents any shift of capacity into communities. The performance and inspection regime will need to change to consider overall population health, not just organisational performance measuring, to facilitate a significant shift to a neighbourhood health service.

- The reluctance of clinicians and other professionals to use new technology at scale and as effectively as we could e.g. virtual consultations for people at care homes allowing ambulance personnel to undertake see and treat initiatives (also for people with chronic illness who are at home). The Prison Service is making better use of tele-consultation than the NHS, so learning can be taken from there.

- Hospitals too often bring back patients for review at out-patient clinics when other alternatives are available e.g. teleconsultations. Particularly in rural areas this places great pressure of patients and their families to travel often by public transport.

- The lack of 7-day services and infrastructure.

Enablers

- Virtual wards and the use of different technology will allow us to do more in communities.

- Create more flexible opportunities for work. For example, staff may be willing to provide brief hours of work that fit in with carer responsibilities, e.g. provide 3-4 hours of work a week to enable nursing staff can have meal breaks. Too many nurses report not being able to take proper breaks due to pressures on wards. This would also help to reduce the employment of agency staff.

- Provide care whenever feasible in the home to avoid having to transport people by ambulance to clinics and then back home again.

- A training and development academy for social care providers to enable them to undertake delegated health and care tasks to ensure a competent and skilled workforce and offer.

- Diagnostic services in communities.

- Re-purposing funding away from acute to care communities to fund local service e.g. therapy, GP and DN.

- Enhanced community reablement, mental health reablement and dementia reablement.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Challenges

- The scale and complexity of the NHS and wider care system and the costs associated with significant investment in technology. There is also a challenge in achieving consensus in relation to the nature of the technological improvements made and we know from experience that clinicians and other professionals will not use technical/digital solutions that they don't feel they own or add value to their role. The Cheshire Connected Care Record went live in 2017 to share summary patient data across GPs, Acute, Mental Health and Social Care Services. However, for various reasons usage is minimal.

- Digital transformation risks exacerbating inequalities through digital exclusion. More effort and resource will be required to support those with greater digital need for example those with literacy challenges, disability, low incomes, rural broadband challenges, or in older age.

- Cybersecurity and mitigating against the risks of significant ransomware related shutdowns.

- Medical training does not adequately train staff in the use of technology to the extent that we should. It needs to be a part of undergraduate training and post graduate syllabi (eg. virtual consultations, digital data sharing, AI etc).

- Suppliers are not employing open standards to facilitate data sharing and interoperability across systems. Data standards that facilitate easy sharing between different supplier's systems need to be enforced.

- The single biggest failure is the fact that there are multiple standalone systems that don't integrate with one another within the same hospitals/ ICB areas let alone across the country – until a common approach is adopted there is no chance of progress – also a national approach to Caldicott principles is required.

- There also need to recognise we still have a whole generation for whom digital isn't the default.

Enablers

- A commitment to reducing digital exclusion by providing funding and/or initiatives to upskill residents and staff in the use of digital resources.

- The use of creative technology e.g. the Happiness Programme which is evidenced based in terms of falls prevention, social stimulation and improved dexterity for those people with Dementia or similar cognitive conditions

- Population health and segmentation and proactive risk stratification planning e.g. high intensity users, frailty and dementia.

- Data scientists and BI performance analysis.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Spotting Illness

Challenges

- Waiting lists, lack of staff and resources across all parts of the system, GPs, Mental Health, Acute Trusts and Community Services.

- A reluctance to share patient data, nervousness re. data protection.

- Over reliance on what is offered e.g. screening – identifies people who have disease but also those for whom it may never cause harm. This can lead to unnecessary demand.

- Information regarding a family history of a condition is not necessarily used as effectively as it should be to screen/advise the next generation. There is potential to do more.

- Individuals unable to access any provision to even start the discussions, voice concerns etc. Many can't use the digital appointments etc so end up ignoring early warning signs.

Enablers

- AI facilitated screening

Tackling the causes of ill health

Challenges

- Societal norms that accept and promote food and drinks high in fat, salt and sugar, over-eating, drinking to excess, drug-taking and vaping. A failure by successive governments to address the wider determinants of health in more deprived communities including, poverty, educational attainment, raising and supporting young people's aspirations, the quality and affordability of housing, reasonably paid and secure employment, neighbourhoods and environments that deter or prevent people from walking or cycling; poor air quality, reduced or removed funding for key public services that focus on prevention and early intervention, including NHS dental services, maternity services, mental health services, career advice and youth services; over-complexity in the system that causes confusion for people seeking help and advice at an early stage (they give up and don't bother)

- As the demand for affordable housing increases, we will see more residents living in inappropriate housing including poor housing conditions which can impact on their health and wellbeing.

- Bias in the data as it primarily comes from the white British population, but other minorities may be more at risk

- Being aware of mitigating against data in relation to certain communities having poorer life chances because of way society sees them. Discrimination e.g. screening that fails to take into account different skin colours/ clinical overshadowing for people with learning disabilities and life expectancy is therefore reduced (particularly for Gypsy, Roma and Traveller Communities). Similarly, language Barriers and information which is sent to patients is not in their own language, causing them to miss appointments and has led to fatalities.

- Time for clinicians and care professionals to ask those holistic questions. There is a lack of confidence / knowledge regarding solutions to improve social wellbeing being that are available and a lack of funding for solutions to be available.

- Lack of understanding of behaviour change theory - this is vital for everyone to understand, both in terms of their own personal behaviours and in terms of advising others. There are instances of poor implementation of the Mental Capacity Act when people are unable to make informed decisions about their treatment, and this can lead to patients being unable to receive appropriate health care pre-admission and pre-discharge.

- The ethical challenges of being able to react to crisis but also understanding the important role of avoiding crises.

- Stigma associated with disability, death, poverty, mental health and obesity. People (both patients and professionals) are afraid of these issues therefore don't raise them until crisis point rather than at the point of early intervention. We need a whole range of campaigns to tackle stigma in relation to these issues. We also need to ensure that health needs to be a key theme across all policies - for example, wellbeing and preparing for adulthood outcomes should be as important as educational attainment outcomes. Similarly, there needs to be better recognition of coercion and control by family members or Domestic Abuse, leading to patients being unable to attend appointments.

- There should be a whole systems approach to tackling overweight and obesity led by national measures such as extending the tax on sugary drinks to foods excessively high is saturated fat and salt. Policies on obesity should consider planning to promote physical activity, food provision and support

regarding digital device usage (avoiding sedentary behaviour) rather than focusing on weight loss injections as a panacea of long-term condition prevention.

- Universal primary prevention should not be lost amidst secondary prevention and targeted prevention initiatives: remembering Rose's prevention paradox- the greatest numbers will benefit through hybrid approaches, yet the NHS tends to promote targeted and secondary prevention as a priority.

- Lack of awareness that population health management requires the following:

  - Robust evidence-based interventions that can be applied to the populations identified
  - A systematic approach (such as use of the Joint Strategic Needs Assessment) to assess the most beneficial population/ health issue that population health management resource should be applied to
  - An understanding that population health management is moving into "screening" and as such careful consideration of screening criteria is relevant. Adverse impacts should be carefully evaluated in relation to population health management approaches.

Enablers

- Continuation and expansion of social prescribing models as part of the approach to prevention early intervention

- A more proactive, inclusive and holistic approach to SEND and mental health.

- Innovative approaches to homelessness such as the Macari Foundation in stoke on Trent offer one model of support: https://macari-foundation.co.uk/the-centre/

Q5. Please share any specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

• Quick to do, that is in the next year or so

- Three-year funding settlements for local authorities (including the Public Health Grant)

- Ring-fencing prevention budgets within other budgets (NHS and other Government departments)

- Safe injection suites to reduce drug related deaths.

- Reinstatement of funding for hospice care (for hospice at home and in-hospice care). This is critical in relation to improved palliative and end of life care and in response to the Assisted Dying bill.

- Promote advance care planning in primary care

• In the middle, that is in the next 2 to 5 years

- Introduce a 'polluter pays' approach to taxation eg public health harms of gambling (costs borne by companies making profits. Additional social value contributions from companies that are producing products that are negatively impacting upon or facilitating negative impacts upon population health (eg. foods high in salt, fat and sugar, vapes, social media, mobile phones etc)

- The banning of vapes except as a smoking cessation tool.

- The introduction of minimum unit pricing for alcohol. Widening the tax advantages of lower alcohol drink options e.g. 2.5% for beer and making them more accessible within pubs and bars

• Long term change, that will take more than 5 years

Review in light of H&W Strategy / Blueprint

Cheshire East Place System Winter Plan 2024/2025

Version 3: 11/11/2024

Slide Index

Review of Winter Plan 2023/24 – Reflection and Learning

Our Joint System Reflections

- Staff capacity to support change within identified timescales
- Workforce recruitment difficulties in recruiting alongside a growing and increasingly complex workload
- Non-Recurrent funding streams, not knowing how much funding will be available and when
- To work together on a joint systems Communication Plan
- The two Acute Trusts are working with ECIST to improve criteria led discharges and weekend discharge planning
- Continued development of virtual wards
- Cheshire East System focus is on all year-round operational resilience which is resource intensive

Winter Plan Risk Profile

Whilst mobilising the System Winter plan and enacting a number of additional Winter schemes that provided additional capacity, several wider system competing priorities and risks where managed at a system level during Winter as detailed below:

- Spikes of significant operational pressure across the system including challenges in discharging people to the most appropriate care settings such as specialist dementia nursing placements and domiciliary care in rural locations
- Winter Planning and ongoing assurance monitoring
- System recovery following Bank Holiday breaks and junior doctors' industrial action
- Raac Plank risks at Mid Cheshire Hospital Foundation Trust
- Responding to regional and national funding directives and producing capacity plans, monitoring spend and reporting on activity
- Maintaining quality and safety provision for the people of Cheshire East
- Workforce Challenges across the Health and Social Care system
- Junior Doctor Industrial Action

All of the above additional system challenges continued to be effectively managed and priorities across the system which should be recognised as exemplary joint system partner working in achieving across our Integrated Care System in Cheshire East Place

All of the above additional system challenges continued to be effectively managed and priorities across the system which should be recognised as exemplary joint system partner working in achieving across our Integrated Care System in Cheshire East Place

Introduction - Forecast Winter 2024/25

Winter planning is a statutory annual requirement to ensure that the local system has sufficient plans in place to manage the increased activity during the Winter period and plans have been developed in partnership with Cheshire East system partners across the place.

The overall purpose of the Winter plan is to ensure that the system is able to effectively manage the capacity and demand pressures anticipated during the Winter period October 2024 to 31 March 2025.

Our system plans ensure that local systems are able to manage demand surge effectively and ensure people remain safe and well during the Winter months.

The planning process considers the impact and learning from last Winter, as well as continued learning to the ongoing UEC system priorities.

Plans have been developed on the basis of robust demand and capacity modelling and system mitigations to address system risk.

Our system ambition is to ensure a good Winter is delivered by supporting people to remain well and as healthy as possible at home, having responsive effective services, and a system that is resilient, resolution focused and has a shared vision to deliver meaningful positive Health and Wellbeing outcomes for the population of Cheshire East

Forecast for Winter 2024/25

The following challenges have already been identified

- Cost of living rises
- System workforce challenges across the ICS.
- Care Home beds capacity challenges (dementia nursing beds)
- Seasonal flu vaccination remains a critically important public health intervention and a key priority for 2024 to 2025 to reduce morbidity, mortality and hospitalisation associated with flu at a time when the NHS and social care will be managing winter pressures whilst continuing to recover from the impact of the coronavirus (COVID-19) pandemic.
- This year's Autumn flu and Covid vaccine programmes will start later. Vaccinations began in October 24 for those most at risk
- Mental Health – ED & In patient mental Health delays
- Primary Care collective action
- Urgent care recovery
- Elective Recovery
- Additional NHS funding is not expected in Quarter 3 & 4
- Providers have identified additional high impact interventions. Prioritisation process subject to additional funding
- Clear message from the North West Winter Event 2023 – 'not to start anything new'

Delivering operational resilience across the NHS this winter

January 2024

Recovering Urgent & Emergency Care (UEC)

Primary Care Recovery Plan

Elective Recovery Plan

} Strong basis to prepare for winter

Key Ambitions 2024/25:

(1) 76% of patients being admitted, transferred, or discharged within 4 hours

(2) Ambulance response times for Category 2 incidents to 30 minutes on average

(3) The percentage of people (type 1 attendances) who are delayed over 12 hours from arrival to the ED. Target is <2%

(4) 14 day length of stay (LOS) – target is <25%

Key Focus

- UEC recovery plan – ensuring high-impact interventions are in place
- Operational surge planning
- Effective system working across all parts of the system
- Supporting our workforce
- Provider Market Sustainability & Oversight
- Good quality care and support for people

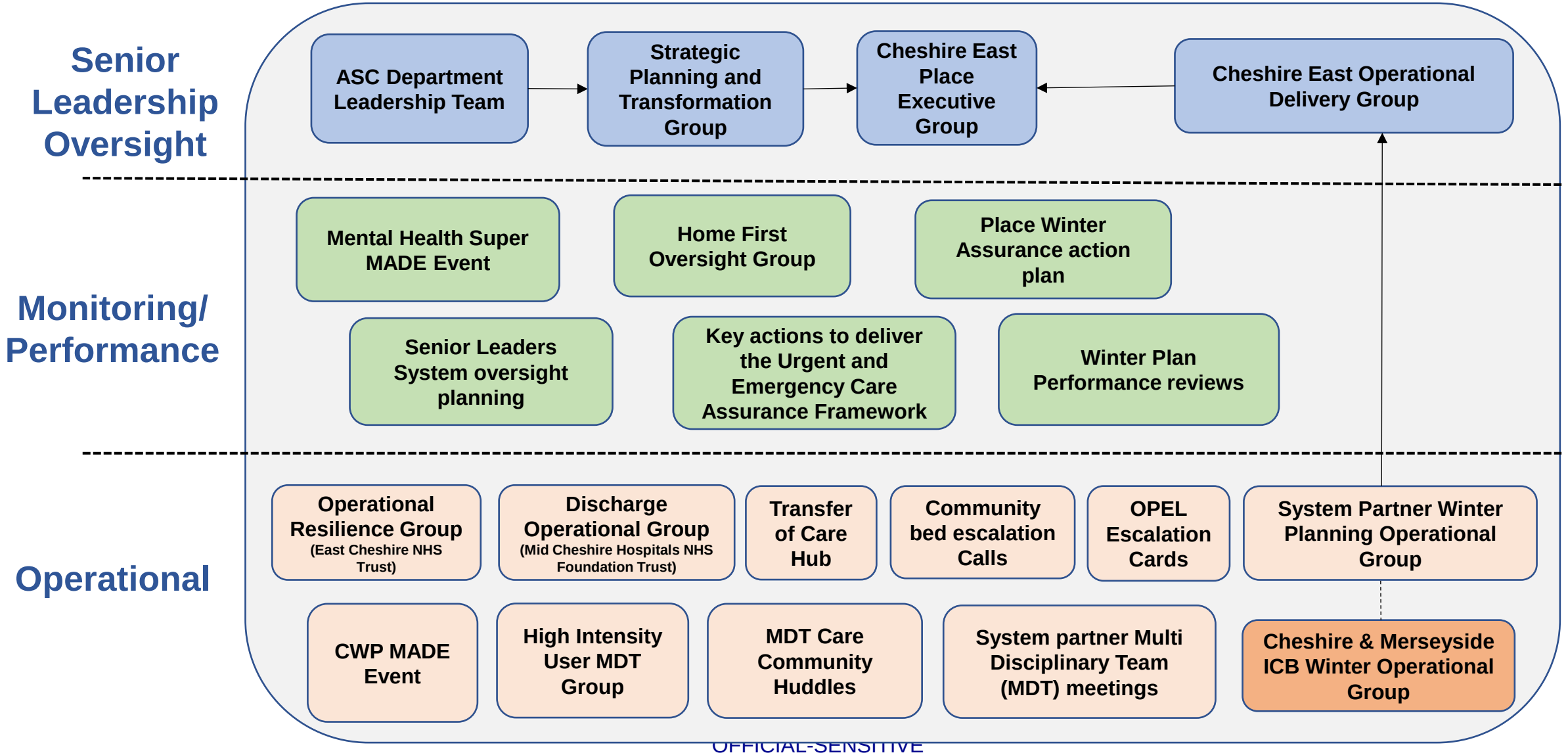
Ambition for Winter 2024/25

A&E 4-hour standard	• 76% of patients being admitted, transferred or discharged within 4 hours
Cat 2 ambulance mean response time <30 mins	• Category 2 ambulance calls are for condition such as stroke or chest pain that require rapid assessment
12-hour time in department	• The percentage of people (type 1 attendances) who are delayed over 12 hours from arrival to the ED. Target is <2%
14-day LOS	• target is <25%

Our system ambition is to ensure a good Winter is delivered by supporting people to remain well and as healthy as possible at home, having responsive effective services, and a system that is resilient, resolution focused and has a shared vision to deliver meaningful positive Health and Wellbeing outcomes for the population of Cheshire East

Monitoring, Oversight and Governance Structure

NHS
Cheshire and Merseyside

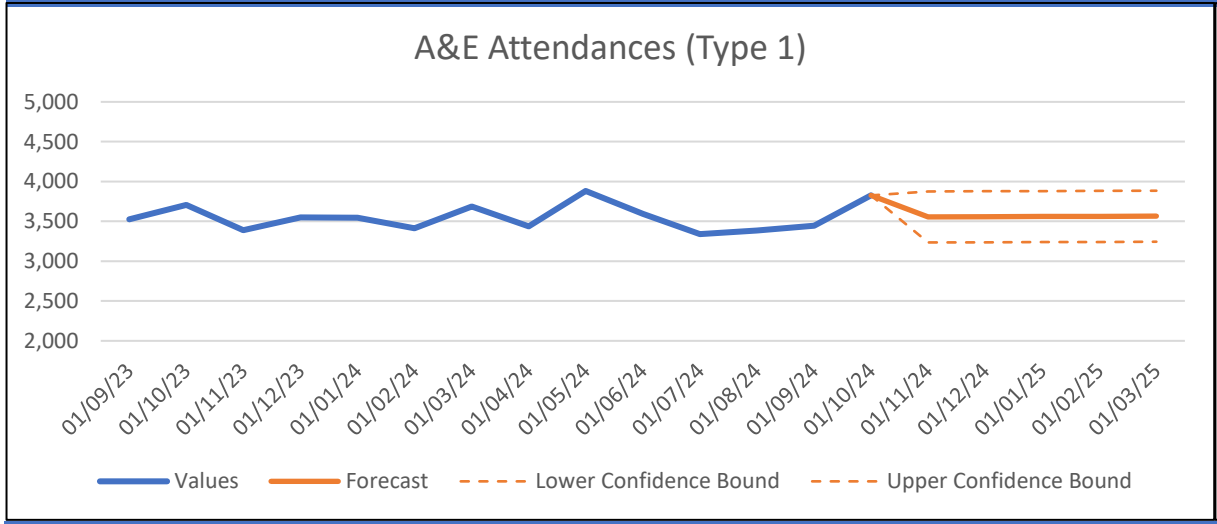


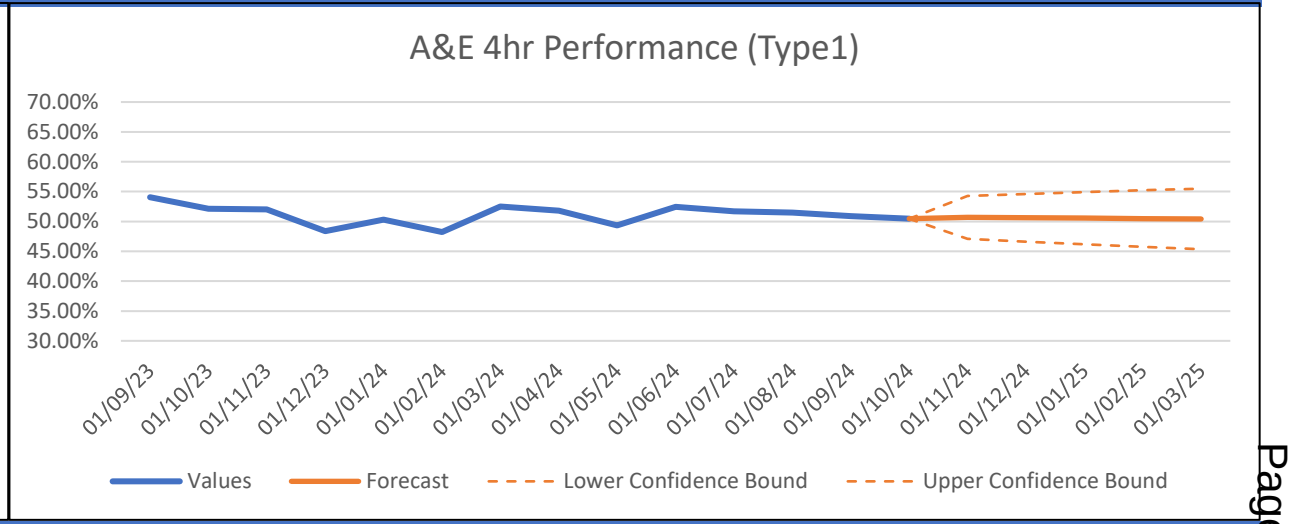
Demand Forecasting

Context:

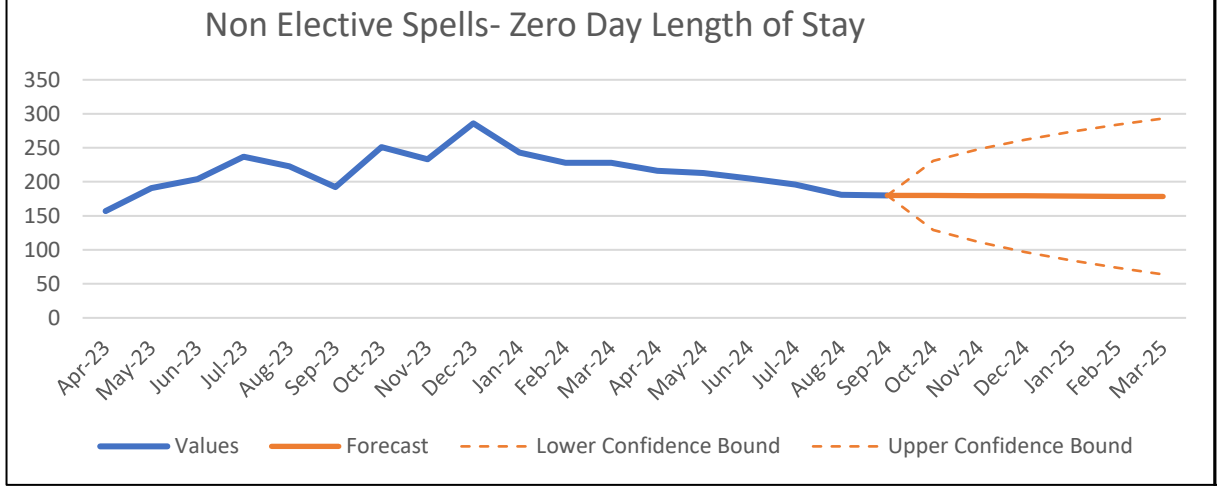
ECT Urgent & Emergency Care Activity Summary. This includes A&E activity and 4 hour performance and Emergency Admissions.

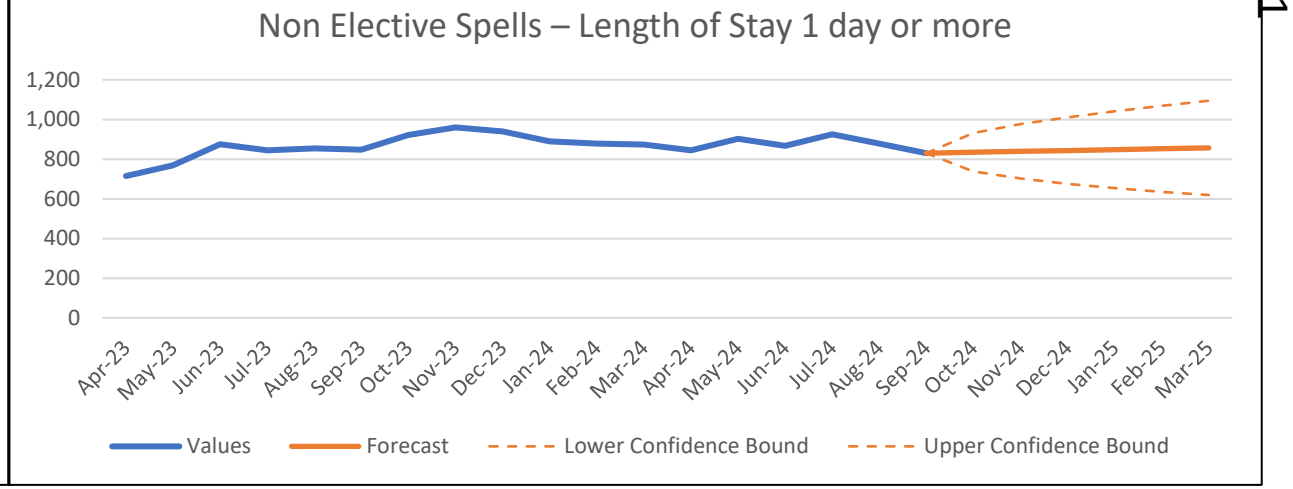
East Cheshire NHS Trust – A&E Attendances & Performance





East Cheshire NHS Trust – Non Elective Spells

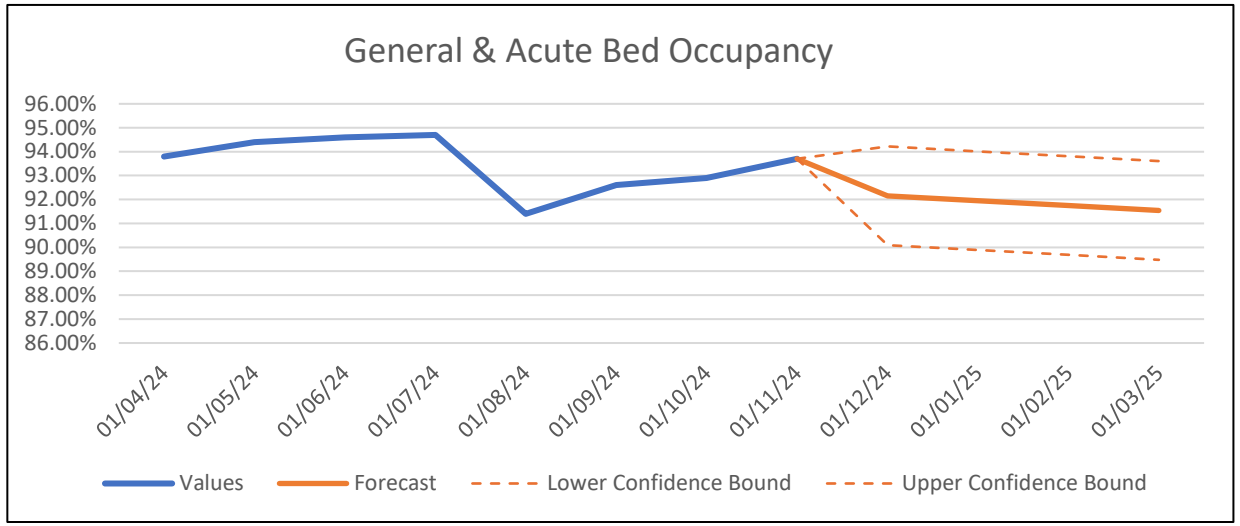


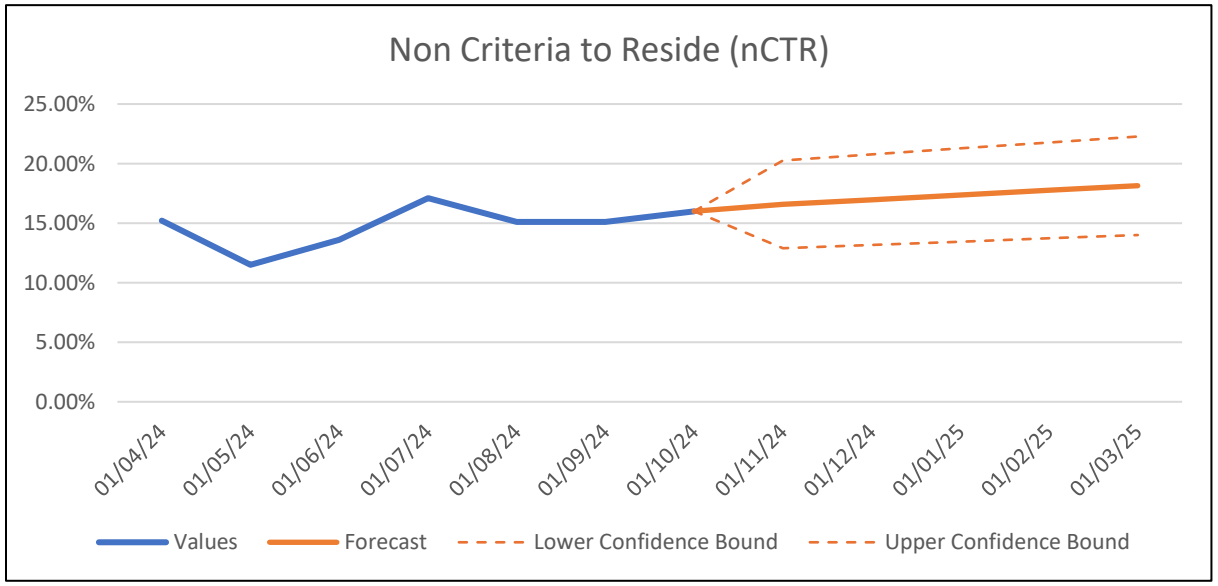


Data Source: ECDS & SUS inpatients

Demand Forecasting – Bed Occupancy & Non Criteria to Reside

East Cheshire NHS Trust

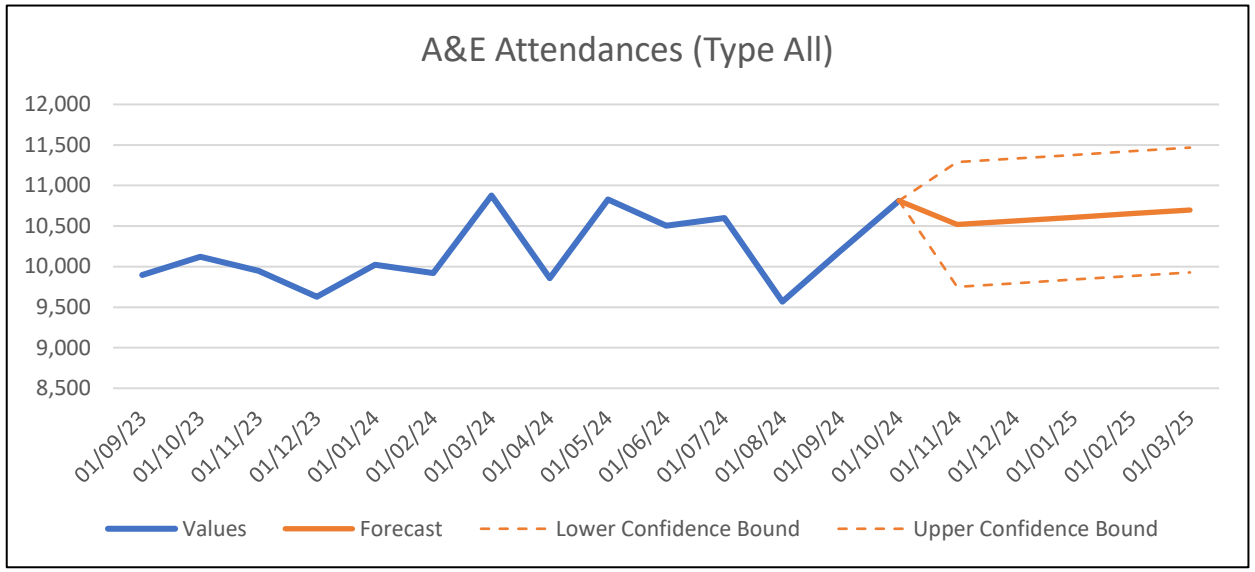


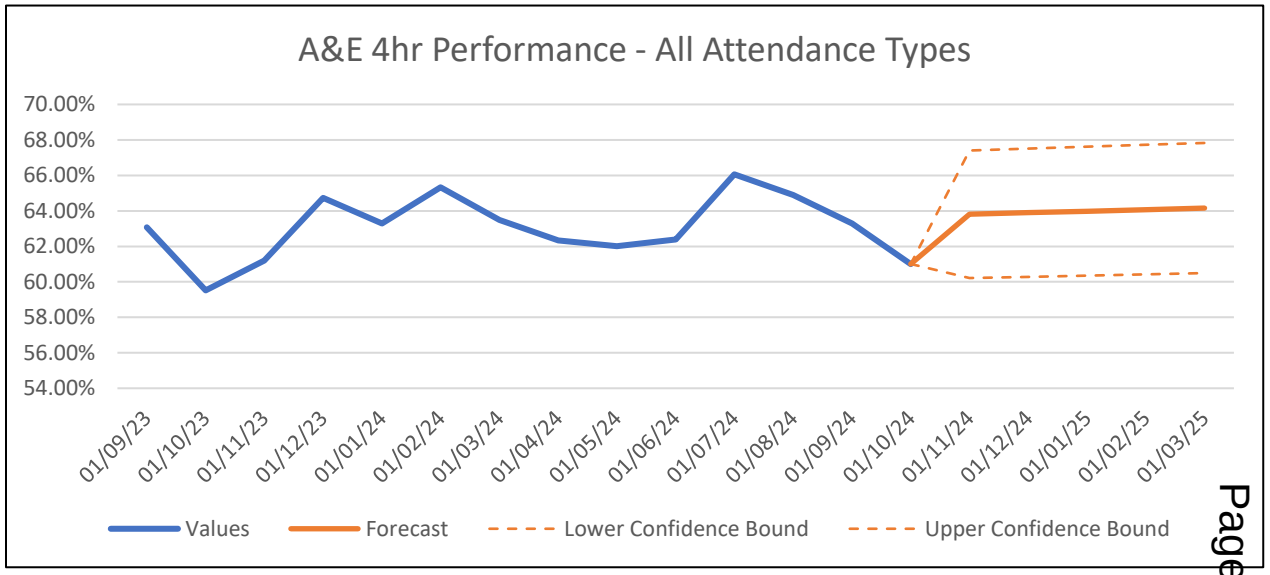


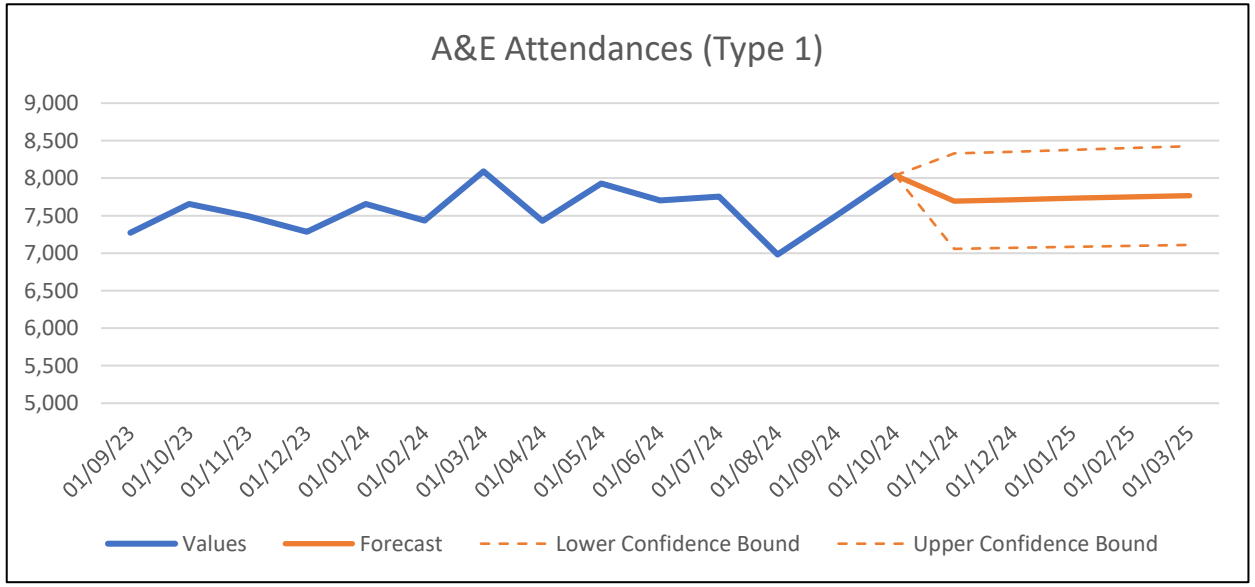
Data Source: ICB UEC Recovery Dashboard

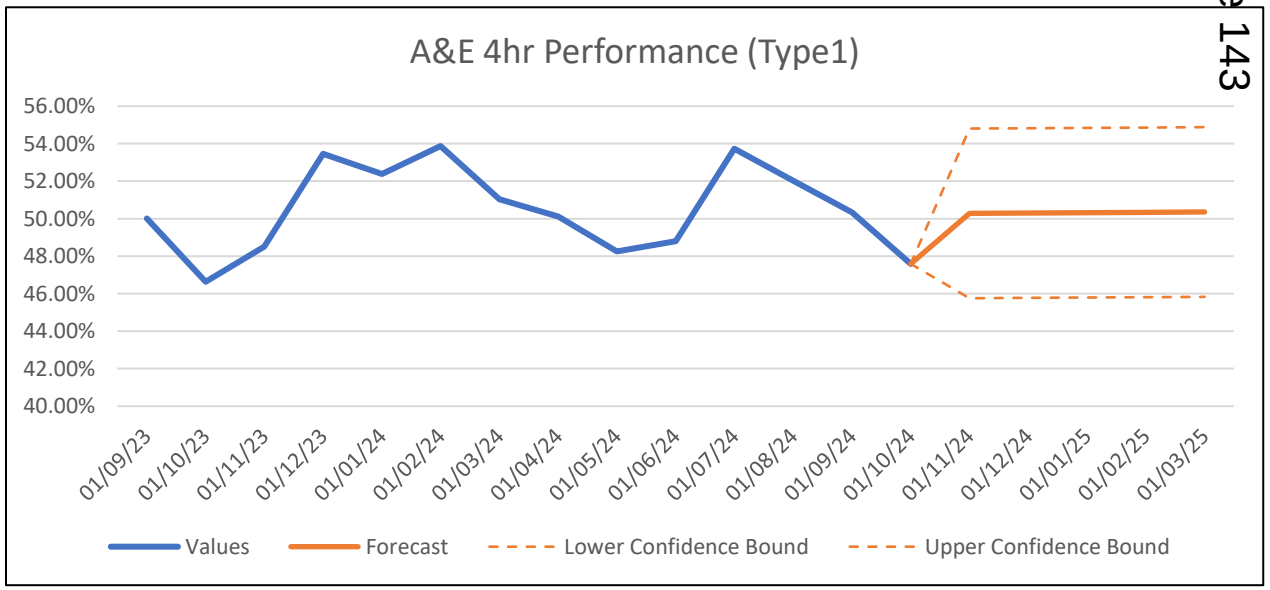
Demand Forecasting

Mid Cheshire Hospitals Foundation Trust - ED





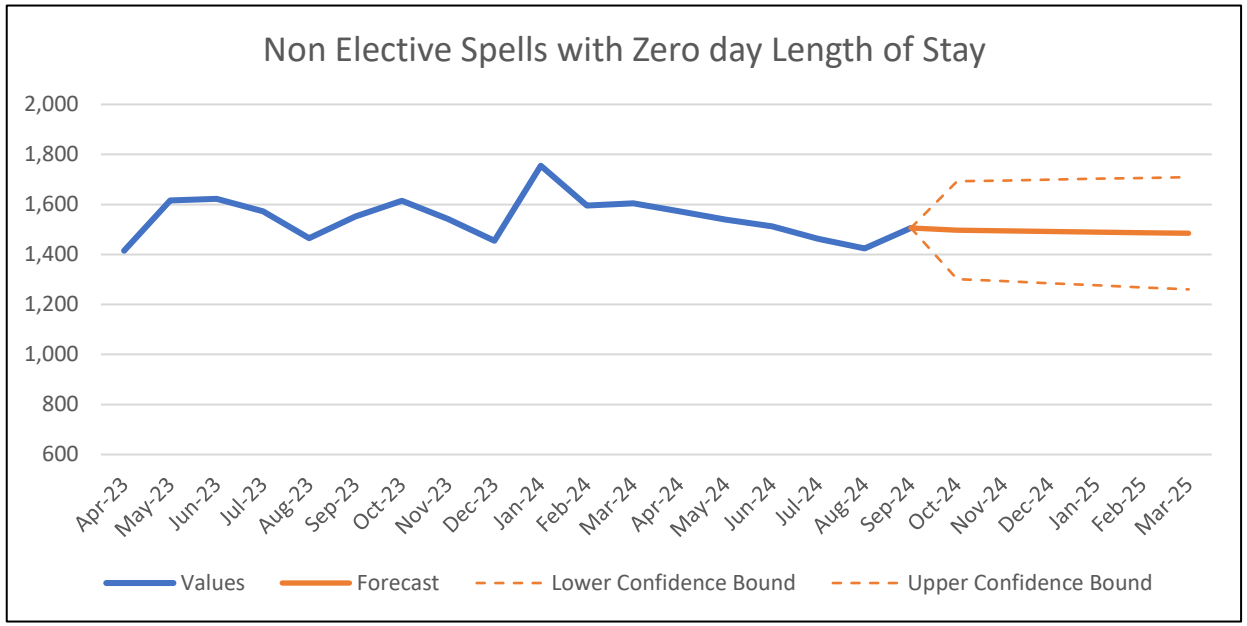


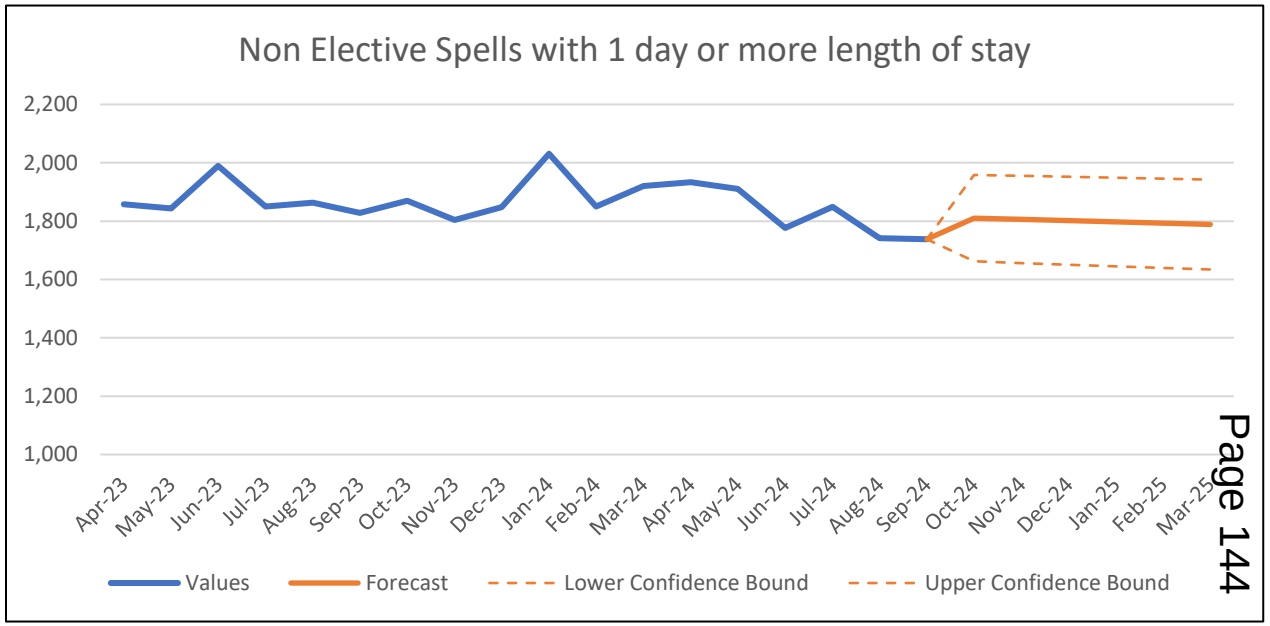


Data Source: ECDS & SUS inpatients

Demand Forecasting

Mid Cheshire Hospitals Foundation Trust - NEL

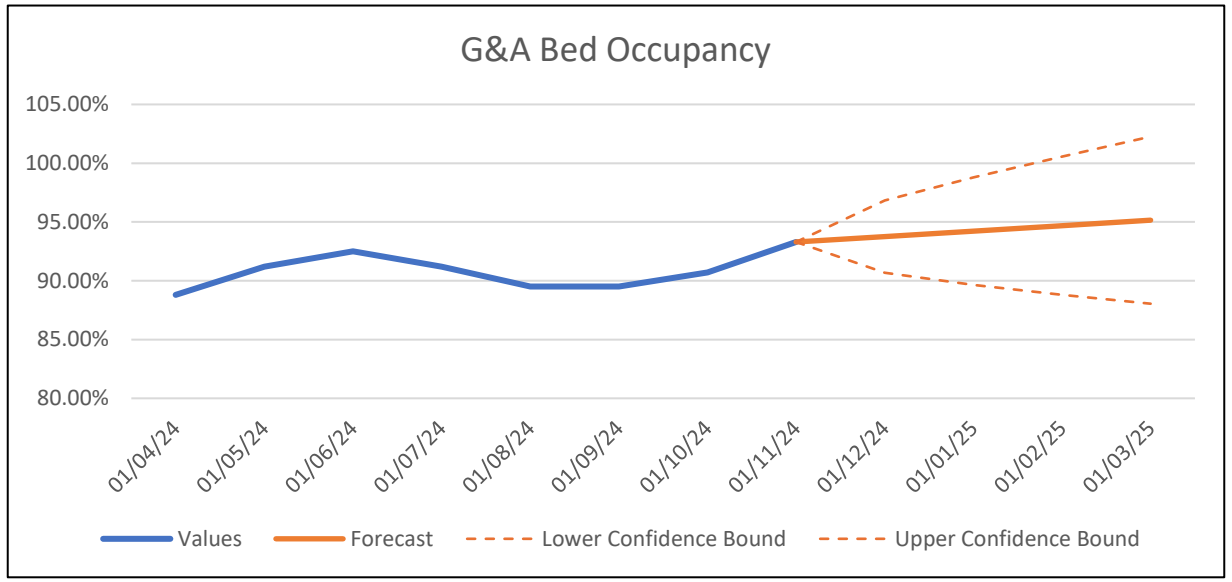


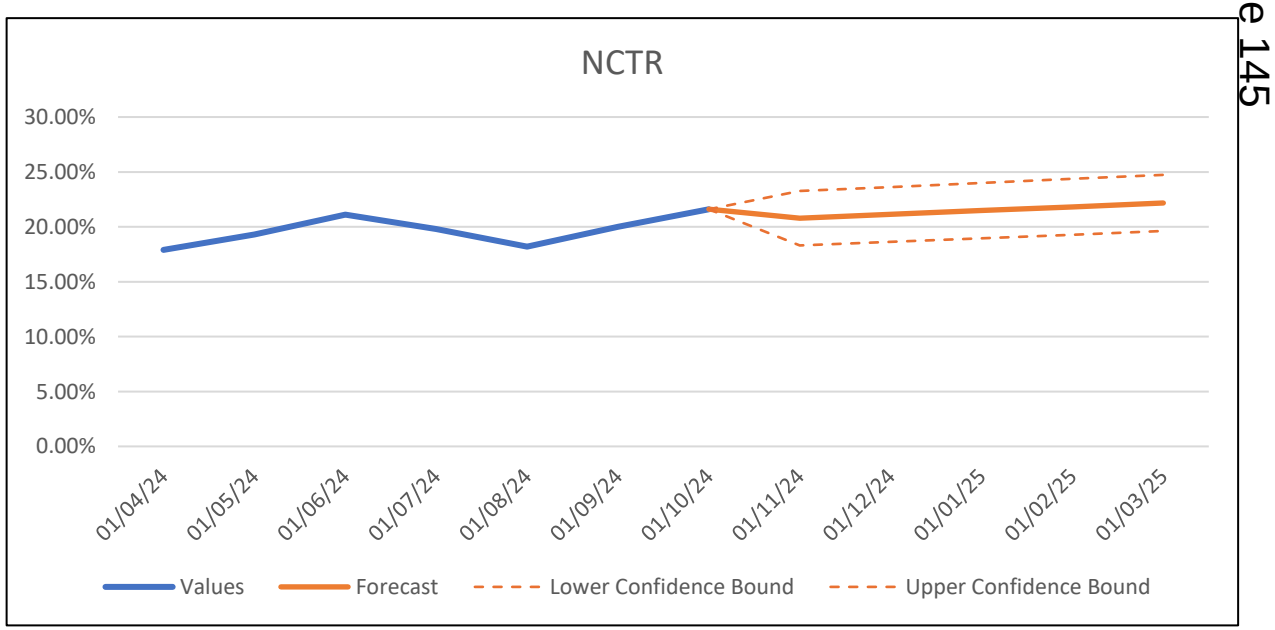


Data Source: ICB UEC Recovery Dashboard

Demand Forecasting

Mid Cheshire Hospitals Foundation Trust





Performance Management & Escalation

Cheshire East Assurance:

- ✓ Daily Multi Disciplinary Team meetings
- ✓ Weekly Capacity Dashboard – System understanding of current capacity issues and risks
- ✓ Patient harm reviews, reflective learning and measures and controls implemented to reduce harm – Quality & Safety Forum
- ✓ Monitoring of key improvement initiatives to demonstrate system impact and effectiveness
- ✓ Outcomes for individuals in D2A and Reablement Support
- ✓ Utilise data to target admission avoidance activities
- ✓ Review and utilise A&E forecasting tool
- ✓ Realtime system monitoring – NHS A&E wait times app includes East Cheshire NHS Trust and Mid Cheshire Hospitals NHS Foundation Trust
- ✓ Cheshire East Operational Delivery Group
- ✓ Winter System Oversight call
- ✓ System escalation calls to monitor capacity and flow
- ✓ Infection Prevention and Control Operational Group flexibility to step up and combined with daily MDTs
- ✓ Primary Care APEX System
- ✓ Implementation plan for the updated Operational Pressures Escalation (OPEL) framewok – Key actions Place/SCC
- ✓ System Coordination Centre System Calls – Oversight of a real time reporting tool for Cheshire & Merseyside - SHREWD (Single Health Resilience Early Warning Database)

Winter Planning Escalation

System Co-ordination Centres

- Revised operational standards issued for implementation by 01 November
- Central co-ordination service to providers of care across the ICB supporting patient access to safe, high quality care
- Responsible for the co-ordination of an integrated system response using OPEL Framework alongside provider and ICB policies.
- OPEL Framework contains specified and incremental core actions for the SCC at each stage of OPEL.
- Responsible for supporting interventions on systemic issues that influence patient flow.
- Concurrent focus on UEC and the system's wider capacity including, but not limited to, NHS111, Primary Care, Intermediate Care, Social Care, Urgent Community Response and Mental Health services.
- **3 Expected outcomes from SCC operations:**
- **Improved visibility of operational pressures:**
- **Real-time co-ordination of capacity and action:**
- **Improved clinical outcomes**

Operating Pressure Escalation Level (OPEL) Framework

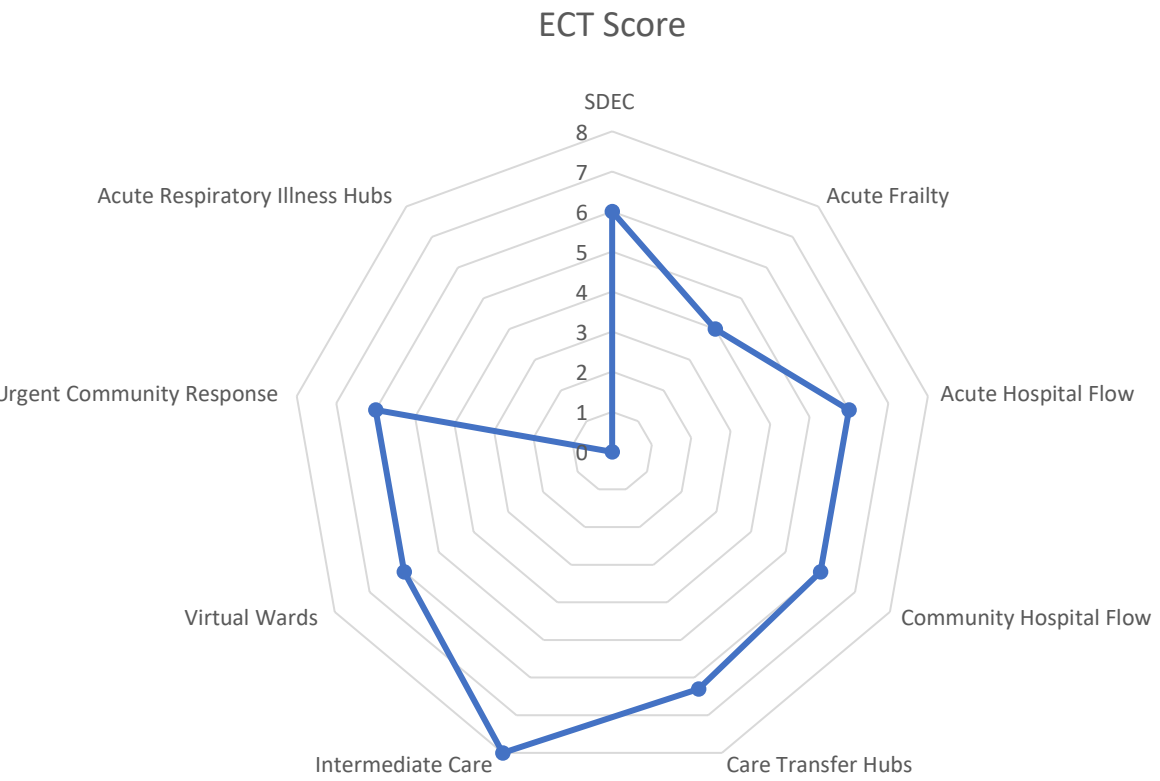
- New OPEL framework issued for Acute Trusts, to be implemented by 01 November 2023 using real time data.
- Real time data system in place - SHREWD
- OPEL score out of 50 across 10 parameters centred on ambulance handover, co-horting, ED attends and performance, majors and resus pressures, time to treatment, wider bed state including NCTR and corridor care
- ICB level OPEL will be determined automatically by the Trust declarations, with a proportion of the score for each acute site going towards the OPEL score for the ICS
- C&M SCC will operate daily calls through winter, likely minimum 2x OPEL declarations per day
- Action cards are defined nationally, ICBs need to define their triggers and action cards for system actions with local partners e.g. at Place level
- **Further work required to agree what the key actions are for Place at each OPEL stage, at ICB level and beyond, in particular escalation with local partners at OPEL 3 and 4**

High Impact Actions	Overarching principal of the winter plan Link to the High Impact Actions – Cheshire East Place
Same Day Emergency Care	Maximise the use of the Same Day Emergency Care triaging model for people, thus ensuring that people are fast-tracked to the right specialist at the start of their visit to hospital. SDEC will continue to reduce hospital admissions and in turn improve the person experience and help the hospital manage patient flow
Frailty	Specialist nurses are deployed in the EDs across Cheshire East as part of the frailty response with the aim of avoiding hospital admissions.
Inpatient Flow & LOS	
Community bed productivity and flow	East Cheshire specific focus on Pathway 2 cluster model Length of Stay and P3 self-funding patients Length of Stay through Transfer of Care Hubs and multi-disciplinary team meetings, and transformation support to review community Length of stay pathways. A significant investment has been committed from the Adult Social Care Discharge Investment Fund to support the implementation of the Discharge to Assess model along with providing funding to purchase additional spot purchased bed base capacity when required, to meet the deficit indicated within the Demand and Capacity analysis. The funding has supported some initial double running costs, thus allowing the model to be fully implemented and support the reduction of a number of beds across the system.
Care transfer hubs	The Transfer of Care Hubs in ECT & MCHFT IS THE system-level place whereby (physically or virtually) all relevant services (for example, acute, community, primary care, social care, housing and voluntary) are linked to coordinate care and support for people who need it – during and following discharge and also to prevent acute hospital admissions. Daily Transfer of Care Hub escalation calls take place focus is to progress discharges (including community beds) in real time escalation.
Intermediate care demand and capacity	Cheshire East place are fully engaged in the 12 week programme to identify gaps in the system
Virtual wards	Roll out of intravenous and sub cutaneous therapy provision to virtual wards has been completed with a number of areas increasing their intravenous at home offer. Continue to promote Virtual Wards and pathways and increase bed occupancy targets.
Urgent Community Response	Monitoring Performance impact and effectiveness against a bespoke set of UCR metrics
Single Point of Access	To support patients to access care more easily, Care Community Services have Single Points of Access for patients and referrers to access support and care. The single point of access aligns to the care community (neighbourhood) footprint.
Acute Respiratory Infection Hubs	We don't have any acute respiratory hubs in Primary Care in Cheshire East. The two locations that were mobilised last year ceased at the end of the funding.

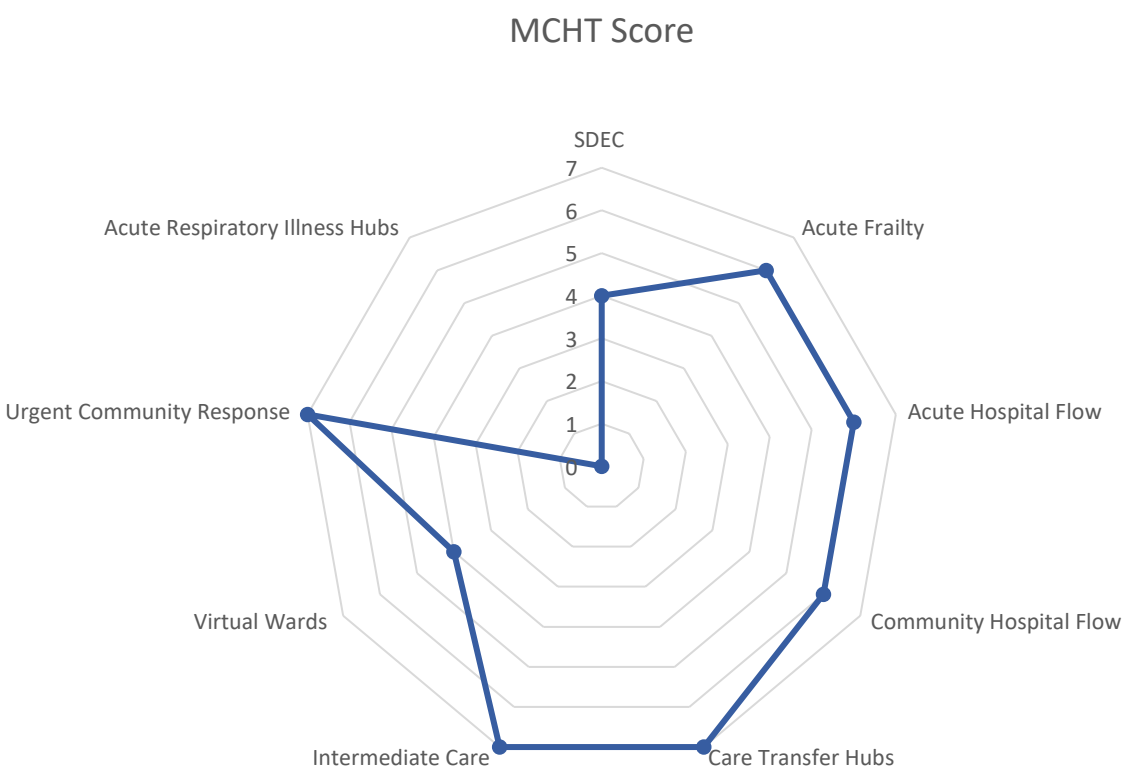
	High Impact Interventions – Actions . **Requirement to focus on 4 areas, national visit & maturity assessments**	System Roles & Responsibility
1	❖ **Same Day Emergency Care**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.	East Cheshire NHS Trust Mid Cheshire Hospitals FT
2	❖ **Frailty**: reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.	East Cheshire NHS Trust Mid Cheshire Hospitals FT
3	❖ **Inpatient flow and length of stay (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients	Cheshire & Wirral Partnership FT East Cheshire NHS Trust Mid Cheshire Hospitals FT
4	**Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.	Cheshire & Wirral Partnership FT East Cheshire NHS Trust, Central Cheshire Integrated Care Partnership
5	❖ **Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.	Transfer of Care Hubs System Partners
6	**Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab	ICB & System Partners
7	**Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge.	East Cheshire NHS Trust, Central Cheshire Integrated Care Partnership
8	**Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission	East Cheshire NHS Trust, Central Cheshire Integrated Care Partnership
9	**Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment	Cheshire & Wirral Partnership FT
10	**Acute Respiratory Infection Hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.	Primary Care East Cheshire NHS Trust, Central Cheshire Integrated Care Partnership

Maturity Self Assessments September 2024

East Cheshire NHS Trust



Mid Cheshire Hospitals Foundation Trust



Score out of 8	Maturity Level
0-2	Early Maturity
3-5	Progressing Maturity
6-7	Mature
8	Benchmarkable Maturity

Maturity signifies the right components to deliver a better experience for people in line with national ambitions

Maturity assessments help ensure that national improvement is tailored to the areas of greatest need and highlights areas of best practice nationally.

Mental Health & Community Collaborative Priorities

Cheshire East Place

Mental health support communications toolkit to find the right support

https://webstore.cwp.nhs.uk/smh/toolkits/cheshireeastmay23.pdf

Key headlines for Winter 2024/25

- ✓ First Response services continue to develop the First Response ethos.
- ✓ The Crisis Line receives around 4,000 calls per month.
- ✓ Implemented the Rapid Response Service to convey people away from Emergency Departments once mental health beds have been identified
- ✓ Observational support into the Emergency Departments (ED's).
- ✓ In addition to this the British Red Cross are working with CWP services to support high intensity users of Liaison and Crisis Line services and a new MH side by side triage process has been implemented plan in place to roll out to all Eds
- ✓ Development of the Discharge Facilitation Team to support flow both within CWP beds but also to support flow across out of area beds.
- ✓ Working with both Cheshire and Merseyside Police to complete a deep dive around people being detained on Section 136 in line with a wider action plan led by Cheshire and Mersey.
- ✓ 2 Mental health response vehicles (Bebington and Northwich) mobilised to support community response and divert ambulances called by MH patients as clinically indicated.

Cheshire & Wirral Partnership Mental Health Winter Plans

Actions taken and plan to increase capacity in acute/ community service.

The established bed base across Cheshire and Wirral Partnership NHS Foundation Trust is 320 beds.

Number of beds available:

CONTRACTED	Commissioned beds
NWBB - Crewe	12
Priory Notts - Coppice	6
ELYSIUM Bluebell - Huyton	9
ELYSIUM Leo - Warrington	2
CHESTER/ Bowmere Hospital	
BEECH	22
JUNIPER	24
WILLOW	7
CHERRY	11
WIRRAL/ Springview Unit Clatterbridge	
LAKEFIELD	20
BRAKENDALE	20
RIVERWOOD	13
BROOKLANDS	10
MEADOWBANK	13

CONTRACTED	Commissioned beds
EAST/ Macclesfield	
MULBERY	26
SILK	15
SADDLEBRIDGE	15
OAKTREES	0
ALDERLEY UNIT	10
MAPLE	18
EASTWAY	8
GREENWAYS- LD Inpatient Unit / Macclesfield	12
INDIGO- CAMHS INPATIENTS / CHESTER (TIER 4)	16
CORAL- CAMHS INPATIENTS / CHESTER (TIER 4)	14

Richmond Fellowship and	14
ECHC Crisis Beds	3

Mental Health

	Mental Health Operational Services Supporting People and the System
1.	Mental Health Floating Support delivered by Making Space, providing 75 hours of support in both the North and South of Cheshire East. This service is has been recommissioned and will build on the successful model which is in place as part of a low-level mental health pathway.
2.	Complex Needs DPS – A framework containing over 160 providers, which contains providers who can support people with MH Support Needs. Services commissioned under the framework include supported living (including step down provision) and outreach provision. This is currently being reviewed with a new framework to be developed called the Complex Needs Care Provider Collaborative. This has a timeline of September 2025 for go live.
3.	Mental Health Rapid Response Reablement funded via the ASC discharge funding supporting facilitated discharge provided by ISL has been extended until 31/03/25. This along with the Mental Health Floating Support Service and Reablement Service forms part of the low-level mental health pathway. This service is consistently at full capacity (46 hrs per week) and is playing a vital role in providing short term interventions
4.	3 Mental Health Crisis beds which are located in Crewe, Macclesfield and Congleton delivered by East Cheshire Housing Consortium. These crisis beds support step up/down referrals and are in place until 31 March 2025. A review of crisis beds is underway covering Cheshire West, Cheshire East and Wirral to look at future delivery models.
5.	ISL in reach support to each ED. This is highly effective and provides 1to1 support to people supporting with de-escalation support and 1to1 bespoke support for people. It also offers additional staffing support within each ED. A further £250k has been approved via the BCF for a bespoke model for each hospital ED (Macclesfield and Leighton) from 1 April 2024 to 31 March 2025 proving 8am till 8pm cover 7 days a week.
6.	Additional £15k ring fenced to support carers and facilitated discharge and hospital avoidance.
7.	Crisis Cafes Crewe and Macclesfield and a pathway has been developed between the domestic abuse service directly to crisis cafes and trained the staff in DA awareness. These contracts are currently in place until March 2025 and CWP (as the contract holder) are looking at conducting a procurement exercise in the near future.
8.	CWP Community Mental Health Transformation is now phasing its engagement work down and mobilising new models of care. At the core of this is having practitioners operating at PCN level as part of a multi-disciplinary team with GP Practices. MH services will operate on a person-centred needs basis rather than referral criteria. This should address some of the volume incidence of community crisis and re-admission of people previously discharged back into the community.
9.	CAMHS - Additional investment has gone in to improving access and reducing waiting times however workforce shortage remain challenging to recruit to. A gap we need to address is working with Education Teams. A system planning session is required to explore how we address the gap moving forward.
10.	Talking Therapies (IAPT) Additional investment made to improve access and reduce waiting times in the North of the patch.
11.	Acute Beds Demand and capacity review underway for completion September (Cheshire & Wirral). A CWP worker is to lead on this work, with a view to create flow, reduce out of area placements. There is a need to understand the investment from West and Wirral into Winter planning to improve flow.
12.	Weekly MAADE meetings which is a new format to include admissions and discharges in one meeting
13.	Weekly oversight and Governance around the system VOIDS to support discharge flow – weekly SITREPS are now stood up and shared amongst the system.
14.	Underutilized hours in commissioned service Routes – being repurposed to support MH Discharge
15.	Home For Christmas weekly meetings to be stood up including providers, both Trusts and CWP for additional oversight and support to get people home for Christmas

Primary Care

- ✓ Primary Care Network led Extended Hours for evening and Saturdays
- ✓ Primary Care Access Recovery Programme including transition to a new model of modern General Practice.
- ✓ Robust and resilient General Practice Out of Hours service including Acute Visiting Service.
- ✓ Care Communities Business cases to extend Primary Care Assessment – Respiratory, Frailty, High Intensity Users, Falls – Subject to additional funding
- ✓ The nationally commissioned Community pharmacy consultation service (CPCS) as this will have a potentially bigger and synergistic impact with the Pharmacy First minor ailments service on lower acuity conditions. CPCS takes referrals from general practice and NHS111, while Pharmacy First provision also takes walk ins
- ✓ Primary Care resilience and activity data
- ✓ Exploring initiatives to enhance the falls prevention programme, including access to falls exercise classes and care homework (System)
- ✓ Health & Wellbeing services for Asylum seekers and Refugee communities
- ✓ Full implementation of the Primary / secondary care interface recommendations
- ✓ Roll out of the General Practice OPEL system to support system pressures reporting
- ✓ SDF Proposal Funding – This will be used across the Care Communities:
  - **Congleton & Holmes Chapel (CHAW)** - Additional sessions to help during Winter pressures and reduce A&E Admissions. One GP session per week in the hub for training, mentoring, supervision and appraisal support.
  - **Congleton & Holmes Chapel (CHOC)** - To fund PCN Clinical Educational Lead role for 7.25 months. This will provide clinical mentorship for a number of PCN ARRs team members. At Scale funding will be used to increase clinical capacity.
  - **Crewe Eaglebridge** - Additional 40 GP sessions across the reporting period. Plus funding to support ARRS clinical leadership.
  - **Crewe GHR** - Additional 40 GP sessions across the reporting period. Plus funding to support ARRS clinical leadership.
  - **Nantwich & Rural** - ARRS role supervision, training and education. At Scale funding enables PCN to increase capacity to deal with the expected increase in requests for urgent assessment and treatment of winter related illness
  - **Middlewood** - Continued clinical supervision for ARRS Roles. Funding will support 2.5 additional GP sessions per week for a 4 month period (including on-costs)

Care Community Investment 2024-2025:

NHS Cheshire and Merseyside

- **Eastern Cheshire Care Communities** (CHAW, CHOC, Knutsford, Macclesfield, BDP)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 Aim: 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 Service, 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** The service will be delivered in the leg club model of multi-disciplinary team working. All High Intensity Users 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
- Health Neighbourhood Voluntary Infrastructure and Model of Support, see attached paper for further reference of the invested schemes and funding allocation: Projects were categorised based on service provision under the following themed areas.
    - Universal Community led social prescribing.
    - Provide targeted advice, guidance, and support.
    - Mental Health Targeted Health and Wellbeing Cafes
    - Physical Health Targeted Community Clinics

Care Communities

Cheshire East Care Communities will all have a joint focus on supporting high intensity users, including falls prevention this winter. Winter Schemes are being developed to support this cohort of people. **Note Subject to additional funding**

The operational delivery of each scheme has been determined by local need and service delivery, to ensure that it makes the most impact and is the most outcome focused for the people receiving services

These schemes will be linked and support the Cheshire East Winter Plan for 2023/24, by lowering admission to hospital and enabling people to live safe and well at home and in their communities.

The schemes will support the priorities and responsibilities of the Integrated Care Board. They will support the responsibilities of working together to deliver a resilient winter, as well as supporting mental health provider pathways, social care priorities and supporting the acute trusts.

Overview of Schemes

Knutsford Home First - High Intensity User Ward - Caring for high intensity users in hospital and within their own home, in keeping with the Home First initiative. The aim is to reduce the number of unplanned or crisis contacts by proactively case managing this cohort of patients using an MDT model of care/virtual community wards.

Bollington, Disley, Poynton (BDP) - Access to services (Provision of transport to access services) - To reduce DNAs, home visits and access inequity by supporting residents with transport issues (due to economic, geographical, winter weather difficulties or individual patient needs) to attend essential appointments for their health and well-being.

Bollington, Disley, Poynton (BDP) - High Intensity User - Rapid Short-Term Clinical and Social Care - To provide high quality, rapid short-term clinical and social care, to avoid admissions to hospital or aid early discharge of high-intensity service users.

Macclesfield - High Intensity User Virtual Ward - Macclesfield Care Community are focusing on high intensity users of services, to reduce the number of unplanned or crisis contacts by proactively case managing a cohort of patients using an MDT model of care.

Congleton & Holmes Chapel (CHOC) - High Intensity User Urgent Care - To provide proactive care to high intensity primary care respiratory patients (including those that are likely to require hospital attendance/admission).

Chelford, Handforth, Alderley and Wilmslow (CHAW) - Responsive Integrated Care - Help CHAW patients with respiratory conditions to be managed appropriately in the community reducing unnecessary admissions to secondary care.

Crewe - High Intensity User Mitigation and Education (Paediatric Focussed) - Trial a model of care pilot at Eaglebridge PCN which would address both HIU needs but also serve as a model for other patients who may otherwise be directed straight to ED.

Care Communities continued

Crewe - The Crewe Leg Club - Relaunching the Community Leg club in Crewe. The approach has been adapted to contribute towards reducing winter and on-going pressures for primary care, secondary care, and community services.

Sandbach, Middlewich, Alsager, Scholar Green, Haslington, Brereton (SMASH) - High Intensity User - Falls Prevention - SMASH are looking to expand out to an app which will be used for patients over the age of 65. Our first port of call would be to send a message to our patients through Accurx to gain data on falls prevention.

Nantwich - High Intensity User - Falls Prevention - Nantwich and Rural are looking to expand out to an app which will be used for patients over the age of 65. Our first port of call would be to send a message to our patients through Accurx to gain data on falls prevention.

Aims

All main aim of all the schemes is to prevent admission or readmission to hospital, by identifying risks, health need and providing the right support and access to services to people in their own homes and/or local communities. It is vital to identify the High Intensity Users in the system so that we can assist in preventing them from hospital attendance in the future

System Impact, benefits

By identifying and targeting High Intensity Users is expected to reduce attendances at Primary and Secondary Care, as the patients will be supported earlier in the journey before requiring urgent care. Examples of system impact could be: possible prevention of need for urgent appointments (including A&E attendance), reduce requests for emergency GP appointments, maintain or reduce A&E attends, which would have a positive impact on department overcrowding and patient flow, increased co-ordination of care for patients by proactive planning, increased collaboration across the system.

Anticipated Quality Outcomes

There are many anticipated quality outcomes of the schemes for people, these include:

- Reduction in inequalities (enabling all access to appointments) particularly for those who live in areas with limited public transport, have economic difficulties or require additional support to access services.
- Reduce deterioration in health.
- Patients feel supported in maintaining their health and wellbeing.
- Reduce isolation of patients.
- Holistic, joined up, proactive care for High Intensity Users
- Improved experience of care and outcomes for patients that are high intensity users of services.

Cheshire East Discharge to Assess Model of Care (by Hospital Footprint)

	Provider	No beds	Bed Type
East Cheshire Trust	Wilmslow Manor	10	Nursing
	Eden Mansions	5	Nurs dementia
	Henning Hall	4	Nursing
		2	Nursing dementia
	The Rowans	4	Nursing
	Tabley House	3	Nursing
	Leycester House	6	Residential
	The Willows	4	Nursing
	Prestbury House	6	Nurs/res/dementia
	Aston Ward	27	Rehab
	Subtotal	71	
Mid Cheshire Trust	Clarendon Court	8	Nur/res/dementia
	Telford Court	8	Nursing dementia
	Twyford House	5	Res/res dementia
	Station House	10	Nursing D2A
		2	CIB
	Alexandra Mill	5	Nursing/Nursing Dementia
	The Elms	3	Residential SRB
	Turnpike Court	2	Residential Dementia SRB
	Elmhurst	30	Nursing/Nurs Dementia
	Subtotal	73	
	Total Beds	144	

Mid Cheshire Hospital Foundation Trust Winter Plan

1. The Winter Plan 2024/25 is based on ensuring two key principles:
    i. To create a winter ward for escalation due to demand (30 Bed) as soon as RAAC works allow. This will now be in mid December 2024.
    ii. To invest in a number of non-bed based schemes that have either been proven to work over previous winters or as part of rapid tests of change undertaken during summer-autumn 2024. These are all aimed at creating additional weekend or evening capacity or enabling delivery of workstreams which are part of the wider UEC and Flow Transformation Programmes.
2. The Winter Plan 2024/25 includes provision for the additional capacity needed to support delivery of our My Next Patient Programme (additional transfer teams) and flow improvement (length of stay team).

Bed Based Services	
Scheme	Plan
Winter ward (30 beds)	30 beds to be opened from December 24 to end March 25. Current plan is that Ward 19 will be the Winter Ward.
Elective service resilience	
Ward 9 – Inpatient Elective Orthopaedics	Ward 9 to remained as an Orthopedic inpatient elective service.

This plan represents the best possible targeted investment in bed capacity, enhancements to weekend and evening capacity and two key elements of the UEC and Flow Transformation Programme. Rationale for including schemes is based upon schemes having worked previously, been tested in the last six months and/or being necessary to deliver the transformation programme.

Hospital Services (Non-Bed-Based Services)		
Scheme	Duration (Months)	Plan
CAU Paediatric Nursing	4	To support increased acuity.
CAU Paediatric Medical Support	4	Additional consultant ward time to support earlier discharges during the evening.
ED Paediatric Support	3	To support increased activity during the winter.
Additional Transport Discharge Vehicles	6	To avoid failed discharges 'on the day' and support a higher level of discharges resulting from additional beds being open.
Pharmacist support for ED	12	Permanent funding to support the ED teams and reduce LOS in ED.
Pharmacist support for Wards	4	Reduce LOS due to increased support for discharge arrangements and care planning.
Therapy Support	4	Reduce LOS due to increased support to deliver care / treatment plans.
Transfer Team	4	More timely movement of patients from ED to the wards.
GP Out of Hours	5	ED attendance avoidance.
Prescribing Pharmacist	3	Pharmacy cover between 17:00 and 20:00 to support TTOs and avoid failed discharges.
4th Consultant @ the weekend	3	Additional 9 hrs (Sat and Sun) of Acute Consultant time to facilitate discharges.
ST1/2 General Surgery to support ED	3	Additional surgical doctor between 08:00 – 20:00 (Sat and Sun) to support ED and facilitate earlier discharges.
IV at home	4	expansion to include BD service
My Next Patient transfer team capacity	5.5	Transport team in place for MNP moves pre 10 am and accelerated transfer at 4.30pm
LoS /Flow team	5.5	LoS reduction team –digital management of all P0,P1 patients on gateway, discharge management early facilitated discharge
SDEC Weekend Opening	4	Opening of the SDEC assessment area on Saturdays and Sundays to avoid admissions to the core bed base.
Discharge Lounge – Weekend Opening	4	Opening of the Discharge Lounge on Saturdays and Sundays to create core bed availability earlier in the day.
Pharmacy – weekend support	4	Extended opening times for dispensary.
ED – 2nd Registrar (Nights	4	To support senior decision making and discharges from ED overnight.

East Cheshire Trust Schemes

East Cheshire NHS Trust

UEC Programme	Workstream	Description	Benefits
Hospital @ Home	UCR / VW Responders	To support the increase in VW utilisation and UCR referrals	Increased utilisation and response times supports the AVS / VW / UCR Home 1st principles
	ED Nursing / Navigation	Dedicated navigation team and support for surges in extremis. HCA for nursing care provision	Redirection and streaming away from ED Safety – corridor care
	Acute Medicine Registrar	To provide dedicated timely senior reviews within the Emergency Department and promote H@H principles / admission avoidance	Senior clinical decision preventing unnecessary admissions
Inpatient Flow	30-day Challenge - nurse co-ordinators Ward 2 & 4	To improve the ward and board principles and support inpatient flow and discharge	Senior Ward Leadership timely discharge planning.
	Length of Stay	Acute therapy deconditioning prevention – additional resources to provide therapy to all ward areas daily	Reduction in LOS
	Discharge	Registered Nurse to support the discharge lounge to facilitate early flow	Early flow from wards / discharge Ability to finish off treatments in the DL
	Discharge	Pharmacy discharge team expanded to support rapid medication reviews and discharge processing	Timely discharge
	Outliers	Surgical / Orthopaedic and Medical junior drs to ensure clinical reviews of outliers	Safe management of Surgical / Orthopaedic / Medical Outliers

East Cheshire Hospice Contribution to Cheshire East Winter Plan 2024-25

Overview

East Cheshire Hospice (ECH) provides services for the population living in the northern locality of Cheshire East. It offers a specialist 15-bed in-patient unit staffed by a Multi-Disciplinary Team (MDT) for both palliative and end of life care patients, four community teams delivering care @Home 24/7/365, living well services for all disease groups and a range of family support services such as Carer Wellbeing programmes and all age bereavement support. It is fully integrated with the Specialist Palliative Care Team in North Cheshire East.

All of the above resource will be deployed to support the System through Winter 2024-25.

Referral criteria and forms for ECH services are available here: How to refer - East Cheshire Hospice

What is different from Winter 2023-24 that will improve performance in 2024-25

- Daily MDT huddles for Palliative and End of Life Care (P&EoLC) patients are now well-established improving performance in patient flow and crisis avoidance
- Knutsford Home First (KHF) team is operating to its capacity keeping people at home for longer or getting them out of hospital sooner
- Additional Hospice @Home capacity has, together with KHF, increased resource by 100% from Winter 2023-24
- 0.8WTE Community Palliative Care Consultant now in post and fully inducted and supported by ECH MDT

East Cheshire Hospice Contribution to Cheshire East Winter Plan 2024-25

Action Plan for winter 2024-25

- Continue to use the MDT Daily Huddles to identify early patients who are deteriorating and who would benefit from admission to ECH or receive care at home to avoid hospital admissions
- Offer the System one (possibly two depending on availability) winter pressure step down beds for people who meet the criteria
- Ensure all referrers are aware of and practiced in the referral process for ECH
- Subject to availability there will be ad hoc facilitation of late afternoon rapid discharges from hospital to home outside of normal Specialist Palliative Care Team's hours of operation
- Specialist assessment of long-stay hospital patients who do not reach the threshold for Specialist Palliative Care Team (SPCT) invention but who could benefit from optimisation during an ECH in-patient stay
- Use ECH resource to ensure the SPCT is fully staffed throughout the winter
- Support Care Homes through ECH 24-hour Advice line 01625 666 999
- Subject to availability, offer rapid response Clinical Nurse Specialist support to P&EoLC patients at Home in and out of business hours
- From January 2025, Palliative Advice Centre East (PACE) will be working with acute, virtual wards and primary care services to wrap additional support and care
  co-ordination around P&EoLC patients earlier in their disease/co-morbidities/frailty journey to avoid crisis admissions to hospital

Infection Prevention Control provided by Cheshire & Wirral Partnership Foundation Trust

Infection Prevention & Control measures are as follows:

- ✓ Single Point of Contact for all telephone requests for advice & support from the IPC Team – Tel: 01244 397700 (Mon – Friday between 9am & 5pm, except BHs)
- ✓ Single point of contact for all e-mail communications – cwp.ipct.admin@nhs.net
- ✓ IPC link Meetings – held quarterly, with emphasis on outbreak management from September onwards.
- ✓ Ongoing support via IPC audit and review.
- ✓ Ongoing Training offer regarding all aspects of IPC, including outbreak management, chain of infection, PPE and Antimicrobial Stewardship.
- ✓ Review and communication of IPC related guidance, including Covid-19 guidance.
- ✓ Outbreak visits and support, with bespoke advice.
- ✓ Support to the Multidisciplinary approach regarding the Risk Assessment for possible early bed opening during outbreaks in care settings.

North West Ambulance Service

Every Second Counts - Help us save more lives this winter. Every year, we face increasing demand for our service during the colder months. It's important to us that when you need us the most, we are there for you. It's no secret that our 999 service is there to bring you emergency care when in a life-threatening situation, but our 111 online service is equally there to support you with your urgent medical needs.

This year, we launch our winter campaign **Every Second Counts** to continue to support and inform our public on which service best suits your medical needs. We want to ensure you understand what our services are for and when to use them. We ask you the public to stop and think:

•Is this a life-threatening illness or injury? **Think 999**
•Is this an urgent injury or illness? **Think 111 online**
•Do you feel unwell or is an injury causing you pain? **Think walk-in centre or GP**
•Can you treat your symptoms at home? **Think self-care, first-aid kit and well-stocked medicine cabinets**

Our Hero Next Door campaign aims to recruit community first responders (CFRs) all across the North West. CFRs are ordinary people who do extraordinary things as volunteers for the ambulance service. They find the time to save the lives of their neighbours whilst going about their normal routines. The idea of the campaign is to show people that volunteers can go about their everyday lives and have no other healthcare connection but still find time to be a hero!

CFRs can be called upon to attend incidents such as cardiac arrest as well as other emergency situations, so that they can start lifesaving treatment as quickly as possible before the ambulance gets there.

Only required to commit a few hours per week, a CFR could be anyone over the age of 18 and doesn't require any previous training. For more information visit our **volunteer** section.

West Midlands Non Emergency Patient Transport

In Hours

- Non means tested, eligibility criteria dependent on medical requirement
- **Winter Plan due October**
- prioritise patient discharges
- Increased support around bank holidays

Out of Hours – Details of transport Services organised by

East Cheshire Trust

Mid Cheshire Hospital NHS Foundation Trust

Mental Health

- Cheshire and Wirral Partnership NHS Foundation Trust commissioned Independent Support Living (ISL) contract in place in reach support to mental health patients in A&E
- ICB funded secure transport - utilise Response 365 to ensure quality & value

Cheshire Police

- **Safer Streets** - Working together for even safer streets in Cheshire. Safer Streets is an extensive initiative that sees Cheshire Police ramping up its determination to make Cheshire's streets even safer. It aims to benefit everyone who visits, lives or works in Cheshire.

Safer Streets
Working together for even safer streets in Cheshire

- **Safety Buses** - 'Safe space' safety vehicles, branded as Safety Buses, patrol city and town centres where there are high levels of night life. They are clearly visible and provide a safe space for vulnerable people. The vehicles have on-board safety equipment such as defibrillators, first aid kits, phone chargers and bottles of water. They are staffed by police officers and community safety specialists from partner agencies who are on hand to ensure that anyone in need of help is cared for until they are able to get home safely.

- **Personal safety app** - The Hollie Guard personal safety app helps the user to discreetly alert their chosen emergency contacts, pinpoints their location, and sends video and audio evidence directly to their mobile phones. An alert is automatically generated if the user doesn't arrive safely at their destination. The app is free to download here Hollie Guard Personal Safety APP

Hollie Guard

- **GoodSAM** - GoodSAM technology has revolutionised emergency call handling, providing enhanced capabilities and additional reassurance to callers. It has enabled vulnerable people to receive immediate face to face video communication, instant location tracking for those who are lost and the ability to upload attachments that can be used as future evidence.

Cheshire Constabulary

Cheshire Fire & Rescue Service

- ✓ Promotion of ways to keep well and warm during winter via our comms channels and community engagement **Cheshire Fire & Rescue Service - Keeping Warm**
- ✓ Safe and Well visits
- ✓ Reminder of flu vaccine offer to over 65's during Safe and Well visits
- ✓ "Keep warm" packs with a number of other agencies, given out during a Safe and Well visit
- ✓ Working with partners Cheshire East Council and the NHS to look at ways to prevent some of the consequences of Winter Pressures, particularly with the added pressure of the energy price increases.
- ✓ Safe and Well offer for residents who may use unsafe fire practices to heat themselves/homes
- ✓ Candles in the home – how to use them safely
- ✓ Chimney fire safety
- ✓ Carbon monoxide/gas safety
- ✓ Christmas safety tips - **Cheshire Fire & Rescue Service - Christmas**

Cheshire
Fire & Rescue Service

Communications

Strategic Approach for UEC Communications 24/25

Cheshire and Merseyside System Recovery Plan

In order to respond to the System Recovery Plan, UEC has moved into a structured multi partner approach with overall strategic governance being led by the ICB and within five multi partner UEC recovery footprints. This allows for overall strategic and assurance at system (Cheshire and Merseyside) level which includes specific 'at scale' workstreams with local recovery footprints focussing on local pathways and improvement across partners.

Cheshire and Merseyside UEC Communications Group

From October 2024, the existing System Pressures Cell will be repurposed into the UEC Communications Group in line with this strategic approach and in response to the UEC Recovery Plan.

The repurposing element will make clear the alignment between partners across the Cheshire and Merseyside system and have at its core a partnership approach which includes clearly reflecting the specific responsibilities for NHS C & M (ICB) and each of its system partners by sector and locality.

Cheshire East Assurance:

Our system winter campaigns will be based around the following 'key pillars'

1. Prevention: Reducing avoidable hospital admissions by helping people stay well – with a focus on people with respiratory illnesses, frailty, falls awareness & prevention, mental health awareness and suicide prevention. This includes the flu and Covid vaccination programmes.

2. Signposting: Reducing inappropriate attendances by helping people choose the right service, linking to the national Help Us Help You campaign, Pharmacy First, GP access, emergency dental care, NHS 111, Urgent Treatment Centre's and other urgent care services.

3. Self-care: Messages in relation to the promotion of pharmacies to get expert advice, gastrointestinal illnesses, with hand washing/hygiene advice, alcohol awareness, respiratory illness and common childhood illnesses.

Cheshire East Council
Adult Social Care Winter Plan 2024/2025

Introduction

Winter planning is a statutory annual requirement to ensure that the local system has sufficient plans in place to manage the increased activity during the Winter period and plans have been developed in partnership with Cheshire East system partners across the place.

The overall purpose of the Winter plan is to ensure that the system is able to effectively manage the capacity and demand pressures anticipated during the Winter period which this year runs from November 2024 to 31 March 2025.

Our system plans ensure that local systems are able to manage demand surge effectively and ensure people remain safe and well during the Winter months.

The planning process considers the impact and learning from Winter 2023/24, as well as learning from the system response to Covid-19 to date. Plans have been developed on the basis of robust demand and capacity modelling and system mitigations to address system risk.

Our system ambition is to ensure a good Winter is delivered by supporting people to remain well and as healthy as possible at home, having responsive effective services, and a system that is resilient, resolution focused and has a shared vision to deliver meaningful positive Health and Wellbeing outcomes for the population of Cheshire East.

Adult Social Care Winter Priorities and Responsibilities

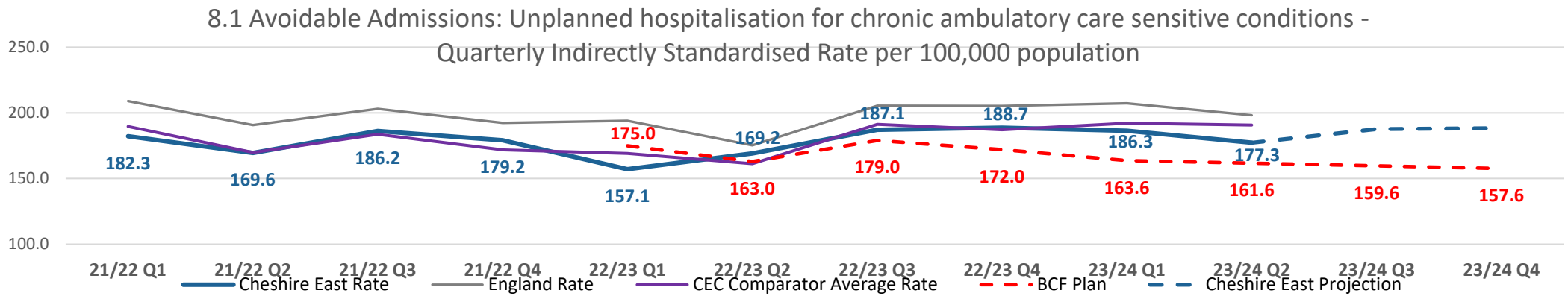
Local Adult Social Care Priorities 2024/25
Workforce Capacity, Market Sustainability and Improvement
Intermediate Care and Discharge from Hospital – including Transfer of Care Hubs (TOCH)
Better Care Fund Capacity and Demand
Unpaid Carers
Public Health and Infection Prevention and Control (IPC)
Energy and Adverse Weather
Reablement and Shared Lives
Mental Health
Governance and Oversight

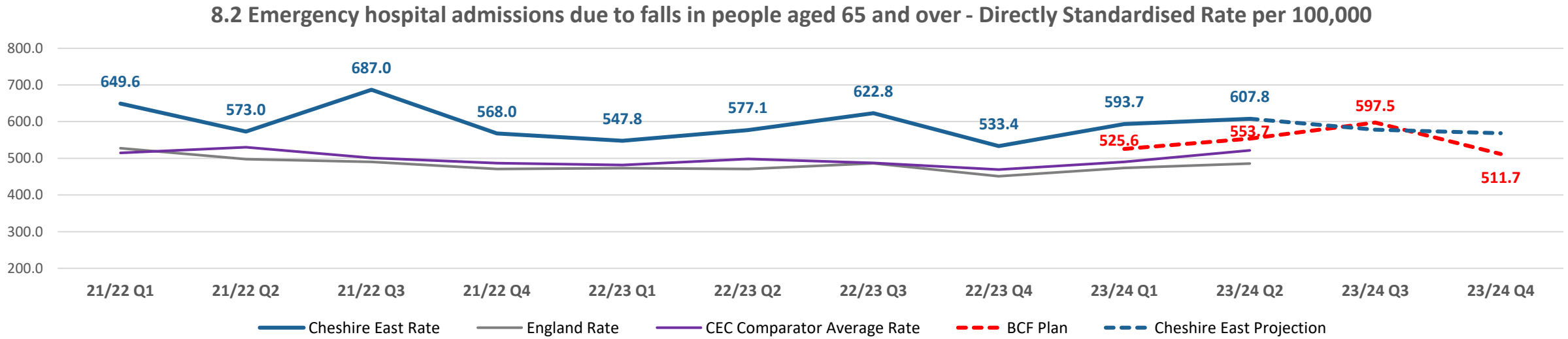
Adult Social Care Winter Ambitions
To meet a fluctuating demand and maintain flow with safe, responsive and outcome focused Health & Social Care services
Ability to access community provision unhampered by covid or other viral infections & Infection Prevention
To protect, expand and retain a healthy and resilient workforce
To support and improve access to Primary Care
To promote Self-Care and help our population to 'Choose Well' when contacting Adult Social Care Services
To maximise the transformation momentum and current resources to construct a sustainable model of Home First delivery
Increased use of Voluntary Community Faith Sector
To attain performance recovery as agreed with NHSE/I and achieve favourably amongst Cheshire & Merseyside peers A&E attendances reduced and no ambulance delays
High uptake in the Flu and COVID-19 vaccination boosters
People deemed to no longer meet the criteria to reside in hospital have clear exit and support routes out
Robust governance and system oversight

Demand Forecasting

Better Care Fund 2024-25

Metrics Report - Charts

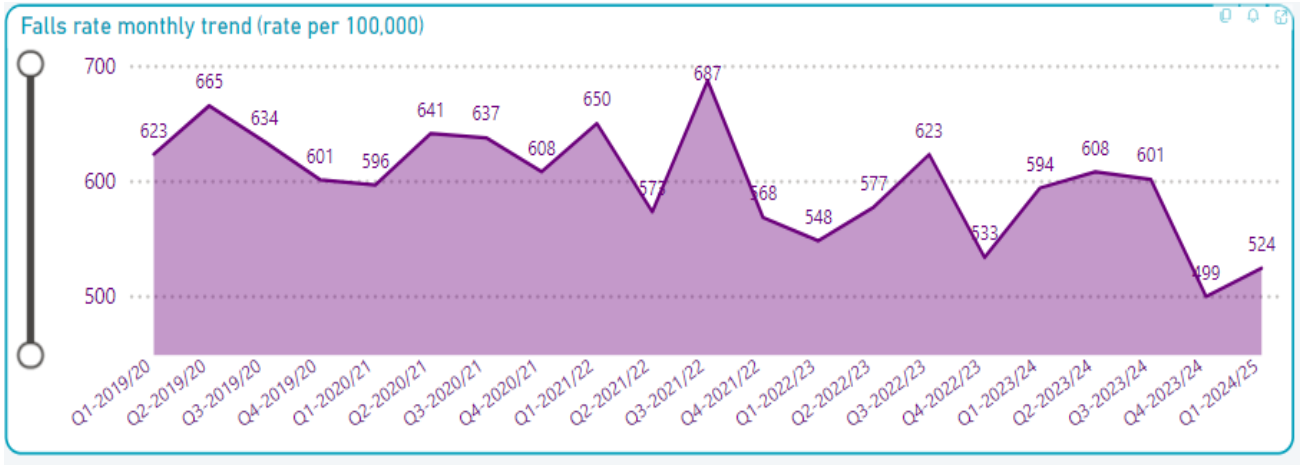


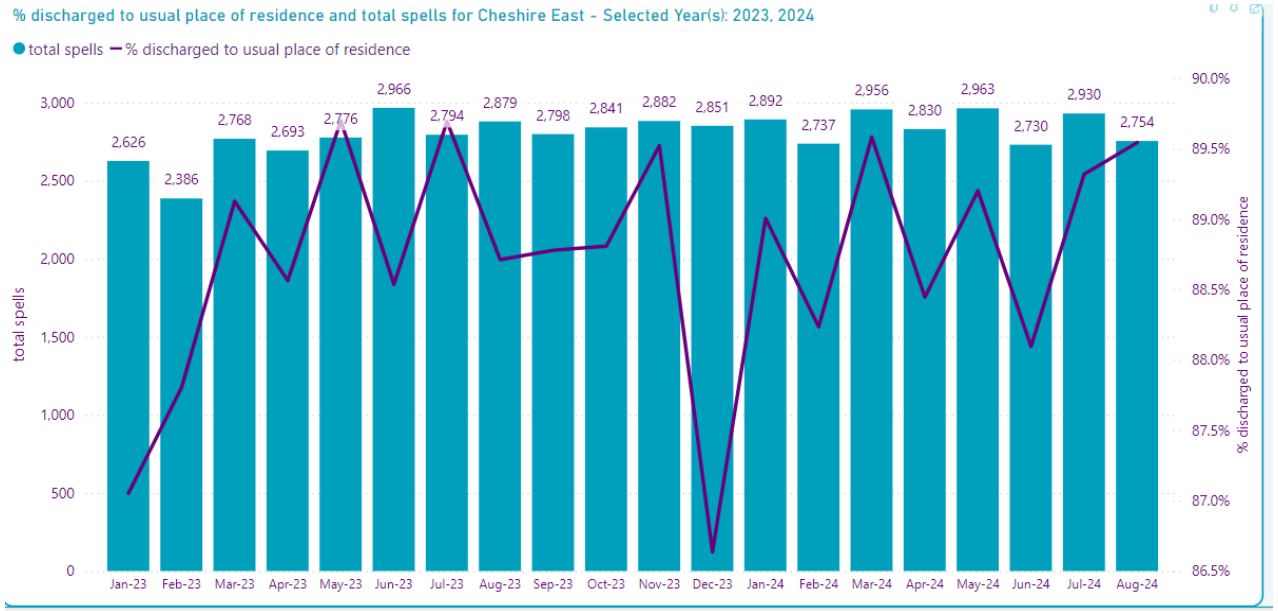


Demand Forecasting

Better Care Fund 2024-25

Metrics Report - Charts





Market Capacity, Sustainability and Improvement

To ensure provider market risk management oversight, the Council, ICB and Hospital Trusts have established a number of tools to appropriately manage the care home and domiciliary care market. These include the use of a quality dashboard, capacity tracker and bed vacancy management. Tangible results from this work to-date have included us targeting low quality homes for intervention by deploying district nurses.

There are strong relationships between partners to highlight and share system risk information and then deploy appropriate resources. A narrative care market strategic overview is produced on a regular basis, strategic data is produced and shared and a live strategic risk register is maintained.

We ensure data sharing arrangements are in place to enable rehabilitation/recovery plans to be shared by partners providing services to people, to streamline pathways and reduce duplication.

We will also hold:

- Regular and effective contract management meetings with our Adult Social Care providers (ensuring winter plans and contingency plans are in place)
- IPC risk management calls
- Provider Forums

Two integrated falls prevention specialist therapists have been recruited. They will operate across Cheshire East to provide falls prevention specialist care in the community, including in clinic and care home settings.

Intermediate Care and Discharge from Hospital

D2A Cluster Model
A significant investment has been committed from the Adult Social Care Discharge Investment Fund to support the implementation of the Discharge to Assess model, along with providing funding to purchase additional spot purchased bed base capacity when required, to meet the deficit indicated within the Demand and Capacity analysis.

System Resilience blocked booked beds (formerly referred to as Winter Pressure beds) are in place to aid pressures - 5 blocked booked system resilience beds are available until 31st March 2025,

Home First Community Prevention Reablement:
To support the identified capacity gap, an investment proposal is being taken forward to enhance the delivery for Community Reablement which would operate on a hybrid multi-disciplinary model of service delivery.

The aim of this investment and additional workforce infrastructure is to design a model of support that effectively responds within the first 72 hours of a person experiencing an escalation of their health and social care needs. The service will provide short-term social care rehabilitation, to support people to become or remain independent at home achieving the right outcome and work closely with the Care Communities.

Approved Mental Health Professionals Cover
To provide cover evenings & weekends for ECT and MCHFT, to support the increased number of Mental Health Act Assessments.

Adult Social Care Discharge Investment Fund
15 additional discharge funding schemes have been commissioned to the value of £2.3m. These include additional staffing, equipment, beds and payments, to coordinate, support and deliver home first models of care and timely discharges from hospital. Reablement is recognised as being a key partner in preventing avoidable hospital admissions and ED attendance.

The Transfer of Care Hub
The system-level place whereby (physically or virtually) all relevant services (for example, acute, community, primary care, social care, housing and voluntary) are linked to coordinate care and support for people who need it – during and following discharge and also to prevent acute hospital admissions.

There is a pre-existing mechanism for the Ready for Discharge Date to be identified for pathway 1-3 people, which is recorded on the Gateway System (Mid-Cheshire), and EMIS (Egton Medical Information Systems) East Cheshire, which in turn are fully accessible by health and social care colleagues. Pathway 0 people are discharged as soon as they are identified as having a Ready for Discharge date.

Business as usual system escalation calls are in place daily (Mon-Fri) where individual case escalations can be progressed.

Through the Transfer of Care Hubs, multi-disciplinary team meetings and transformation support , we review community length of stay pathways. Criteria to Reside data is collated daily within the acute trusts, identifying discharge ready date and community bed capacity.

Implementation of specific pathways for delirium and step-up capacity have been completed.

Roll out of intravenous and sub cutaneous therapy provision to virtual wards has been completed with a number of areas increasing their intravenous at home offer.

Cheshire East Council – Additional Discharge Fund

Number	Scheme	Summary
1	Approved Mental Health Professional Cover, evenings & weekends for ECT and MCHFT	Approved Mental Health Professional Cover, including evenings & weekends for East Cheshire Trust and Mid Cheshire Hospital Foundation Trust
2	Assistive Technology & Gantry Hoists to reduce double handling care packages	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.
3	CAH Investment Increase 2023/24 Non-Recurrent	To ring fence the whole £1.2 million allocation of the Adult Social Care Discharge Fund to provide a fee increase to Cheshire East Care at Home providers to ensure ongoing sustainability, growth and ongoing investment across the sector.
4	Home First Occupational Therapist	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.
5	Community Support Volunteers	Hospital facilitated discharge and home support service 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.
6	Increased General Nursing Assistant Capacity care at home via CCICP	Expand GNA service to continue to support bridging people awaiting domiciliary care at home in the East locations of Cheshire East.
7	Mental Health Rapid Response Outreach	Timely Mental Health Act assessments which will impact upon person, family/ carers, psychiatrists, CWP, ED departments, police, and other partnership agencies.
8	St Pauls Extra Miles	Cheshire East Council and its partners will collectively deliver integrated support to patients in hospitals in Cheshire East and service users of its Adult Social Care teams. The services will have a view to supporting their admission avoidance, discharge from hospital and preventing their readmission. In addition, they will support people known to Cheshire East Councils Adult Social Care teams to remain independent in their own home.
9	Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital	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.

Cheshire East Council – Additional Discharge Fund

Number	Scheme	Summary
10	Spot Purchase Beds and Cluster Model	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. • 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.
11	Care Community Joint Bid	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

Cheshire East Council – Additional Discharge Fund

Number	Scheme	Summary
		• 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
12	AED In Reach	The service will provide 168 hours per week of support: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)
13	Residential Care Home Competence Nurse	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. 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.
14	Practice Development Nurse	The opportunity for an experienced nurse to work with the Quality matron for community beds in supporting external providers to deliver safe outstanding care to our patients either in their own homes or in care homes. This role will focus on staff competency development and the delivery of training and education to a wide range of staff with varying experiences.
15	Community Support Connectors In TOCH	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.

Support for Unpaid Carers

Identifying Carers

Carers need to be identified as early as possible to ensure that appropriate support, advice, and information are offered to them. Often carers only seek or are offered support once they reach a crisis point. Early identification can support the carer with the tools, knowledge, and confidence to enable them to manage their caring role, while still having a life of their own and maintaining their own health and wellbeing. Through Accelerating Reform Funding, a provider, Mobilise, has been commissioned to deliver a digital platform for carers across the Cheshire and Merseyside footprint (including Cheshire East), providing free online support and a peer-to-peer community for unpaid carers, enabling carers to access support at any time in a way that works for them. The Carers Hub are refreshing their communications and engagement plan to further develop and strengthen partnerships and referral pathways with local community health, educational services/settings and social prescribers, to ensure ongoing promotion of the Carers Hub offer, to increase the identification of unpaid carers and the number of carers supported over the winter period and onwards.

Carer Respite

Joint work across Cheshire and Merseyside to implement Accelerating Form Funding includes a proposal to invest in innovative ways to enhance the carer breaks offer in Cheshire East which provides unpaid carers more choice and control in the support they receive and has positive impacts on the carer's health and wellbeing. This includes planned carer breaks as well as a Community Reablement Service offering crisis intervention for carer respite, provided by our in-house Care4CE Team to prevent carer breakdown/ escalating need. This would include personal care for the cared for (if required). It is planned the pilot will commence during the winter period.

Support to Carers this Winter

It is vital that we support our unpaid carers to stay well this winter. We will be continuing to support our carers to:

- Receive the flu vaccination
- Register as a carer with their GP
- Register with the Cheshire East Carers Hub

Carers Strategy 2021-2025

The Cheshire East Council All Age Carers Strategy 2021-2025 was coproduced with carers, health and VCS partners with the aim of developing an effective partnership to support all carers in Cheshire East, ensuring unpaid carers receive the support they need, when they need it. A key priority of the strategy is health and wellbeing and we will continue to work across the borough, with key partners to ensure a diverse offer is available for our carers of all ages to stay healthy, well active and to have fun this winter. Plans are currently being developed to re-fresh the strategy beyond 2025, in partnership with key stakeholders, including carers.

Support for Unpaid Carers

Pilot Carer Respite Scheme

Joint work across Cheshire and Merseyside to implement Accelerating Form Funding includes a proposal to invest in innovative ways to enhance the carer breaks offer in Cheshire East which provides unpaid carers more choice and control in the support they receive and has positive impacts on the carer's health and wellbeing. This includes planned carer breaks as well as a Community Reablement Service offering crisis intervention for carer respite, provided by our in-house Care4CE Team to prevent carer breakdown/ escalating need. This would include personal care for the cared for (if required). It is planned the pilot will commence during the winter period.

Commissioned Adult Carer Respite

An assessed number of allocated nights are awarded and can be used when a carer is unable to support the person that they care for, for a period of time. Typical examples of this are when a carer would like to plan a holiday, break or perhaps has a hospital stay scheduled.

Heliosa – Nursing Respite
Heliosa is a nursing home in Congleton. It is very welcoming, with staff, residents and relative's having fun and laughter and being very pleased with the wonderful care feeling part of a big family.
CQC – Care Quality Commission Rating - Good
Latest inspection: April 2021

- X3 Beds – Heliosa – Nursing/ Dementia
- X1 Heliosa – Emergency Bed

Bucklow Manor – Residential Respite

Home in Knutsford has a carer's respite bed, and some people choose to just spend some time with us during the day but if they chose to stay with us residents will have their own room which can be personalised with familiar objects and family photographs. Of course friends and family are always welcome to drop in anytime to visit.

CQC – Care Quality Commission Rating - Good
Latest inspection: January 2023

X2 Beds – Bucklow Manor – Residential/ Dementia

Commissioned Learning Disability Carer Respite
Accommodation based respite support for individuals with learning disabilities in Cheshire East is one part of respite support service. The focus is on providing modern and flexible support which aims to enable the cared for person to retain and develop skills and independence.
The service enables Carers to have a break from their caring role, knowing the cared for person is being appropriately supported.

- 3 beds at Warwick Mews (Macclesfield)
- 1 emergency bed Warwick Mews (Macclesfield)
- 1 bed at Hani Grange (Handforth)
- 2 beds at Valleybrook (Crewe)

Public Health & Infection Prevention Control

Public Health priorities over the winter period will be as follows:

- Promote and support the seasonal flu vaccination programme (led by the NHS). The campaign started on the 3rd October 2024 and will end on 31st March 2025.

- Cheshire East Council staff flu vaccination programme - free flu vaccines will be available for all staff who wish to have it. This will be via community pharmacies as well as clinics held across corporate buildings (Crewe Municipal, Delamere House, Westfields and Macclesfield Town Hall). We have worked with CWaC colleagues to include CWaC pharmacies in a bid to increase accessibility.

- Supporting the Cheshire Wirral Partnership (CWP) Living Well team to deploy the 'Living Well Bus' to venues/geographies across the borough, providing seasonal booster vaccinations (including COVID-19, flu, pneumococcal and a range of primary immunisations) as well as broader physical and mental wellbeing assessments, to ensure our most vulnerable people are best protected.

- Winter messaging will include:
  - Washing hands (including respiratory hygiene – 'catch it, bin it, kill it'
  - Sanitising surfaces
  - Getting seasonal flu and COVID-19 vaccinations
  - A healthy diet - good nutrition **and** hydration
  - Antimicrobial Resistance (AMR) – Champs will be launching a campaign aimed at parents and young people

- We will support CWP IPC colleagues with outbreak management, as appropriate – Making sure settings/providers report outbreaks of infectious disease to UK Health Security Agency (UKHSA)

- Health Improvement colleagues will be supporting 'Keep Warm this Winter' messaging and dependent on the national budget outcome (Wednesday 30th) this may reach a new group of people who become eligible for pension credit.

- A series of Hydration webinars have been delivered to Cheshire East care providers (including Care Homes, Supported Living and Domiciliary Care). More will be scheduled and delivered over the coming weeks - It is essential that vulnerable people stay hydrated over winter.

- Keep Warm Kits will be distributed, as per need and vulnerability. Distribution is via the Local Area Co-Ordinators, Social Workers, Library Staff and Community Development Team. They either respond to need identified through a home visit, or in the case of libraries can assist if someone comes in and asks for help (assuming there is some genuine evidence of need).

Infection Prevention Control

- CWP are commissioned to provide an Infection Prevention and Control (IPC) service to all care homes in the CEC footprint. Our contact details and operational hours are below.
- Winter preparedness has included : promoting seasonal influenza and Covid-19 vaccinations to staff and residents, reinforcement of IPC practices specifically decontamination, personal protective equipment (PPE) usage, distribution of the UK Health Security Agency (UKHSA) flu pack when it is published and guidance on how to recognise and report a potential outbreak at the earliest opportunity.
- In the event of a provider having an outbreak of communicable disease such as acute respiratory illness or diarrhoea and vomiting the IPC service will support the provider with co-ordination of the outbreak response, IPC advice and guidance, site visits where deemed clinically necessary, signposting to other stake holders for support.
- CWP will issue a weekly Situation Report (SITREP) to key partners across the health economy. This SITREP outlines which providers are closed due to an outbreak, the reason for the outbreak and the latest update on the situation. The frequency of this communication can be increased if required. If any partners are not receiving this SITREP and would like to be included on the circulation list please contact us using the details below.
- The IPC service will work with partners including but not limited to secondary care discharge planning teams to support patient flow, UKHSA and local authority public health.

Monday – Friday (09:00-17:00hrs excluding bank holidays)
Tel: 01244 397700
Email: cwp.ipct.admin@nhs.net

For urgent advice and outbreak reporting outside of normal working hours contact UKHSA on 0344 225 0562

Energy and Adverse Weather

Adult Social Care Teams and Providers will be helping people stay safe this winter. Support available includes:

- Prompting all providers to update their business continuity plans to prepare for any disruptions this winter. This includes having access to all data should disruption occur and identifying people most at risk (via RAG rating).
- Communicate regularly with providers, including sharing key points from the government's Adverse Weather and Health Plan, to help support their planning and response to adverse weather in winter. Communicate any national and local issues that may affect them and the people of Cheshire East and signpost them to support.
- Health Improvement colleagues will be investing in 'keep warm' kits that will be distributed through libraries, communities team etc. There will be a Winter Wellbeing Comms Plan, with regular media responses.
- Encourage people who depend on electricity to power medical equipment to speak to their healthcare provider about what to do in the event of a power cut and to ensure equipment and backup systems have been recently serviced and tested.
- Urgent Community Response: The Urgent Community Response services provided by Central Cheshire Integrated Care Partnership and East Cheshire Hospitals NHS Trust operate 12 hours a day, 7 days a week, is a multidisciplinary service which responds to falls within 2 hours of referrals.

Cheshire East Council Reablement

Community Reablement – Short-term intervention

. Continue to support hospital discharges Mid & East Cheshire NHS Trusts working as part of the TOCH teams and offer home visits prior to discharge where environmental or equipment issues are identified to avoid a readmission to hospital.

. Continue to support system partners in bridging care packages with IPOCH (Mid Cheshire Trust).

. Work towards an increase in referrals into Reablement for all discharges where no care needs were previously required to maximize a return to full independence for people.

. Continue to signpost to third sector and universal services including Community Connectors and volunteers, Carers Hub

. Continue to develop hospital avoidance by supporting Urgent Community Response and Virtual Wards.

. Support therapy rehabilitation for people at home or on Pathway 2 and support functional assessments.

. Deploy staff in times of system pressures into ED.

. Currently supporting Aston Ward Pilot in Congleton with daily individual and group therapy sessions aiming to increase mobility and independence and reduce care packages prior to discharge.

. Continue as the Service of Last Resort for Provider Failure.

. Supporting the Prevent/Reduce Enable Programme.

Mental Health Reablement – Short-term intervention (6 weeks)

. Respond to urgent referrals from Liaison Psychiatry and the mental health wards to reduce hospital admission and to support safe discharge home.

. Continue to take referrals from a wide range of referrers including the Community Mental Health Team, Home Treatment, Liaison Psychiatry, First Point of Contact, CWP Crisis Line, Housing, Children's Services, GPs, Talking Therapies, Substance Misuse Services, Complex Care Nurse, Probation.

. Continue to provide support for adults with social care issues such as housing , debts , also improving mental health with coping techniques and a self-help approach, promoting social inclusion, building self-esteem and goal setting.

Dementia Reablement – Short-term intervention (12 weeks)

. To provide outreach, information and Reablement support to adults newly diagnosed with Dementia in the early to moderate stages.

. Provide time limited interventions of up to 12 weeks to support individuals to achieve outcomes that support them in maximizing their independence through social interaction within the community.

. Reduce the need for care provision by offering strategies and information on equipment to support in the home, such as assisted technology and memory aids.

. Work closely with other Health & Social Care professionals to provide a fluid support experience to those diagnosed with Dementia.

Cheshire East Council Shared Lives

- To continue to provide intermediate support, respite support or community support to any vulnerable adult over 18 years old who meets Cheshire East Council's eligibility criteria.
- To continue to work in partnership with health and social care colleagues to provide practical support to address the social care issues that impact on customers physical and mental health.
- To continue to take referrals from a wide range of referrers including the Community Mental Health Team and First Point of Contact.
- To respond to urgent referrals for emergency respite or placement offers we can support to reduce the risk of a person going into a care bed or hospital.
- To offer emergency sessional support throughout the day to give a family member a break from their caring role.
- To continue to signpost to third sector services including the Carer's Hub and Dementia Cafes & voluntary groups.
- To work closely with other Health & Social Care professionals to provide a holistic person-centered service.
- To continue to support people with complex physical or mental health needs to remain as independent as possible in the community.
- Support people to increase their self-confidence, develop daily living skills, engage in employment/education or voluntary work.
- Provide support to people with daily living skills to enable them to live as independently as possible.
- To promote the flu vaccination and covid boosters, for both people who receive support, and our carers and staff team.

Mental Health

	Mental Health Operational Services Supporting People and the System
1.	Mental Health Floating Support delivered by Making Space, providing 75 hours of support in both the North and South of Cheshire East. This service is has been recommissioned and will build on the successful model which is in place as part of a low-level mental health pathway.
2.	Complex Needs DPS – A framework containing over 160 providers, which contains providers who can support people with MH Support Needs. Services commissioned under the framework include supported living (including step down provision) and outreach provision. This is currently being reviewed with a new framework to be developed called the Complex Needs Care Provider Collaborative. This has a timeline of September 2025 for go live.
3.	Mental Health Rapid Response Reablement funded via the ASC discharge funding supporting facilitated discharge provided by ISL has been extended until 31/03/25. This along with the Mental Health Floating Support Service and Reablement Service forms part of the low-level mental health pathway. This service is consistently at full capacity (46 hrs per week) and is playing a vital role in providing short term interventions
4.	3 Mental Health Crisis beds which are located in Crewe, Macclesfield and Congleton delivered by East Cheshire Housing Consortium. These crisis beds support step up/down referrals and are in place until 31 March 2025. A review of crisis beds is underway covering Cheshire West, Cheshire East and Wirral to look at future delivery models.
5.	ISL in reach support to each ED. This is highly effective and provides 1to1 support to people supporting with de-escalation support and 1to1 bespoke support for people. It also offers additional staffing support within each ED. A further £250k has been approved via the BCF for a bespoke model for each hospital ED (Macclesfield and Leighton) from 1 April 2024 to 31 March 2025 proving 8am till 8pm cover 7 days a week.
6.	Additional £15k ring fenced to support carers and facilitated discharge and hospital avoidance.
7.	Crisis Cafes Crewe and Macclesfield and a pathway has been developed between the domestic abuse service directly to crisis cafes and trained the staff in DA awareness. These contracts are currently in place until March 2025 and CWP (as the contract holder) are looking at conducting a procurement exercise in the near future.
8.	CWP Community Mental Health Transformation is now phasing its engagement work down and mobilising new models of care. At the core of this is having practitioners operating at PCN level as part of a multi-disciplinary team with GP Practices. MH services will operate on a person-centred needs basis rather than referral criteria. This should address some of the volume incidence of community crisis and re-admission of people previously discharged back into the community.
9.	CAMHS - Additional investment has gone in to improving access and reducing waiting times however workforce shortage remain challenging to recruit to. A gap we need to address is working with Education Teams. A system planning session is required to explore how we address the gap moving forward.
10.	Talking Therapies (IAPT) Additional investment made to improve access and reduce waiting times in the North of the patch.
11.	Acute Beds Demand and capacity review underway for completion September (Cheshire & Wirral). A CWP worker is to lead on this work, with a view to create flow, reduce out of area placements. There is a need to understand the investment from West and Wirral into Winter planning to improve flow.
12.	Weekly MAADE meetings which is a new format to include admissions and discharges in one meeting
13.	Weekly oversight and Governance around the system VOIDS to support discharge flow – weekly SITREPS are now stood up and shared amongst the system.
14.	Underutilized hours in commissioned service Routes – being repurposed to support MH Discharge
15.	Home For Christmas weekly meetings to be stood up including providers, both Trusts and CWP for additional oversight and support to get people home for Christmas

Communities

- **Winter Wellbeing Goods** - Purchasing items to keep people safe and warm at home due to the impact of fuel poverty. This in turn should drive down unnecessary cold home related hospital admissions/winter related deaths.
- **Community Support Connectors** - Dedicated Communities staff based at Macclesfield Hospital and Leighton Hospital. They have a focus on **reducing care packages** and **Increasing hospital discharge** by providing constructive challenge and alternative provision through **Community Support Packages.** Packages include but not limited to:-
  - **Practical support** referrals will be actioned by the Community Support Connectors and carried out by the VCFSE sector. Support will include Pre-discharge home inspection – removal of trip and fall hazards, clutter removal, deep cleans, personal shopping, utilities top up, medication collection, advocacy, winter wellbeing items (slow cookers, blankets, hot water bottles), handyman service, minor adaptations and community equipment.
  - **Advice, guidance and advocacy** referrals will be actioned by the Community Support Connectors for support such as: emergency food and fuels, mental wellbeing, befriending, hot food delivery, transport to appointments, benefits advice/ form completion and dementia support.
  - **Assisted tech** key safe, lifeline installation, medication carousels, OT identified equipment, toilet frames, walkers, perching stool, mobile hoists etc.
- **St Pauls Commission** - Integrated Community for the Community and Discharge Support Team. The service will relieve some of the current system pressures around hospital discharge and care at home for Pathway 0, 1 and 2 patients and prevent, delay or reduce the need for ASC intervention. St Paul's will provide: Removal or replacement of home items such as a bed to make way for hospital equipment or to position the patient in a safer environment such as the ground floor, transport patients from hospital to their place of residence, will undertake a home needs assessment to establish the needs of the person, including: Emergency food parcels, hot meal delivery, medication collection and drop off, shopping, wellbeing checks, heating, lighting, initial light cleaning, signposting to other relevant services for example food banks or befriending for on-going support, obvious home safety issues which require attention prior to returning home, transport to medical appointments, advocacy.
- **Cost of Living Information Sharing** - E-mail, Web Page and Telephone Line as well as online communications campaign and offline marketing (COL Posters, leaflets at GP surgeries)
- **Food Poverty Coordination** - We have employed a staff member via CVSCE who is providing infrastructure support for the VCFSE sector to ensure sustained activity to support food poverty.
- **Household Support Fund (HSF)** - the HSF grant provides crisis support to financially vulnerable households most in need. The fund is also available to support those adults and families struggling to afford household basics including food, energy, and wider essentials. The HSF is available to trusted professionals to refer financially vulnerable adults and families that they work with for support.

Adult Social Care Operating Framework

NHS England Operating Framework - Winter Planning

No	NHSE System Responsible	10 High Impact Interventions (Recommended Winter Role and Responsibilities)	ASC Baseline	Action Required to Support	Action Owner	Due by	Comment/update
1	ASC	**Care transfer hubs**: In partnership with local authorities, implement a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and reablement	Delivered	The Transfer of Care Hub is the system-level place whereby (physically or virtually) all relevant services (for example, acute, community, primary care, social care, housing and voluntary) are linked in order to coordinate care and support for people who need it – during and following discharge and also to prevent acute hospital admissions. The ToCH should: •Link a wide range of health and social care and wider services •Play a key coordinating role to aid not only discharge, but also admission avoidance if this makes sense locally due to overlapping services and staff, based on the principle of 'no place like home' •Operate seven days a week, ensuring discharges are timely and urgent community response standards are met (Hospital discharge and community support March 2022; Gov.uk) •Be responsible for managing the flow of patients into the discharge to pathways 1, 2 or 3 (description of pathways can be found in section 3) •Support safe discharges of people on pathways 1 to 3 through close working with the acute wards, quality assurance of information and practical support, including early identification of people who may become ready for discharge and identifying an estimated discharge date and pathway, focussing on the 'home first' approach •Decide which 'discharge to assess' pathway each person should be placed on (1, 2 or 3) based on the description of the person received from acute wards and assigns a case manager to each person being discharged •Work with the assigned case manager to coordinate and arrange the initial support needed on discharge, liaising with families and care providers •Ensure the staff and infrastructure are available to meet a person's short-term care needs as outlined in their	All System Partners		Managed through Home First Oversight Group
2	ASC	**Make effective use of the Better Care Fund**, including the Discharge Fund, to support patients to leave hospital with a package of care where needed.	All in progress	12 additional discharge funding schemes have been comissioned to the value of £2.3m. These include additional staffing, equipment, beds and payments, to coordinate, support and deliver home first models of care and timely discharges from hospital. Reablement is recognised as being a key partner in preventing avoidable hospital admissions and ED attendance. Additional Social Care Assessors are to be added to the service to provide rapid access to assessments under the Care Act 2014 and Reablement intervention.	CEC		
3	ASC	**Ensure that capacity and resource gaps are escalated, and actions progressed;** all data is submitted for all commissioned beds to the Community Discharge and Acute Discharge SitReps and the Capacity Tracker.	Fully operational	Operational staff provide daily, weekly and monthly SitReps to ensure effecitive senior leadership oversight of all areas. This covers people, planning, and system capacity and incorporates all system partners through effective meetings, events, quality assurance, mutual aid calls, provider engagement, and reporting through an established governance structure.	All System Partners		
4	ASC	**Embed mechanisms to enable monitoring of the impact of intermediate care interventions on people's functional outcomes and their long-term care needs.**	In progress	Performance and Quality Assurance measures in place, including CQC reporting, journey and outcomes audits, residents and registered manager feedback, and timely social care review.	CEC		
5	ASC	**Ensure data sharing arrangements are in place to enable rehabilitation/recovery plans to be shared by partners providing services and to streamline pathways and reduce.**	Fully operational	Data sharing arrangements are in place and governance remains with the system partners and senior managers.	All System Partners		
6	ASC	**ASC First Point of Contact**: To prevent, reduce and delay the need for care and support from the system.	Fully operational	Delivering strength and asset-based approaches to prevent the need for care and support. Multi-disciplinary team, utilising a OT first, incremental model, which signposts and provides information, linking in to housing, equipment, TEC, third-sector voluntary organisations, and universal services.	CEC		
7	ASC	**Supporting NHS winter surge planning**: including considering contingency arrangements for a significant flu or COVID-19 wave.	In progress	Workforce strategy provides a flexible approach to meeting demand in both the community and hospital settings. ASC will utilise previous tried and tested approaches used through COVID-19 to ensure the flow into and out of hospitals remains manageable and streamlined. Additional workforce funding will be used to ensure 7-day ASC response is maintained using streamlined and efficient pathways. Flu and COVID vaccination programme to be stepped-up in addition to health optimisation and infection prevention for all staff.	CEC		
8	ASC	**In-hospital Discharge Process**	Fully Operational	The Transfer of Care Hub is the system-level place whereby (physically or virtually) all relevant services (for example, acute, community, primary care, social care, housing and voluntary) are linked in order to coordinate care and support for people who need it – during and following discharge and also to prevent acute hospital admissions. The ToCH should: Link a wide range of health and social care and wider services; Play a key coordinating role to aid not only discharge, but also admission avoidance if this makes sense locally due to overlapping services and staff, based on the principle of 'no place like home'; Operate seven days a week, ensuring discharges are timely and urgent community response standards are met (Hospital discharge and community support March 2022	All System Partners		
9	ASC	**Discharge to Assess**	Fully Operational	A model of cluster beds has been commissioned to provide a localised offer of care for people whose needs are not yet known and require a period of therapy to rebuild or relearn skills to enable them to return home. This supports a discharge to assess model where no person's long-term care and support needs are assessed whilst an inpatient within an acute setting.	All System Partners		
10	ASC	**Intermediate care demand and capacity:** With local authorities, commission sufficient capacity to meet projected demand for step-down care, including both. home-based and bed-based care, to facilitate the timely discharge of patients from across acute and community hospitals and services.	In progress	Cheshire East are fully engaging with the regional Cheshire & Merseyside data collection 12-week programme as stated below: The three phases of the work programme aimed to answer five questions: 1. What is understood of the numbers of people that are currently requiring services? 2. What are the services that are available? 3. Is there sufficient volume of these services? 4. Are they the right services – should we be commissioning more services or fewer services or different services? 5. Do we know which of the services we use produce the best outcomes for our patients/customers?	All System Partners		

Cheshire East Winter Plan Stress Testing	
Operational Scenario	**System Mitigation**
Lack of Capacity within General Practice to meet winter demand	Primary Care Access Recovery Programme
	Repurpose in hours and extended hours capacity to support urgent / on the day demand
	OPEL: Demand management reporting over winter
	Maximising the use of ARRs - Additional Roles Reimbursement Scheme
	Primary Care Network Acute Respiratory Hubs / urgent on the day Hubs - No funding identified
	Revert to Generics for prescribing in the event of ongoing medicines supply shortage
	Primary Care Network Workforce Planning
	Expanding Community Pharmacy Consultation Service in community Pharmacy
	Population segmentation using John Hopkins model adopted across all GP Practices
	Limited amount of SDF funding has been allocated to support additional GP Capacity between Nov – Feb
Lack of Acute Hospital beds leading to Overcrowding in Emergency Departments	Cancellation of lowest risk Elective procedures to release bed capacity for Urgent Care.
	Enact spot purchasing of Discharge to Assess (D2A) bed capacity across existing D2A cluster model.
	Opening of acute sector G&A beds escalation / winter ward beds (Unfunded)
No Criteria to Reside & Length of Stay (LOS)	Frequent Length of Stay reviews and identified nurses working closely with system partners for all patients who have a prolonged LOS. Staff to expedite discharges to reduce the level of deconditioning.
	Daily MDT calls with system partners to monitor system capacity and flow.
	Senior Leaders system calls
	Care Community Huddle
	Community D2A community meetings to monitor capacity and flow.
	UCR system performance metrics
	Multi Agency Discharge Events (MADE) scheduled every month throughout Winter commencing in September.
	Oversight of people delayed in community beds MADE will take place for those individuals

Cheshire East Winter Plan Stress Testing	
Mental Health Pressures in ED and bed based place	Effective Mental Health escalation procedures in place that ensures all MDT partners are actively supporting discharge plans for any patient within ED
	Bed management 4 x daily calls via Cheshire & Wirral Partnership Foundation Trust
	ISL In reach model of support in place
	Increased ISL Mental Health Outreach capacity aligned to each ED
	High Intensity User support model being worked up by each Care Community
	Weekly MADE events and Super MADEs
Infection Control (IPC) Outbreak within care homes	Vaccination Programmes Adopt the IPC Risk Assessments protocol that supports early admissions into Care Homes on a risk-based approach
Workforce Challenges	Mutual Aid via system partners and providers
	Agency staff for key roles to support the system and a robust staff induction in place
	Organisational repurposing of staff to support system pressure and emerging risk areas
	Joint working between General Nursing Assistants and Reablement to increase workforce and staff capacity
	Heath and Wellbeing programmes to support staff wellbeing
Winter Schemes Opportunities	Expediate any agreed funded scheme to support with any additional capacity that supports the system
System Communication Strategy	Place comms cell in place with key organisational comms reps
	Tactical coordination of the system comms plan. Trigger points and comms messages procedure in development
	Development of a Cheshire East Resident Winter Wellbeing Booklet to be dispatched promoting self-care options
	Cheshire East Council Communities Team Winter Communications offer
Lack of available Domiciliary Care	Undertake urgent social work reviews to release capacity
	Home First Occupational Therapy and reablement assessments via the Trusted assessor role
	Repurposes any available block purchased capacity through Routes Health Care, General Nursing assistants and Reablement to support people who require discharging or to prevent an admission.
	Maximise the use of the commissioned Third sector offer.
	Carers payment to support rapid discharge.
	Maximise the use of Assistive Technology and remote monitoring options.
	Deploy Senior Clinical Leads to ensure we maximise Virtual Ward and Urgent Crisis Response capacity.
	Increase community reablement provision.
	Enact system risk management approach.

Cheshire East System Partner Winter Plans

System Partner	Link To Winter Plans
• Cheshire East Council – Adult Social Care Winter Plan 2024-25	• CEC ASC Winter Plan 2024/25
• North West Ambulance Service – Winter Strategic Plan 2023-24	• NWAS Strategic Plan 2024 link to be added once published
• NHS Cheshire & Merseyside Communications Winter Plan	• NHS Cheshire & Merseyside Communications Winter Plan link to be added once published

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