Evaluation of the Children and Young People's Health Equity Collaborative (CHEC)

Final Report

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Terminology

Term	Definition
Health Equity Champions	Champions are children and young people (CYP) recruited from the local integrated care system (ICS) areas whose role was designed to ensure that the work of the programme was grounded in the voices and experiences of children and young people.
Integrated Care System	There are 42 ICSs in England. They are local partnerships that bring health and care organisations together to develop shared plans and joined-up services. They are formed by NHS organisations and upper-tier local councils in that area and also include the voluntary sector, social care providers and other partners with a role in improving local health and wellbeing.
Integrated Care Partnership	Integrated Care Partnerships are statutory committees that bring together a broad set of system partners (including local government, the voluntary, community and social enterprise sector, NHS organisations and others) to develop a health and care strategy for the area.
Integrated Care Board	Integrated Care Boards (ICBs) are statutory NHS organizations in England responsible for planning and delivering local health services. They manage the NHS budget for their area and work with local partners, such as hospitals and GP practices, to meet the health needs of their population. ICBs replaced Clinical Commissioning Groups (CCGs) in July 2022.

Abbreviations

CHEC	Children and Young People's Health Equity Collaborative
CYP	Children and Young People
DFE	Department for Education
DHSC	Department for Health and Social Care
HPIG	Health Policy Influencing Group
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IHE	UCL Institute for Health Equity
JFP	Joint Forward Plan
LA	Local Authority
LGA	Local Government Association
NHSE	NHS England
OHID	Office for Health Improvement and Disparities
PH	Public Health
RCPCH	Royal College of Paediatrics and Child Health
SEND	Special Educational Needs and Disabilities
SDH	Social Determinants of Health
SRO	Senior Responsible Officer
UCL	University College London
VCSE	Voluntary Community and Social Enterprise

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Executive Summary

The Children and Young People's Health Equity Collaborative (CHEC) was a three-year partnership between Barnardo's, the UCL Institute of Health Equity (IHE), and three Integrated Care Systems (ICSs) - NHS Birmingham and Solihull, NHS Cheshire and Merseyside, and NHS South Yorkshire. Its vision was that all children should enjoy good health and positive wellbeing, reduce child health inequalities and improve the outcomes for CYP from underserved communities by acting on the social determinants of health.

The CHEC sought to demonstrate how health systems can meaningfully strengthen child health equity through action on the social determinants of health, working in partnerships with, local government, and voluntary, community and social enterprise (VCSE) partners, while embedding the views of children and young people (CYP) into strategic decision-making.

Evaluation Methodology

The evaluation of the CHEC was designed to capture both outcomes and learning, using a mixed methods approach across the three participating ICSs. Data collection included:

- Document review of ICS board papers, strategic plans, reflective diaries (completed by ICSs, Barnardo's and IHE), and internal programme reports.
- Interviews and focus groups with over 80 stakeholders, including ICS strategic leaders, operational leads, data leads, VCSE partners, and Health Equity Champions.
- Case studies and examples of good practice highlights that explore local innovations in-depth.
- Framework analysis aligned to the Child Health Equity Framework and programme objectives, assessing contribution to systems change.

Key contributions and outcomes

Although direct attribution of system-level change to the CHEC programme cannot be established, triangulated evidence from interviews, documentation, and data review suggests that the CHEC contributed to progress across the following domains.

Raising the profile of the social determinants of CYP's health - During a period of wider system reform, including the establishment of the ICSs and the CORE20PLUS5, the CHEC contributed to embedding the social determinants of children's health within local and national agendas (although this varied across the three ICS areas, with some having made progress on this prior to being part of the CHEC). Leaders we spoke to reported that issues such as poverty, housing, and school attendance are now more visible in long-term strategies, with children and young people no longer treated as an "afterthought" within local health systems, traditionally dominated by adult priorities.

Delivering interventions to address the social determinants of children's health - Evaluation of the CHEC pilot initiatives – ranging from targeted interventions with underserved families in Cheshire and Merseyside and South Yorkshire, to a study of the potential for social value and corporate social responsibility in procurement to address wider social determinants of health in Birmingham and Solihull – highlights how initiatives guided by child health equity principles can have positive impacts on the health and wellbeing of participating children and young people, with the potential to reduce inequalities. Early findings from the targeted interventions suggest benefits for the at-risk groups engaged, while in Birmingham and Solihull, emerging partnerships between suppliers and community organisations show promise in strengthening support for local children and families. The ongoing challenge for health and care systems is how to focus on the upstream drivers of child health equity and design, deliver, and link services and initiatives in ways that match both the scale and the specific nature of local needs.

Strengthening governance and strategic priorities - The programme strengthened the focus on children and young people's health within system-level discussions and supported ongoing work towards the *re-prioritisation* of children's health alongside adult services. Through its collaborative approach and advocacy, the CHEC complemented wider national and local movements to promote health equity, contributing to collective efforts that encouraged greater recognition of CYP within governance and planning structures.

Building sustainable data infrastructure – Each ICS area has developed or improved their approach to analysing, presenting, and acting on data which is equity-focused and relevant for equity in the social determinants of health. The dashboards created, or enhanced, as part of the CHEC are continuing beyond the programme and have set templates for wider adoption, showing how ICSs can integrate the social determinants of health into routine monitoring and commissioning.

Increased visibility and influence of CYP - the CHEC created formal mechanisms, including the development of the Child Health Equity Framework and the role of Healthy Equity Champions, which gave CYP a stronger voice within ICSs. While their input has not yet translated into consistent strategic influence, their presence has begun to shape conversations, interventions, and local planning, signalling the foundations for deeper involvement in decision-making. Champions across the programme gained skills, confidence, and networks, while also shaping interventions and policy priorities.

Embedding co-production and strengthening VCSE partner roles – The CHEC contributed to the strengthening of the VCSE sector as trusted partners of statutory services and young people. Organisations such as Chilypep in South Yorkshire demonstrated how sustained youth engagement can influence interventions, governance, and system-level strategies. However, there was limited evidence that VCSE partners were systematically included in decision-making and further development of the CHEC programme should consider how the VCSE, and the data they hold, could contribute more.

Developing a proportional, universal approach - Across the CHEC initiatives, local areas are demonstrating elements of a proportionate universal approach - providing universal services and support, with more help given to those in most need. This approach is essential for improving health and wellbeing for all children, reducing health inequalities through action on the social determinants of health, and improving outcomes for children and young people from underserved communities - core aims of the CHEC programme.

National visibility and influence - the CHEC has been referenced in the Hewitt Review, parliamentary committees, and other national forums and NHS conferences. This visibility reinforced local activity, helping ICSs secure senior buy-in and aligning child health equity with broader NHS and government priorities.

Systems change and legacy

The CHEC's legacy lies not only in discrete outputs but also in its contribution to wider systems change. Its work took place alongside national developments, including the statutory responsibilities of ICSs for population health and health inequalities, the CORE20PLUS5: CYP framework, and the ongoing adoption of Marmot principles (eight evidence-based recommendations to reduce health inequalities), all of which have collectively strengthened the focus on the wider determinants of children's health. Within this context, the CHEC demonstrated how upstream, preventative approaches to child health equity can be delivered within the NHS, even amid financial and structural pressures.

Despite financial and structural pressures, the programme supported the development of sustainable infrastructure, dashboards, governance mechanisms, VCSE partnerships, and CYP engagement structures that are continuing beyond its lifetime. It also contributed to a cultural shift: children's health equity is now more visible, more systematically monitored, and more firmly embedded in strategic conversations than when the programme began.

However, progress has been challenging given the resources available to ICSs to take this work forward within a three-year period. Stakeholders highlighted that while the CHEC made important strides, embedding and scaling such approaches require sustained investment, longer timeframes, and capacity dedicated to implementation at place level. Future programmes should build on this learning, ensuring that ambitions to strengthen the social determinants of children's health are matched by the resources and time needed to deliver them effectively.

Overall, the CHEC has demonstrated that the vision of preventative, neighbourhood-based health outlined in the NHS 10 Year Health Plan for England is potentially achievable for children and young people, if the required resources are invested.

Conclusion

The CHEC programme has provided important *proof of concept* for how ICBs and other ICS organisations, including the VCSE sector, and children and young people can collaborate to strengthen the focus on health equity within local systems. Its work demonstrated how partnership-based and preventative approaches can improve outcomes for children and young people, particularly in areas such as mental health, wellbeing, and resilience, all of which sit within the remit of local commissioning and service design.

While the CHEC did not directly address the broader structural determinants of health such as income or housing, it helped to raise their visibility within system discussions and reinforced the importance of intersectoral collaboration in tackling these challenges. The programme, alongside other policy and statutory requirements, acted as a catalyst for change by embedding new ways of working, demonstrating the value of co-production, and strengthening governance and partnerships.

The challenge now is to consolidate and extend this progress so that the gains made are not lost once programme-specific funding ends. The learning, tools, and strengthened relationships developed through the CHEC leave a clear foundation for future work to continue advancing child health equity within and beyond the NHS.

Introduction

Background

The CHEC is a collaboration between Barnardo's, the UCL IHE and three ICSs.

- NHS Birmingham and Solihull ICS
- NHS Cheshire and Merseyside ICS
- NHS South Yorkshire ICS

ICSs are partnerships that bring together NHS organisations, Local Authorities (LAs), VCSE organisations, and others to take collective action on improving health, address health inequalities and contribute to social and economic development. Their remit presents an important opportunity to tackle health inequalities by addressing the social determinants of health; through their Integrated Care Boards (ICBs), responsible for planning and funding most NHS services and through their Integrated Care Partnerships (ICPs), which aim to focus on collaboration to drive improvement for local populations through a health strategy for an area.

The vision of the CHEC is for all children to enjoy good health and positive wellbeing, regardless of circumstance. The CHEC is centred on strengthening the role of the health system in acting on the social determinants of health for CYP. The social determinants of health describe the social and environmental conditions in which people are born, grow, live, work and age and which shape and drive health outcomes.

The CHEC sees action on the social determinants of health as essential in improving health outcomes among CYP and reducing inequalities in health. These include access to good-quality living conditions, experiences, and services during early childhood; good-quality education and opportunities for lifelong learning; households having sufficient income, adequate and affordable housing; and living in connected and inclusive communities in healthy environments[1][2].

Aims of the CHEC

The World Health Organisation defines health equity as the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health equity is achieved when everyone can attain their full potential for health and well-being[3].

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[1] The social determinants of child health - ScienceDirect

[2] Adolescence and the social determinants of health - The Lancet

[3] Health equity (who.int)

The CHEC's Goals, Aims and Objectives

Programme Goals

1. To promote the vision for all children to enjoy good health and positive wellbeing.
2. To reduce inequalities in CYP's health by acting on the social determinants of health.
3. To improve outcomes for CYP from underserved communities.

Programme Aims

1. ICSs strengthen their focus on the social determinants of child health with the aim of achieving more equitable outcomes for children.
2. To actively involve the VCSE sector in identifying and addressing the social determinants of child health to promote more equitable outcomes for children.
3. To strengthen the embedding of CYP's priorities and insights into ICS strategic planning and decision-making processes.

Programme Objectives - Increase focus within ICSs on the social determinants of child health and child health equity by:

1. Strengthening local partnership working.
2. Delivering an intervention or initiative informed by CYP's insights and that addresses one or more of the social determinants of child health.
3. Improving the monitoring and use of key child health equity data.
4. Actively engaging decision-makers by raising their awareness of child health equity and the social determinants of child health to support informed decision-making.
5. Establishing or strengthening formal mechanisms for capturing, integrating, and acting on CYP's priorities and insights within ICS strategic planning processes.
6. To generate and share learning from the evaluation of interventions and initiatives to inform ICS decision-making, strengthen local system partnerships, and support action on the social determinants of child health.
7. To use programme-level evaluation to understand the overall contribution of the CHEC programme to child health equity, support strategic learning across ICSs, and inform future system-wide approaches.

Programme delivery

The CHEC was devised as a three-year programme. Mobilisation started in October 2022 and ended in October 2025, although funding for certain posts (including the Barnardo's project manager for the programme) ended in March 2025. The programme was sponsored by Barnardo's and delivered in partnership with IHE and with the three ICSs listed earlier, who were chosen via a competitive application, shortlisting and interview process. The CHEC operated according to four key workstreams. Each was devised by Barnardo's and IHE after consultation with key partners. These workstreams were:

Workstream 1 – The Child Health Equity Framework

This was developed by the CHEC with direct input from CYP local to the three ICSs. It was adapted from the 2008 Commission on the Social Determinants of Health (CSDH) framework and based on a substantial evidence base about the main drivers of health among CYP. During the development of the framework, workshops took place with over 300 CYP, exploring what the drivers of good health and wellbeing are. This resulted in substantial changes being made to the initial iterations of the framework to reflect these viewpoints. The framework had several intended purposes:

1. To set out the key drivers of health and wellbeing for CYP.
2. To guide the analysis of data and the development of indicators to assess and monitor inequalities in CYP's health and wellbeing and their determinants of health in each ICS.
3. To support and guide ICSs in the commissioning and development of interventions and services to improve CYP's health and wellbeing.
4. To strengthen partnerships between health care, public health, LAs and the VCSE sector, so they can work effectively together to act on the social determinants of health.

Workstream 2 - Data analysis and collation

This workstream was intended to support partner organisations to create and iteratively refine an assessment of child health equity, incorporating CYP's insights, stakeholder intelligence, VCSE sector insights, LA and healthcare data. The purpose of this workstream was to inform identification of priority areas for action on child health equity and support the data requirements of the Child Health Equity Framework as specified above. As will be evidenced throughout this report, the focus of this workstream was reframed to address emerging challenges and ensure the practical applicability of its outputs.

Workstream 3 - Interventions in the ICS areas

This workstream involved the development of pilot interventions in each ICS area, which were intended to be based on the findings from the framework, data workstream, and produced with CYP's voice and influence. The aim of these pilots was to support improvements in child health equity through acting on the social determinants of health. These interventions were evaluated by IHE with the findings presented in Section 9.

Workstream 4 - Health Equity Champions

The involvement of CYP was central to the CHEC. In the early stages of the programme, this involvement focused on the consultation exercise to develop the framework (mentioned above). As the project developed, the team introduced the Health Equity Champion role. The role of the Health Equity Champions was designed to ensure that the work of the programme was grounded in the voices and experiences of children and young people. Champions were recruited from across the local ICS areas to inform and co-produce the design and delivery of activities. They were asked to contribute their own perspectives as equal partners in shaping the programme.

Governance of the CHEC

The CHEC had a governance structure comprising four key aspects:

- **Development Committee meetings** - held every 8 weeks - these meetings brought together the wider operational group of the CHEC to provide updates across the partnership and to discuss existing and emerging risks across the programme.
- **Children and Young People's Health Equity Board meetings** - held every 4 months - this was a senior stakeholder group whose role was to be accountable for the oversight and guidance of the CHEC, to provide strategic insight for health equity, influence national health policy, and offer expertise and advice for further strategic partnership working. Stakeholders included, Barnardo's, IHE, the Senior Responsible Officers (SROs) for the CHEC, representatives from National Health Service England (NHSE), the Local Government Association (LGA), the Royal College of Paediatrics and Child Health (RCPCH), the Race Equality Foundation, and the Education Endowment Foundation.
- **Evaluation steering group meetings** - held every 6 weeks - these meetings brought together leads from across the CHEC to inform both the programme evaluation and the intervention evaluations. They provided opportunities to share updates and discuss existing and emerging risks related to the evaluation workstream.
- **Data workstream meetings** - held every 2 weeks - these meetings brought together the data leads from each of the ICS areas to discuss progress within the data workstream alongside Barnardo's and IHE.

The ICS areas

To understand the progress made in the three ICS areas who took part in the CHEC, it is important to consider the point at which they started. Below is a summary of the work they were already doing in relation to child health equity, why they wanted to join the collaborative, and some of the key challenges faced by CYP in their geographical locations.

NHS Birmingham and Solihull

NHS Birmingham and Solihull ICS had made a strong and strategic commitment to tackling health inequalities across its diverse population. At the heart of this effort was a dedicated Health Inequalities (HI) Core Team, which led the implementation of a comprehensive Five-Year Strategy. This strategy was rooted in the ICS's Long-Term Plan and guided by principles from the ICS Inception Plan, which were soon to be embedded in a 10-year Master Plan. The strategy prioritised six key areas: maternity and infant mortality, early childhood health, major disease prevention, mental health, disability inclusion, and support for vulnerable groups such as migrants and homeless individuals. These priorities were supported by foundational "building blocks" and a unified approach to working that emphasised community co-production, targeted prevention, and proportionate universalism.

Birmingham and Solihull ICS had been eager to join the CHEC to deepen its impact. Serving 1.3 million people in one of England's most materially deprived regions, the ICS viewed this partnership as a vital opportunity to address entrenched childhood health inequalities. The collaborative offered a platform to work alongside thought leaders like Sir Michael Marmot and organisations such as Barnardo's, enabling Birmingham and Solihull ICS to influence national policy, share best practice, and strengthen its cross-sector partnerships. The ICS also brought valuable insights from initiatives like the Birmingham Poverty Truth Commission, which amplified the voices of those with lived experience of poverty.

The challenges facing CYP in NHS Birmingham and Solihull are stark. The region grapples with high levels of child poverty, elevated infant mortality rates, and concerning levels of childhood obesity. Access to mental health support, especially for Black and minority ethnic communities, remains a pressing issue, alongside gaps in early years services and widespread fuel poverty. In response, the ICS articulated a bold vision for 2027: to make Birmingham a great place to grow up, where children were healthy, safe, respected, and supported to thrive. This vision was underpinned by a Children's Plan focused on inclusion, safety, and integrated support.

NHS Cheshire and Merseyside

NHS Cheshire and Merseyside ICS had demonstrated a deep and longstanding commitment to tackling health inequalities, particularly those affecting CYP. With over 27% of the population under 18 and many living in areas of significant deprivation, the ICS had prioritised early intervention and prevention through a range of collaborative programmes. Central to this was the "Beyond" transformation programme, which had been co-produced across the public health system, with input from Social Care, Directors of Public Health and NHS Providers. It focused on key areas such as healthy weight, respiratory health, emotional wellbeing, learning disabilities, autism, diabetes, and epilepsy. The programme was underpinned by a population health approach and supported by robust data analytics, including the use of cross-agency datasets and deprivation indices to target areas of greatest need.

The ICS had been eager to join the CHEC to further its mission of reducing health inequalities, viewing it as an opportunity to align its existing work, particularly the Beyond programme and the Marmot-informed Cheshire and Merseyside wide "All Together Fairer" strategy-with national efforts, ensuring that CYP across the region benefited from evidence-based, data-driven improvements in health and wellbeing.

The challenges facing CYP in Cheshire and Merseyside were stark. The region has some of the highest levels of deprivation in England, with over 67,000 children living in absolute low-income families. Educational attainment is below average, obesity rates are high, mental health needs are increasing, and hospital admissions for self-harm and asthma are more frequent than the national average. Breastfeeding rates are low, and a higher proportion of children are in local authority care. These issues were compounded by significant disparities in healthy life expectancy across the region.

NHS South Yorkshire

NHS South Yorkshire (SY) ICS had long been committed to tackling health inequalities, with a vision to ensure everyone in the region had the best possible start in life and support to live well for longer. Since its inception as a first-wave ICS in 2016, NHS South Yorkshire had built strong collaborative foundations across its partners, culminating in the formation of NHS South Yorkshire in July 2022. The ICS's top priority was improving population health outcomes and reducing inequalities from pre-birth through to old age, guided by a three-pronged approach: civic engagement, community empowerment, and health service transformation.

Civic efforts included working with local authorities and the Mayoral Combined Authority to influence public policy and promote inclusive growth. Community initiatives focused on strengthening local partnerships and assets to help residents manage their health. Within health services, SY ICS addressed clinical variation and prioritised prevention, supported by robust partnerships with local authorities and the voluntary sector.

SY ICS had been eager to join the CHEC because it recognised that meaningful change for CYP required a proactive, equity-driven approach. With 1.357 million residents, 43.2% of whom live in the most deprived areas nationally, the region faces stark challenges. It is home to over 328,000 children and young people aged 0–18 and around 411,000 aged 0–25, many of whom experience poverty. Yet, there was a strong collective will to drive change. The SY CYP Alliance fostered a movement focused on improving outcomes for all CYP, emphasising collaboration across sectors including housing, education, health, and community organisations.

The ICS identified key issues affecting CYP through direct engagement, data analysis, and collaboration with the voluntary sector. Young people voiced concerns about mental health, service accessibility, and lack of understanding around identity and disability.

Data highlighted troubling trends in child mortality, maternal health, obesity, oral health, and developmental delays. The impact of Adverse Childhood Experiences (ACEs) was particularly pronounced among looked-after children and those with chronic conditions. VCSE partners also flagged issues such as poor sleep, domestic violence, and barriers to education and employment.

To address these challenges, SY ICS set clear priorities: amplifying CYP voices, promoting early intervention, improving outcomes for chronic conditions, enhancing urgent care access, reducing waiting times, expanding mental health services, and building a resilient workforce. Innovative models of care, including end-of-life support, were also explored.

Report structure

This report examines the impact the CHEC programme has had over the last three years. It draws on evidence collected from a range of sources to assess the extent to which the collaborative has achieved its aims and objectives. The next chapter explores how the evaluation was designed, including the role of IHE in designing and delivering the evaluation of the pilot interventions in the three ICS areas. The findings of the evaluation are structured according to the key programme objectives, and will explore what the CHEC had hoped to achieve, present evidence regarding what has changed (and how that happened), provide an overview of the key enablers and challenges that helped or hindered the CHEC programme from achieving its objectives, and present good practice case studies to support other areas wishing to address child health equity in their locality. The final chapters present the overall conclusions of the evaluation, summarising the extent to which the CHEC's aims and objectives have been achieved, before making recommendations for future collaborative efforts to improve the health and wellbeing of CYP through addressing the social determinants of health.

Methodology

Evaluation aims

The overarching aim of this impact evaluation was to assess the extent to which the CHEC has driven systems change to address inequalities in child health, through addressing the social determinants of health in three ICS regions.

The key research questions guiding this evaluation included:

Outcomes

- To what extent have the key outcomes of the CHEC programme been achieved?
- Have there been other outcomes because of the CHEC programme?

Mechanisms

- What are the mechanisms for change in the CHEC and what impacts (intended or unintended) do they lead to?

Contexts

- What are the contextual factors that affect implementation of the programme - at the programme and at the ICS level?

Next steps

- What can be learnt from the CHEC programme to strengthen healthcare system action on the social determinants of children's health?

Evaluation approach

This evaluation has used the framework of realist evaluation. Realist evaluation[4] is a theory-based approach to evaluation which seeks to understand what works, for whom, in what circumstances and in what respects. It emerged in the 1990s as a response to criticisms of traditional evaluation approaches. At the time, most social policy evaluations either used experimental approaches (such as randomised controlled trials) that could *measure* the difference between two points, or more qualitative approaches that could *describe* the difference between two points - but neither could explain *how* the difference was achieved. It was the desire to understand causality between interventions and outcomes that led to new evaluation approaches such as realist evaluation. For more information on this approach, please see Appendix A.

In the first stage of the evaluation, we coproduced a theory of change with Barnardo's and IHE to demonstrate the outcomes the CHEC was hoping to achieve, the mechanisms that might lead to those outcomes, and the contexts that helped or hindered them. At that stage in the process, the mechanisms and contexts were a hypothesis about how the collaborative might achieve the key outcomes. This hypothesis informed how we

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[4] Pawson, R. and Tilley, N. (1997) Realistic Evaluation. Sage: London

designed our data collection tools so that we captured evidence about what was achieved, how, and in what contexts. In this report, we explain how outcomes (aligned to the key objectives) were achieved, and the contexts that enabled or hindered their progress. See Appendix B for the initial theory of change that was designed at the start of the evaluation.

The interim evaluation

In February 2025 we presented an interim report which outlined what had been achieved to date by the CHEC. The interim report was based on qualitative interviews with people who had been working on the programme from Barnardo's, IHE and the ICS areas. It also drew on data collected through an online reflective diary where partners reported on their activities and progress.

Refining the scope of the evaluation

Following the interim report, we worked with Barnardo's, IHE and the three ICS areas to refine the evaluation aims and activities to ensure the programme evaluation would reflect what partners needed from it. We also worked with partners to identify additional forms of data that could be used to evidence progress against the CHEC's aims and objectives.

Data collection approaches

All interview, focus group and workshop topic guides were designed according to the evaluation aims and objectives. Participants were provided with information about the purpose of the evaluation and were given the opportunity to ask questions before taking part. Topic guides and information sheets were reviewed by the project team and participants could choose to not be directly quoted if they wished.

Stakeholder roles

Participants involved in the evaluation represented a range of roles across the CHEC programme and partner organisations. These roles reflected the programme's multi-layered structure and ensured that insights were gathered from strategic, operational, technical, and youth perspectives.

- **ICS Leads** - senior representatives with strategic roles within each ICS, responsible for the overall design, delivery, and strategic oversight of the CHEC programme at a local level.
- **Data Leads** - data analysts leading on the design, development, and use of dashboards and datasets to monitor children's health equity.
- **Engagement Leads** - practitioners coordinating and directly supporting the involvement of children and young people (CYP) in each ICS, ensuring their voices informed programme design, delivery, and evaluation.
- **Health Equity Champions** - young people recruited through the CHEC programme to help ensure that the work of the programme was grounded in the voices and experiences of children and young people.

Interviews and workshops with Health Equity Champions

Over the course of this evaluation, we have engaged with 17 Health Equity Champions. We spoke to four in the first stage of the evaluation (to inform the interim report) and a further 13 in the final stage We used a range of approaches, which were designed with CYP and in consultation with Barnardo's. This included 1-2-1 chats, group discussions and workshops. In the final stage of the evaluation, we delivered a workshop with Champions where they fed into the evaluation design and provided their views on what was important to ask of professionals. We also held workshops to understand what they had gained from being a Health Equity Champion and what they felt could be improved. Table 1 presents an overview of the activities with CYP and the ICS areas they represented.

Interviews with the project team (Barnardo’s and IHE)

We carried out interviews with the project teams at Barnardo’s and IHE for both the interim report and final evaluation. In phase 1 of the evaluation, interviews began in August 2024 and continued until December 2024. In the second (final) phase of the evaluation we spoke again to some key members of the project team to capture their final reflections on what the CHEC had achieved and what could be learnt.

Interviews with ICB programme staff, LAs and VCSE partners

During phase 1 of the evaluation, we spoke with 21 professionals from across the ICS areas, including professionals in ICBs, LAs and VCSE organisations. We had been unable to start these interviews until a data sharing agreement had been signed between M.E.L Research and IHE (as the data would be relevant to both evaluations and topic guides were designed collaboratively). This process took some time and was officially signed in December 2024. We received names and contact details for people to be interviewed from the ICSs in January 2025 and completed 21 interviews between mid-January and the start of March 2025. The interview topic guides covered several areas, including partnership working, CYP engagement, the interventions and impacts to date. There were some challenges in combining topic guides with IHE, namely the number of areas to cover and the limited time that people had to take part. Consequently, we agreed with IHE that in phase 2, there would be situations in which both IHE and MEL Research interviewed the same people.

In phase 2, we spoke with another 21 professionals from ICS areas, including professionals in ICBs, LAs and VCSE organisations. It is important to note that there were significant challenges in the NHS during 2025 (including the disbanding of NHS England and significant budget cuts for NHS Integrated Care Boards). This understandably impacted on the capacity of key people within NHS organisations and so we did not re-interview people if they had taken part in phase 1 of the evaluation, unless it was completely necessary. We worked with the evaluation steering group and the project team to identify key people who were involved in different aspects of the programme. This included people with operational experience, strategic leaders, those involved in working with CYP and those involved in the data workstream.

Analysis of reflective Padlets (online diaries)

Each partner in the programme was provided with a reflective online Padlet where they could keep track of their activities and achievements. In October 2024, we redesigned the Padlets due to low completion rates and changed some from individual to group ones. Completion of the Padlet diaries has been variable during the evaluation with some partners completing them more regularly than others. Despite this, we have been able to obtain some valuable insight into the CHEC programme activities through this method.

Desk review

In addition to the primary data collection methods described above, we also conducted a comprehensive review of documents relevant to the CHEC programme. These included Joint Forward Plans published by ICBs, Children and Young People’s Health Equity Board minutes, ICB meeting minutes, presentations delivered, newsletters, articles and reports. In total, we reviewed 49 documents as part of the evidence review. Each document was reviewed in line with the aims and objectives of the CHEC programme to review evidence of if and how they had been achieved.

To protect participant anonymity, particularly given the small sample sizes within individual ICS areas and stakeholder groups, detailed disaggregation of participation data has not been provided. Instead, overall participation figures are summarised below, reflecting engagement across the main stakeholder groups involved in the evaluation, including Barnardo's and IHE programme staff, ICB representatives, LA and VCSE partners, and the Health Equity Champions.

Participant overview

Phase 1
Data collection included interviews with Barnardo's and IHE staff, ICB representatives across the three participating systems, LA and VCSE partners, and a focus group with Health Equity Champions, alongside analysis of Padlet diaries.

- Participants contacted: 49
- Participants engaged: 40

Phase 2
Follow-up data collection comprised interviews with Barnardo's and IHE staff, ICB representatives, and local partners, including from the VCSE sector, as well as workshops with Health Equity Champions and analysis of Padlet diaries.

- Participants contacted: 76
- Participants engaged: 52

To protect the identities of those who have taken part, we have not included job titles or ICS areas next to quotes. We have referred to all Barnardo's and IHE participants as 'Project team participants', all ICB staff, VCSE and LA partners and external stakeholders as 'ICS participants' and all CYP as 'Champions'. Next to each quote, we provide the participants' code (either individual interview or focus group number), their role and whether they took part in phase 1 (P1) or phase 2 (P2) of the evaluation.

Analysis

All qualitative data, including interviews, Padlet entries and secondary data sources have been analysed thematically, and in line with the realist evaluation framework. All analysis has been reviewed by the MEL Research evaluation project manager.

The data collected during the evaluation has been used to answer the key research aims (and associated questions). Where possible, a range of data sources was used to evidence the findings (thereby strengthening their veracity).

Limitations and challenges

There are several limitations and challenges associated with this evaluation. The first concerns the challenging situation in the NHS at the time of writing, which has impacted on both the programme and the evaluation. In the case of the evaluation, it has been difficult for senior leaders and operational staff to find time to participate. In respect of the programme, the rapidly changing structure and priorities within the NHS have created additional complexity for implementation, including challenges in securing the resources needed to meaningfully include CYP voices.

The second relates to programme delivery and continuity. Staff changes within Barnardo's meant that the composition of the team leading the programme shifted during its lifetime. While this brought new perspectives and renewed energy, it also created challenges for continuity and knowledge transfer, which may have influenced the pace and consistency of delivery across regions.

Finally, the timeframe in which this programme and the evaluation have operated in has been challenging. While the CHEC programme was launched in October 2022, the evaluation wasn't commissioned until March 2024. This meant that much of the programme activity had taken place prior to any evaluation (resulting in the Interim Report reflecting on early implementation). Moreover, data collected in phase 1 of the evaluation could not happen until January 2025. This pushed data collection for phase 2 into the summer holiday period, which has impacted response rates to interview requests.

Despite these challenges, we have been able to gather views and perspectives from staff across each of the ICS areas to understand the impact that the CHEC programme has had.

Summary of Findings

Table 1 - Summary of findings

	Outcomes	Overall Strength of Evidence No Evidence Limited Evidence Good Evidence Strong Evidence	Summary of findings
Objective 1	Effective partnerships have been developed and/or maintained within the ICSs including with LA and VCSE partners to understand and address CYP health inequalities.	🟢	Strong evidence from interviews, reflective diaries, and the desk review that the CHEC strengthened existing partnerships and, in some cases, facilitated new collaborations between ICBs, VCSE partners, and statutory partners.
	VCSE partners are included in planning and decision-making regarding children's health.	🟠	Limited evidence that VCSE partners were systematically included in decision-making, though strategic documents suggest growing recognition of their role and future potential for deeper involvement.
	Raise the status of the VCSE sector contribution.	🟡	Good evidence that the VCSE sector's contribution was valued and increasingly visible across ICSs, with the CHEC helping to amplify their role and raise the profile of youth-led voices, though decision-making influence remains limited.
	Improved partnership working between ICS areas	🟡	Good evidence that the CHEC fostered new cross-ICS collaboration, breaking down silos and building strong relationships between leads and data teams in different ICS areas, with early signs of longer-term systems change.

	Outcomes	Overall Strength of Evidence				Summary of findings
		No Evidence	Limited Evidence	Good Evidence	Strong Evidence	
Objective 3	Current gaps within health system data are highlighted and understood, with plans in place to fill them.				●	Strong evidence from documents and interviews that the CHEC highlighted child health data gaps, with new dashboards and monitoring plans developed, though persistent challenges remain around primary care, LA integration, and linking data to outcomes.
	ICSs understand data on the social determinants of children's health and their impact on CYP			●		Good evidence from interviews and documents that ICSs are beginning to, or strengthening, their understanding of data on the social determinants of health, with clear examples of impact in some areas, though uptake and integration into decision-making remain uneven across ICSs.
	VCSE sector data is captured and accessible to all partners and there is improved understanding of VCSE sector held data.	●				We found no evidence that VCSE sector data was captured and accessible to all partners.
Objective 4	ICSs understand the social determinants of CYP's health				●	Strong evidence from interviews and strategic documents that ICSs consistently understand the social determinants of CYP's health, with the CHEC reinforcing existing priorities in some areas and helping to embed social determinants of health more tangibly into strategic planning in others.
	There is greater prioritisation of CYP within population health management plans for ICSs				●	Strong evidence from interviews and documents that the CHEC has supported the increased prioritisation of CYP within population health management plans in some ICSs, aligning with pre-existing priorities in others; however, translation into concrete budgetary or structural change remains uneven.

	Outcomes	Overall Strength of Evidence No Evidence Limited Evidence Good Evidence Strong Evidence	Summary of findings
	Population health management approaches give proportional support for underserved communities.	🟠	Limited evidence that population health management approaches are giving proportional support to underserved communities, with some examples in one ICS and isolated interview evidence elsewhere, but little indication that the CHEC directly influenced this focus.
Objective 5	The issues that matter to CYP inform ICS strategic planning.	🟡	Mixed evidence that CYP priorities inform ICS strategic planning, with strong early influence via the CHEC framework and local initiatives, but inconsistent integration across regions.
	CYP feel like their input matters and will be acted on.	🟡	Good evidence that CYP felt their contributions were valued, though confidence in whether input would be acted upon was mixed, with stronger examples of impact in some ICSs than others.
	Benefits to CYP directly	🟡	Good evidence from Champion focus groups and ICS interviews that involvement in the CHEC directly benefited CYP, particularly through increased confidence, skills, wellbeing, and opportunities.

Findings - Objective 1

Strengthening local partnership working

Context

When ICS areas applied to be part of the CHEC programme, they were required to evidence their existing partnerships. This was because partnerships were seen to be the cornerstone of the CHEC[5]. While each ICS area had different types of partnerships in place, they all could evidence existing structures for the CHEC programme to become part of. It is therefore important to recognise that the impact of the CHEC has been weighted towards strengthening partnerships as opposed to developing new ones (although this has been achieved in some areas).

Role of the CHEC in fostering partnership working

Partnership working was a foundational element of the CHEC programme and was deeply embedded in how it was designed. From the outset, all partners shared a unified vision: to reduce health inequalities for CYP through a preventative, place-based approach. This common purpose helped to foster strong collaborative relationships across sectors.

Governance structures such as the Children and Young People's Health Equity Board, alongside the involvement of local leads operating within wider ICS partnerships, ensured that strategic direction, evaluation, and decision-making were guided collectively. Multi-agency collaboration was evident throughout the programme, with Barnardo's, the IHE, ICBs, local government, VCSE organisations, and wider statutory services, including health and social care, all playing key roles. The active engagement of local government partners was particularly important in connecting system-level priorities with place-based delivery and ensuring alignment with broader local strategies to improve children's health and wellbeing. Co-chairing of workstreams and joint planning of activities further reinforced this collaborative ethos.

Outcomes

The below discussion presents evidence from a range of sources to demonstrate the extent to which key outcomes aligned to this objective have been achieved. After discussing the evidence of outcomes, we consider what it was about the CHEC programme that led to those outcomes (referred to as mechanisms) and the contextual factors that supported or hindered the achievement of the outcomes.

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[5] While CYP are considered a key partner in the CHEC, their involvement is presented in section 13 of the report.

Effective partnerships have been developed and/or maintained within the ICSs including with LA and VCSE partners to understand and address CYP health inequalities.

We found strong evidence that effective partnerships had been developed/maintained as part of the CHEC.

In all three ICS areas, the CHEC was seen to have built upon strong, pre-existing relationships with VCSE partners. Participants described the CHEC as bringing together fragmented efforts and enhancing existing relationships:

> *"CHEC has been a catalyst for bringing people together and uniting some of this fantastic work." (ID7, ICS, P2)*

During the desk review, we found explicit references to the CHEC's role in developing or maintaining partnerships. In NHS South Yorkshire, ICP Board Papers in June 2025 referenced cross-sector collaboration between VCSE partners, NHS, education and local authorities, highlighting programmes such as the Friday Fun Club (NHS South Yorkshire's programme intervention). These papers also noted that learning from the CHEC initiative has helped to inform the ICB's strategic direction for children and young people's commissioning, particularly through data-informed insights, strengthened collaboration, and a system-wide commitment to amplifying the voice and influence of young people. Moreover, internal documents from the three ICS areas outlined how vital VCSE organisations had been in the design and delivery of the CHEC programme. Their input started with the consultation exercise on which the framework was based, where VCSE organisations played a key role in engaging with CYP.

In addition to strengthening existing partnerships, we found examples of new partnerships being developed because of the CHEC programme. For example, in NHS South Yorkshire's reflective diary, they describe their close working relationship with Rotherham United Community Trust (RUCT) who have been a key partner in delivering their intervention. They also described developing relationships with new schools to increase the number of children who could take part in the Friday Fun Club. In NHS Cheshire and Merseyside's reflective diary, they described several partnerships that strengthened because of their involvement in the CHEC programme, including with the Dolly Parton Imagination Library, BookTrust and Family Nurse Partnership programme who are key partners in their intervention (see Section 9).

Overall, the CHEC was described as having a positive influence on partnership working at the ICS level. For one participant, it was credited with significantly improving partnership working between VCSE partners and NHS providers (ID38, ICS, P2). Similarly, others reflected on how partnership working had changed since the CHEC:

> *"I think it [partnership working] has changed…I think it's becoming more important to people. I think we're now working in systems where people are really realising that we've got to work together in order to make the biggest difference that we can make." (ID25, ICS, P2)*

> *“Structurally it has added weight to stimulating an infrastructure around CYP, which has been a catalyst… The CHEC board itself has created partnerships which didn’t exist before in one entity.” (ID42, Barnardo’s, P1)*

Trust between partners in different sectors was reported to have grown, fostered by shared values and long-term relationships.

> *“I think it’s shared values… I’ve worked at [VCSE organisation] for 16 years and this is the best I’ve seen it working, being integrated into NHS services and policies.” (ID22, ICS, P2).*

The available evidence suggests that the CHEC has played a key role in both maintaining partnerships to address child health inequalities and, in some cases, developing new ones.

VCSE partners are included in planning and decision-making regarding children’s health

We found limited evidence that VCSE partners were included in decision-making regarding children’s health.

In our desk review we found some evidence across the three ICS areas to suggest that at a broader level, VCSE partners are included in planning and decision-making regarding children’s health. For example, in NHS Birmingham and Solihull, the Birmingham Poverty Truth Commission report (2024) explained how VCSE organisations had contributed to listening events that shaped strategic responses to child poverty and food insecurity. In NHS Cheshire and Merseyside (where a VCSE representative co-chairs their ICP), ICB Board papers from January and March 2025 referred to VCSE partner engagement in the coproduction and service redesign of Special Educational Needs and Disabilities (SEND), with structured input into board-level decisions. In NHS South Yorkshire, their NHS Joint Forward Plan (March 2025) explained how VCSE organisations are part of the CYP Alliance, a formal mechanism for integrating CYP and VCSE sector priorities into ICS planning. These documents suggest a partnership approach to addressing children’s health in the three areas.

In our interviews with strategic leads in the ICSs, we did not find evidence to suggest VCSE partners were currently included in planning and decision-making regarding child health equity, however, a leader in one ICS suggested they wanted VCSE organisations to take a more active role:

> *"They're really key to it [addressing child health equity] because they quite often are much closer to some of the communities you want to get to than the statutory organisations. They are delivering services and programmes in a way that is more innovative because it's light touch. So, I think we would want to work with them as equal partners, recognising what they bring to the table independent of any kind of funding or commissioning that we do direct with them." (ID29, ICS P2)*

In another ICS area, a senior leader commented how they were trying to partner more effectively with the VCSE sector:

> *“So, there is something about how we could partner differently at the local level, perhaps with a slightly more creative devolution deal to go." (ID13, ICS, P2)*

These quotes demonstrate that while there may be a commitment to meaningful collaboration with VCSE partners moving forward, this has yet to translate into VCSE partners being included in the decision-making process.

Raise the status of the VCSE sector contribution

Good Evidence

We found good evidence that the VCSE sector's contribution is valued across the three ICS areas, and there is some evidence that the CHEC has contributed to this.

Evidence from the desk review suggests that in all three ICS areas, VCSE partners are considered key contributors to addressing child health equity. In NHS Birmingham and Solihull, their Joint Forward Plan (2025) situates the VCSE sector as key partners, highlighting how the NHS is investing in the sector to help address some of the social determinants of health. In reference to the CHEC specifically, an article by Rukshana Kapasi (Director of Health, Quality and Inclusion at Barnardo's) and Patrick Vernon (Chair of NHS Birmingham and Solihull ICB) explained how VCSE organisations in Birmingham have been involved in innovative procurement and digital inclusion projects, with their role discussed at ICB level (indicating strategic recognition).

In NHS Cheshire and Merseyside, their Joint Forward Plan acknowledges VCSE organisations as essential partners in delivering CYP-focused programmes. Similarly, their ICB Board papers (January and March 2025), explain how VCSE sector engagement is embedded in SEND co-production and service redesign, with board-level awareness of their contributions. In relation to the CHEC specifically, their Beyond[6] newsletters detail the vital role of VCSE organisations in shaping the framework and delivering the intervention.

In NHS South Yorkshire, ICB Board papers (June 2025) explain how VCSE organisations are embedded in governance and delivery structures, with their contributions influencing strategic direction. With respect to the CHEC programme, several documents (e.g. internal updates and progress reports) refer to the vital role of VCSE organisations, particularly Chilypep who are recognised for amplifying CYP voices and influencing regional health strategies - demonstrating increased visibility and strategic value.

These documents suggest a genuine appreciation of the VCSE sector across the three ICS areas.

This sentiment was reiterated during interviews with ICB staff, who emphasised that VCSE partners are key to addressing child health equity at a local level, with some participants valuing their different approach:

> *"They are delivering services and programmes in a way that is more innovative" (ID29, ICS, P2)*

While it is difficult to be sure of the extent to which the CHEC programme has raised awareness of the contribution of the VCSE sector, it is clear from the evidence we have seen that all three areas value their VCSE partners. However, as discussed, the VCSE sector continues to have a limited role in decision-making across many areas, indicating that further work is needed to raise their status to that of equal partners within

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[6] Beyond is the CYP Transformation programme in Cheshire and Merseyside. It is a partnership across the Integrated Care Partnership (ICP) landscape with Local Authorities, health, and the voluntary, community and social enterprise (VCSE) sector with a focus on children's early intervention and prevention.

ICS governance. There are, however, emerging examples of stronger representation. For instance, within the NHS Cheshire and Merseyside Health and Care Partnership, where the VCSE sector is represented at the highest level through the appointment of Rev Canon Dr Ellen Loudon as Co-Vice Chair.

In one ICS, a VCSE partner interviewee highlighted that the CHEC had strengthened awareness of the VCSE sector contribution within local systems and explained that CHEC's emphasis on equity and partnership raised the visibility of their work within ICS discussions and provided a platform for youth-led voices to be heard by senior leaders. For example, CYP involved in their programmes presented directly to the local Mayor and other professionals at the ICP Board meeting, where their manifesto generated four follow-up requests from NHS leaders within two weeks:

> *"They then created a manifesto… they launched it at this meeting and there were lots of higher professionals there and the Mayor… and from that they got four completed opportunity requests within two weeks from senior leads in the NHS to work with them on direct points." (ID22, ICS, P2)*

The CHEC was also seen as contributing to a new tone of collaboration between statutory services and the VCSE sector, with young people being listened to at higher levels than before:

> *"The young people have had so many recent opportunities to work with the ICS that it's really now set a tone for the work that they do, and they're being heard really, really high up." (ID22, ICS, P2).*

Improved partnership working between ICS areas

In addition to the outcomes envisaged by the CHEC programme, we were able to find good evidence of a new outcome during the evaluation. This refers to cross-ICS collaboration that has been a key achievement of the CHEC programme.

Many ICS respondents commented on good working relationships across ICSs, and one added that Barnardo's had done well in fostering good working relationships across three quite different areas. Regular meetings between the ICS leads, and between ICS data leads, were mentioned as being useful for sharing learning and had led to some strong working relationships. For example, one of the data leads described the CHEC 'team' as being them and the other two ICS data leads. One of the ICS leads commented:

> *'The learning between the three ICSs, … those relationships have been a bit of a highlight, I would say (ID9, ICS, P1).'*

Another ICS respondent explained:

> *"It's been really good to do the shared expertise with other ICBs. I think that's been a really big benefit out of the programme. It's been great to meet the other two areas and there's been some really strong bonds formed as well, which is really helpful." (P21, ICS, P1)*

Interview participants recognised that NHS organisations can typically work in silos, with limited sharing of knowledge or resources. However, it was felt that the CHEC was helping to shift this perspective, not only through the data workstream, but also through the working examples of the Child Health Equity Framework developed by public health registrars on issues such as asthma and mental health. This is an important outcome for the CHEC programme which suggests the beginning of a longer-term change in their approach to partnership working.

It was further noted that the CHEC facilitated both local system collaboration and wider influence:

> *"In some instances, local systems have had to come together and work with partners in ways they wouldn't have done as quickly without CHEC… At the same time, evidence from over 300 CYP is now shaping Barnardo's national policy initiatives." (ID42, Project team, P2)*

Mechanisms

We were keen to understand what it was about the CHEC that enabled the above outcomes to be achieved. There were four key mechanisms to emerge from our analysis.

Facilitated partnership working

Barnardo's were described as playing a key role in supporting effective partnership working:

> *"That [collaborative working] wouldn't be possible if Barnardo's wouldn't allow us that kind of that mutual respect of sharing and growing and developing together…They described where we needed to get to, and asked how we thought we might best get there (P23, ICS, P1)*

It is possible that without the approach taken by Barnardo's, it may have been more challenging for ICSs to coordinate between themselves, and with wider partners.

Early and strategic engagement

In one ICS area, VCSE partners were engaged early through workshops that shaped the understanding of health and its wider social determinants. Their leadership in delivering interventions and sharing community insights was pivotal. One stakeholder explained,

> *"We held a couple of workshops at the very beginning of CHEC within the first year or so to understand from their perspective their insights on health and wider social determinants." (ID24 ICS, P2)*

This strategic involvement early on ensured that interventions were grounded in lived experience and local relevance.

Quality of relationships

Strong relationships built on mutual respect and shared goals were consistently cited as central to the efficacy of partnerships. Participants in two ICSs, commented on strong, relationship-based partnership working with clear team roles, mutual respect (ID28, ICS, P2), *"whereby partners worked well together, despite differing views" (ID34, ICS, P2)*. These reflections highlight how trust and relational strength can overcome complexity and differing perspectives.

Development of partnership infrastructure

System-level boards and cross-sector collaboration were seen to have laid the foundation for effective partnerships. People who had attended the Development Committee described it as an operational group that helped keep the programme on track. They valued hearing from the other ICSs as a source of learning and reassurance. People who had attended the Children and Young People's Health Equity Board meetings described them as strategic and future focused and noted that members were influential.

Supporting contexts

In two ICSs, participants explained how the CHEC programme was building on a foundation of mature, pre-existing partnerships. In one ICS, they described how they had already established collaborative structures across ICS partners, which the CHEC was able to strengthen and expand. As one participant noted,

> *“We were on the journey already… we wouldn’t have applied had we not been on the journey already” (ID1, ICS, P2)*

This was reiterated by another ICS who outlined the strength of existing partnership working in their area:

> *"From a public health point of view, these are all partnerships that we would have had anyway. So, you know, public health and local government, we work all the time with the voluntary community sector. We work a lot with housing colleagues; we're always working in that sort of partnership approach because public health is about addressing those wider determinants of health." (ID29, ICS, P2)*

This suggests that existing partnership structures (within ICSs) were key enablers to effective partnership approaches as part of the CHEC.

Constraining contexts

There were some contexts that were felt to have made effective partnership working more challenging.

Resourcing/capacity

Interview participants in all three ICS areas commented on resource and capacity issues that impacted delivery at some point. In relation to partnerships specifically, a lack of financial incentive made it difficult to engage partners to support the intervention. This meant staff had to “*sell*” involvement by highlighting non-monetary benefits such as improved profile, learning, and influence. Outside of the intervention, other partners were sometimes hard to engage due to competing priorities and limited capacity, which meant ICS teams needed to demonstrate the added value of the CHEC compared to existing work on health inequalities, with some partners feeling they were already addressing child health equity:

> *“And they're trying to see what is the benefit of this, versus what we're already doing. What's the added value, those types of things." (ID24, ICS, P2)*

Staff changes

The second issue related to changes in staffing. This was raised by one ICS and the Barnardo’s project team. In Barnardo’s reflective diary, they explained how a number of staffing changes in the project team had affected continuity, particularly for engagement work. In one ICS, a change of leadership was noted: *"So the challenges were changes of leadership." (ID38, ICS, P2)*. It is somewhat inevitable that there will be changes to key personnel in a programme of this nature, and so resilience in teams is an important factor in supporting continuity. Ongoing ICS restructuring was noted as creating instability, with leaders uncertain about roles and priorities for CYP.

> *“All of the people that are sitting on those boards… don’t know whether they’ve got a job or not in the next few weeks.” (ID43, Project Team, P2)*

Good practice highlights

The below ‘good practice highlights’ are both examples of partnerships that existed prior to the CHEC. In both cases, they were instrumental in facilitating effective partnerships within the CHEC programme.

NHS South Yorkshire - CYP Alliance

Context - ICSs often struggle to embed CYP’s priorities into strategic planning, with their needs frequently overshadowed by adult-focused services. NHS South Yorkshire sought to address this by creating a dedicated CYP Alliance, designed to bring partners together around a shared mission to reduce child health inequalities.

Action - At NHS ConfedExpo 2025[7], NHS South Yorkshire’s CYP Alliance was showcased in the breakout session *“How three healthcare systems are shifting the dial on children’s health and how you can too.”* Programme Director for the Alliance joined a panel with Barnardo’s, IHE, and the other ICS leads to share learning from the CHEC programme. The session highlighted the Alliance’s collaborative model, which convenes statutory services, VCSE partners, and young people to co-design solutions around prevention, early intervention, and addressing the wider determinants of health.

The importance of voluntary sector infrastructure was repeatedly emphasised: “We are fortunate in South Yorkshire to have a voluntary and community sector alliance and so it’s a great way of being able to connect in with the voluntary and community sector.” (ID24, ICS, P2). Similarly, the CYP Alliance itself was described as a partnership enabler in its own right:

“As a whole, the Children and People’s Alliance membership was built on partnership and bringing people together, so I think that all probably helped CHEC work rather than the other way around.” (ID24, ICS, P2).

Impact - The CYP Alliance has played a critical enabling role in supporting the CHEC programme in South Yorkshire. While the Alliance itself pre-dated the CHEC, its established cross-sector partnerships, embedded relationships with schools, and project management capacity provided the foundations for effective delivery. Within this infrastructure, organisations already embedded within local schools were able to facilitate direct engagement with children and young people. This helped the CHEC programme to overcome common barriers of capacity and ensure that young people’s voices were captured through face-to-face engagement and co-production. Interviewees emphasised that these embedded local relationships were a decisive factor in enabling the CHEC’s success:

“The strongest enabler was having a voluntary organisation already embedded with schools, as this overcame the common barrier of limited school capacity. Project management capacity within the alliance was also key to ensuring delivery, and co-production with children helped shape the intervention in a responsive way. Face-to-face interaction with children allowed their voices to influence activities, which was seen as a major strength.” (ID25, ICS, P2).

Its presence at NHS ConfedExpo helped transfer this local learning to a national audience, raising awareness of how CYP-focused alliances can accelerate equity and influence system-level priorities.

Learning - The NHS South Yorkshire CYP Alliance demonstrates how dedicated governance structures can act as a catalyst for partnership. By bringing together statutory bodies, VCSE organisations, schools, and young

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[7] NHS ConfedExpo The **UK's leading health and care conference**, dedicated to driving innovation and improving care for patients and the public.

people around a shared agenda, the Alliance has strengthened collaboration across sectors while ensuring CYP have a formalised platform within ICS structures. This model shows how other ICSs could replicate partnership-based mechanisms to embed children's health priorities alongside adult services.

NHS Cheshire and Merseyside Beyond Programme

Context - The Beyond Programme is NHS Cheshire and Merseyside's integrated health and care transformation programme for CYP. It brings together shared priorities from Directors of Children's Services and NHS leaders, aligned with the Starting Well themes, Core20PLUS5 for CYP, and the All Together Fairer framework. Its focus is on tackling inequalities through a population health approach rooted in prevention and early intervention. Recognising that participation was often inconsistent across the system, Beyond sought to develop a more standardised approach, drawing on the Lundy model of child participation to embed CYP voice within decision-making.

Action - Beyond delivered initiatives and support across the system, creating a framework to standardise CYP participation so that engagement did not depend on geography, access, or individual Champions. This framework provided a structure for partners to embed CYP priorities consistently across governance and delivery.

Impact - The CHEC further strengthened Beyond's role by enabling it to strengthen its work with CYP. Through the CHEC, Beyond was able to test its framework in practice, connect with young people's lived experiences, and demonstrate the value of embedding participation in real-world interventions.

Learning - The Beyond programme shows how system-wide participation frameworks can raise the standard of CYP engagement and position organisations as leaders in this space. Its partnership with the CHEC illustrates how such frameworks can be strengthened when they are grounded in direct dialogue with CYP, ensuring that structures for participation remain practical, equitable, and meaningful.

Findings - Objective 2

Delivering an intervention or initiative informed by children and young people's insights and that addresses one or more of the social determinants of children's health.

Context

A key component of the Children and Young People's Health Equity Collaborative programme was the delivery and evaluation of three pilot child health equity initiatives - one in each of the three ICSs. These pilots provided a practical way for the partnership to test how the Child Health Equity Framework could be applied in local health and care systems to benefit children and young people.

They also supported the programme's broader aims: promoting good health and wellbeing for all children, reducing health inequalities through action on the social determinants of health, and improving outcomes for children and young people from underserved communities.

Each ICS had flexibility in shaping its initiative. They could choose to develop a new intervention - which in some cases required securing additional resources, for example by drawing on other funding pots within the ICB, leveraging existing programmes, or working collaboratively to secure external support - or to build on existing work. Barnardo's and IHE provided guidance and support on the design, development and evaluation of the initiatives.

All initiatives were informed by the CHEC programme's aims and objectives.

The CHEC's guiding principles:

- Use of the Child Health Equity Framework[8]: Each initiative was expected to draw on the Child Health Equity Framework, which outlines the key social determinants that shape children's and young people's health and wellbeing. The framework also highlights how discrimination and exclusion can deepen inequalities ('personal characteristics and intersectionality'). ICSs were encouraged to identify which groups of children and young people in their areas were most vulnerable or marginalised, and therefore likely to benefit from their pilot initiatives. Local data and insight - including the voices of children and young people - were used to identify needs and opportunities, against the framework.
- Prevention and early intervention: Initiatives should focus on supporting children early to give them the best start in life and reduce future demand on services.
- Partnership working: Initiatives should strengthen collaboration between health, public health, local authorities, communities, the VCSE sector, and children, young people and families themselves.
- Building on local assets: Initiatives should make use of existing services, networks and strengths to ensure relevance and sustainability.
- Planning for sustainability: Initiatives should include measures to strengthen systems and build capacity for long-term impact.

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[8] Child Health Equity Framework

Each ICS also received £10,000 from Barnardo's to support engagement with children and young people and had flexibility in how the funding was used.

There is limited practical guidance on how local health and care systems can design and deliver interventions specifically to improve child health equity or address the social determinants of child health; existing frameworks and policies tend to focus on broader population-level health inequalities rather than providing detailed, child-focused implementation guidance[9].

The child health equity pilot initiatives and their evaluations were therefore designed to generate practical learning for the participating ICSs and the wider health and care system. By providing real-world case studies, they offer insights into effective approaches, mechanisms of change, and challenges in practice, which we hope will inform the design of future initiatives and support continued investment in child health equity.

Evaluating the Child Health Equity Initiatives

The Institute of Health Equity was commissioned to support and coordinate the evaluation of the three local child health equity initiatives. This included helping the ICSs develop narrative theories of change, identify key evaluation questions, and select appropriate evaluation tools and measures. IHE also conducted and analysed stakeholder interviews in two phases: the first focused on initiative implementation and early changes, and the second explored early benefits and impacts. ICB data and project teams led the collection and analysis of quantitative and qualitative beneficiary data. IHE then synthesised these findings to produce the evaluation.

This evaluation used a mixed-methods approach to explore the three local initiatives. Data was gathered from a small number of stakeholder interviews in two phases, and available programme monitoring and evaluation data and insights. The evaluation focused on understanding how the initiatives were implemented, identifying enablers and challenges, and capturing early lessons and emerging impacts. Given the limited scale and timeframe, findings are formative in nature and intended to inform ongoing practice and improvement rather than provide statistically robust evidence of effectiveness.

In the remainder of this chapter, we present summary profiles of the three initiatives, summarising key findings from the local evaluations. In the report's conclusion, we discuss how the interventions contributed to one or more of the CHEC programme's core aims. The report's final section provides practical recommendations to help health and care systems design and deliver child health equity initiatives.

Child health equity in practice - early lessons from three local initiatives

Initiative Profile: Out-of-School Youth Clubs and Their Impact on Children's Wellbeing and School Engagement - Lessons from the Friday Fun Club, Rotherham

How and why the Friday Fun Club was developed

The Friday Fun Club was created through collaboration between cross-sector partners, drawing on local data, national research, stakeholder insights, and input from over 300 children and young people. Mental health,

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[9] A National Framework for NHS - action on inclusion health; Local action on health inequalities: evidence papers; Core20Plus5 - An approach to reducing health inequalities for children and young people; NICE and health inequalities; Reducing health inequalities: system, scale and sustainability.

wellbeing, and school attendance were key concerns - particularly for children transitioning from primary to secondary school - and were further affected by the cost-of-living crisis, underfunded youth services, and long waiting times for support. Children consistently said they wanted safe spaces where they could belong, connect, and feel respected and valued. Their voices were central to the final design of the initiative, which prioritises working directly with children and responding to their needs.

The Child Health Equity Framework highlights that educational attainment, attendance, feelings of safety, connection, and being valued are all important social determinants of child health and wellbeing. The programme sought to enhance outcomes across all of these areas.

Overview of the Friday Fun Club

The Friday Fun Club ran for 12 months, comprising two six-month interventions for different cohorts (September 2024 – September 2025). It was a weekly, two-hour after-school programme held at Rotherham United Football Club.

The initiative was delivered through a collaboration between Rotherham United Community Trust (RUCT), which has a strong track record in youth engagement, and the ICS. RUCT led delivery, while the ICS provided initial design support and oversight.

The programme combined fun activities - such as pool, dodgeball, and slime-making - with mentoring and creative health sessions to support emotional wellbeing, confidence, and school engagement. Children co-designed activities at the start of the intervention and on a weekly basis, ensuring that sessions were meaningful and relevant to their interests.

The initiative's main goal was to improve children's mental health and wellbeing by building trust, fostering social connections, and giving them a sense of belonging, agency, and confidence – ultimately supporting better school attendance and engagement in learning. It also aimed to strengthen collaboration across sectors, spark creative solutions to shared challenges among partners, and influence future commissioning models to put children's voices at the centre.

Evaluation approach and limitations

The evaluation primarily drew on qualitative evidence, including 15 interviews with 8 stakeholders (youth workers, project team members, and teachers), 7 of whom were interviewed again in a second phase. Feedback from children and parents was also gathered: the project and delivery team used creative methods such as flashcards and mock press conferences with children, while parents took part in informal 'cake and chat' sessions. Additional evidence came from case studies and project team observations during sessions.

A small number of before-and-after surveys were also completed by children, parents, and teachers, using psychometric tools (Strengths and Difficulties Questionnaire (SDQ), Child & Youth Resilience Measure (CYRM), Children's Motivation Scale (CMS)) alongside a local satisfaction questionnaire. These tools were recommended by the evaluation team to strengthen rigour. However, response rates were low - on average, just over half of pre- and post-surveys were returned - so the data was too limited to draw reliable conclusions.

Who came to the club?

The Friday Fun Club was designed for children aged 9–10 living in Rotherham. The first cohort comprised seven children from the same school (who did not know one another) and was more ethnically diverse than the second cohort. Some had special educational needs or socialisation challenges, but overall, they attended school regularly and were engaged with learning - a mismatch between need and service (this is further explored in the Challenges section).

The second cohort included 8 children from three different schools, many of whom faced barriers to education such as attendance difficulties and behavioural challenges. Many pupils were described as facing a range of social, emotional and mental health (SEMH) challenges, and complex special educational needs, including autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD). Children generally did not participate in other clubs or activities outside school.

Children's engagement and experiences

Overall attendance across both groups was 73.4% (146 out of 199 possible session places). Cohort 1 had higher attendance at 81% (51 out of 63), while Cohort 2 was lower at 69.9% (95 out of 136). The two cohorts had different numbers of sessions, and Cohort 2 missed one week of reporting, which may have affected their results. This level of attendance was described as very good by the youth workers interviewed, who noted that such sustained participation is unusual:

> *"We don't normally see this type of attendance – usually after the first two weeks, it drops off massively." (Youth Worker)*

Parents, youth workers, project staff, and teachers reported that children really enjoyed the club, often describing Fridays as the highlight of their week. Children particularly valued the creative and physical activities - especially slime-making, cooking, pool, and dodgeball - and the friendships they built with peers and youth workers.

> *"I like to come here because it's very fun, and it warms me quite a lot, to be honest." (Child)*

> *"I like coming here on a Friday because we get to play dodgeball, and then I work out, and also play with my friends." (Child)*

Many children developed strong attachments to the club and expressed sadness when it ended. Staff observed that some found it difficult to say goodbye.

> *"We said, this is your last session, and he already knew that … but he kind of chose to ignore that part, and so he started crying, and was very upset. It took a while for him to stop" (Friday Fun Club Project Team)*

How the club benefited children

Feedback from children, parents, teachers, youth workers, and the Friday Fun Club project team indicated that children benefited from taking part in the club in multiple ways. Participation was linked to improved school engagement and behaviour, alongside gains in confidence, self-esteem, self-expression, and emotional regulation. Children also formed new friendships, strengthened peer relationships, and developed social skills, while becoming more engaged in out-of-school activities. Some children, however, benefited more than others, depending on the level and complexity of their needs, particularly in their home environment.

Improved school attendance, engagement, and behaviour

Some parents noticed positive changes in their children's behaviour and engagement at school. For example, one parent described a "massive difference in little ways," sharing that their child was no longer "getting told off each day." Teachers also highlighted the progress they had seen: one remarked that pupils who took part in the first cohort "really impressed us with their attitudes, it was really noticeable," while another noted that the club had nurtured children's love for sport and physical activity, both at school and beyond the classroom.

Many stakeholders noted, however, that the programme's short timeframe and small group size made it difficult to identify clear impacts on school attendance. Overall, while early signs point to encouraging improvements in behaviour and engagement, it is still too soon to confirm measurable changes in attendance.

Improved confidence, self-esteem, self-expression, and emotional regulation

Many stakeholders reported that children showed signs of increased confidence, self-esteem, and social skills. Some became more talkative and assertive, gradually feeling more comfortable expressing themselves in group settings. As one teacher observed, "Pupils [from cohort 2] showed clear signs of confidence development … and they felt more comfortable expressing themselves."

Youth workers also noted improvements in children's ability to process feelings and express frustrations more constructively. One described how "a child's attitude changed drastically … they were more open about things and talkative … [they] knew how to chat, how to handle [their] emotions a bit better, talking to me [and other youth workers] about things that were annoying or upsetting [them]."

New friendships, strengthened peer relations, and social skills

Most stakeholders reported that children were forming new friendships, improving their interactions with others, and feeling more socially connected. The club created opportunities to build relationships both within sessions and beyond, including at school.

Youth workers and teachers shared examples of this change. One youth worker said, "Ten weeks down the line, they were thanking each other for making their Friday nights fun." Another noted that a child "now plays with a new peer group at school, whereas before she would sit alone in the classroom." A teacher from Cohort 2 echoed these positive changes, explaining that many of their pupils formed peer relationships they previously lacked. Another teacher, from Cohort 1, reflected: "The club enabled friendships and social interactions … it helped them develop these relationships, which [will be] supportive of them transitioning to school."

Youth workers also observed children beginning to show greater empathy, tolerance, and consideration for others: "The friendship thing, that's most obvious to me … they tolerate each other a lot more … conflicts have now gone out of the window."

Taking part in other out-of-school activities and clubs

The Friday Fun Club successfully increased children's engagement in activities beyond school, both in the community and at home. Many children who had not previously joined clubs or groups were now taking part in sports and dance activities locally. Parents also described their children becoming curious about new hobbies and sports, showing more interest in trying things such as table tennis, or enjoying creative activities like making slime together at home.

Improved mental wellbeing

Stakeholders rarely articulated “improved mental health and wellbeing” as a direct benefit for children, and, as noted above, the psychometric data collected was too limited to draw reliable conclusions. However, the Child Health Equity Framework - developed from the latest evidence and children’s own insights - shows that many of the benefits reported through the Friday Fun Club, such as forming friendships, feeling part of something, being accepted for who they are, and having safe spaces (explored further in the later section on how the club made a difference to children), are key factors that contribute to children’s mental health and wellbeing.

How the club benefited schools

Schools involved in the Friday Fun Club initiative reported a range of positive outcomes, including improvements in classroom dynamics, pupil behaviour, staff practice, and overall school culture.

One teacher noted that children who took part in Cohort 1 were often influential within their peer groups. After participating in the club, these pupils showed greater involvement in school activities, such as Sports Day and a karaoke afternoon, and more positive engagement overall, which contributed to a more settled atmosphere for the wider year group. As the teacher explained:

> *“I keep behaviour management records and safeguarding records, and I can honestly tell you that that year group finished the year so well … we had a really settled period of time … the [Friday Fun Club] children had a pivotal, fundamental role in the harmony and ambience for everyone else.”*

A youth worker described how a pupil had shared a sensory sensitivity during the club, which affected their experience at school. The youth worker liaised with the school to implement a practical adjustment, which helped the pupil feel more comfortable and supported. As a result, the pupil’s confidence and engagement increased, leading to new opportunities for leadership and participation in school activities.

Wider benefits – families and system-level impact

The Friday Fun Club initiative generated benefits beyond the children, positively influencing families, partner organisations, and local systems. Practitioners reported strengthened sibling relationships and how they were able to advocate for children by linking families to wider support. For example, a youth worker raised concerns directly with teachers during a Team Around the Family (TAF) meeting, resulting in a child receiving a discrete ‘time-out’ card at school when additional support was needed. This removed the family as the intermediary, who may not always have the resources, confidence, or skills to advocate for such practical changes.

> *“In the last two or three sessions, they started to share more about school and the barriers they were facing. That led to me getting involved in the TAF, where I could relay their concerns to the teachers directly, rather than it being the parent.” (Youth Worker)*

The programme also enhanced multi-agency collaboration, building stronger relationships between schools, health, social care, and the voluntary sector:

> *“It’s certainly built up our relationships with the voluntary sector … we’ve got all these contacts now within their schools, within their local areas…. And vice versa, they’d learned a lot from us as well about the health system.” (Friday Fun Club Project Team)*

Friday Fun Club insights have informed service design and commissioning approaches, and the programme has been showcased at forums such as the South Yorkshire Child Health Poverty Summit, highlighting child-led, relationship-focused approaches. While many professional and system-level outcomes were achieved, some were only partially realised. Due to the short timeframe and small scale of the initiative, sustained multi-agency practice changes and the full integration of children's voices into policy and commissioning decisions were not measurably observed, representing longer-term ambitions for the initiative and ICB.

What made the club work

Several connected factors were key to Friday Fun Club's success, highlighted by children, parents, teachers, youth workers, and the project team.

Creating a safe, supportive space

A big part of how the club worked was creating a safe, supportive space where children felt secure, could explore their interests, and build trusting relationships. Holding the club at Rotherham United Football Ground made it feel special and different from school or home, which encouraged children to value the sessions and look forward to them. Small group sizes helped children with additional needs feel included, reduced stress, and made joining in manageable. A mix of activities - like pool, dodgeball, badminton, cooking, or playing on the PlayStation - gave children choices about how to take part, whether that was burning off energy, calming down, or relaxing. The setting also created quiet opportunities for reflection and conversation, such as canal walks, where children could share personal thoughts in a more relaxed way.

Child-led, flexible approach

The child-led, flexible approach strengthened this safe environment. Children could decide which activities to join, how long to stay with them, and when to use their phones or screens, which helped avoid conflict and built rapport. They also gave feedback and suggested activities for future sessions. Having this choice helped them feel more confident because they could try things at their own pace, while seeing their ideas respected and acted on showed them that their opinions mattered. This sense of being heard made it easier for children to trust youth workers and to share their worries and needs.

Relaxed atmosphere

The relaxed, non-judgmental atmosphere - free from school pressures and behaviour rules - meant children could engage at their own pace. Youth workers noticed when something seemed wrong and checked in gently, while giving children the choice to talk when they were ready. They also acted as advocates, for example by working with schools to arrange adjustments for children with sensory needs. This reassured children that someone was on their side. By responding in a respectful, fair way - rather than punishing or excluding - youth workers helped children manage emotions and feel safe to open up. Because they were not in formal roles like teachers or safeguarding leads, children saw them as genuine allies who cared about their wellbeing.

Consistency and diversity among youth workers

A small group of youth workers were able to build trust over time, while a mix of ages, genders, and ethnic backgrounds gave children more chances to connect and feel comfortable. Celebrating children's successes further boosted their confidence and motivation.

Club duration

The six-month length of the club gave time for trust and progress to grow, though some people felt even longer would be needed for lasting change.

Partnership-working

Finally, strong partnership working between the ICB and RUCT combined different strengths – research, delivery, and sports- and youth-work- based engagement – and allowed the programme to adapt well to challenges.

Key challenges and lessons learned

Despite its successes, the evaluation also surfaced some delivery challenges.

Structured activities were less engaging for children

Children across both cohorts often pushed back against structured activities like the memory box or feelings thermometer, which were designed to explore school engagement and emotional wellbeing. Many children expected the club to be mostly about sport and games, and some didn't understand why school had picked them to attend. For others, especially the boys, creative tasks simply didn't resonate. In practice, children opened up far more through informal chats and relaxed activities. These gave youth workers the clearest insight into their wellbeing and school lives, even though the outcomes were harder to measure. The structured activities did, however, serve as a useful framework, helping delivery teams maintain the club's intended outcomes as a guiding focus, even as they prioritised more relaxed and informal approaches that better engaged the children.

Differences in approaches

Partnership working was a real strength, though not always straightforward. The ICB tended to prioritise structured, measurable, screen-free activities, while youth workers favoured flexible, relationship-based approaches. These differing priorities sometimes created tension, with the project team feeling the need to step in more than anticipated to ensure activities remained linked to outcomes and evaluation. At times, they also felt constrained in raising concerns, particularly as they did not have direct management responsibility for delivery staff.

Engaging schools

Engaging schools proved difficult. After initial enthusiasm, some struggled to follow through on commitments such as contacting parents or returning evaluation data. Eligibility was also sometimes unclear: in the first cohort, teachers misunderstood the criteria and selected children who did not have problems with attendance (though they did meet other criteria). This caused confusion for parents and reduced the club's impact. We heard conflicting accounts from schools and the delivery team. Schools said they would have welcomed more communication from the ICB and more opportunities to visit the club, while some youth workers said they had offered additional engagement opportunities that schools did not take up.

Gaps in information sharing

Youth workers reported instances where they were not fully informed about children's complex backgrounds – such as SEND or experiences of recent trauma – before beginning their work with them. This was attributed to limited time during the planning and delivery of the pilot initiative, which also limited the full and timely implementation of formal processes and protocols for information sharing. Without this context, youth workers sometimes misinterpreted children's behaviour and were less able to provide effective, tailored support.

Endings were hard

Some children found it hard and were visibly upset when the club came to an end, but there was no clear or consistent plan for managing this transition. Youth workers tried to ease the process by linking children into other clubs or sports teams, but much of this relied on goodwill and personal contacts rather than formal referral pathways. Stakeholders reflected on how challenging endings can be: for some children, the Friday Fun Club provided sufficient support, while others still needed help and found the ending sudden and unsettling.

Because many interventions are short-term, practitioner relationships are often transient, which can compound vulnerable children's difficulties in developing trust in adults. Although the Friday Fun Club ran for longer than many comparable initiatives (six months, rather than the more typical six to twelve weeks), children's visible sadness at its conclusion suggests a need for more sustained, longer-term provision. Without this continuity, there is a risk that endings may inadvertently compound vulnerability and undermine the trust and stability that programmes like this work hard to build[10].

Evaluation struggles

Evaluation proved challenging. Standardised, paper-based tools recommended by the evaluation team for rigour, were often burdensome, culturally or linguistically inappropriate, and produced limited or unreliable data. Creative, child-friendly approaches designed and implemented by the project and delivery teams – like flashcards and interactive games – were more engaging and gave richer insights but didn't allow precise measurement of outcomes. Schools and families were also often unable or unwilling to complete evaluation forms due to workload pressures, language barriers, or concerns about being judged.

Peer-support component didn't happen as planned

Finally, the peer-support element of the programme did not develop as intended. While strong friendships formed within the first cohort, children were reluctant to integrate or mentor participants from subsequent cohorts. This reflected their desire for a safe and consistent group but limited opportunities to extend peer support benefits.

Recommendations for future delivery

The evaluation findings point to important things for South Yorkshire ICS and other health and care systems to consider when running similar initiatives in the future.

- Prioritise child-led goal setting and co-design, giving children opportunities to choose activities, provide feedback, and shape sessions. This helps ensure interventions reflect children's priorities, build confidence, and foster a sense of being heard and respected.
- Recognise and value the different strengths partners bring. Youth workers' relational expertise is balanced and strengthened by the outcomes-focused approach of health and care systems. Clear roles, co-designed activities, regular communication, and mutual understanding of each other's methods can

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[10] Building Trusted Relationships for Vulnerable Children and Young People

help ensure these approaches complement each other, improving programme coherence and effectiveness.

- Evaluation should use light-touch, child-friendly, and creative approaches, embedded within activities rather than imposed as formal tasks. Wherever possible, children and families should be involved in designing the evaluation methods to ensure they are acceptable and easily understood. While quantitative measures can be useful, and necessary, for larger-scale interventions, this small pilot clearly benefited more from qualitative feedback, observation, and case studies.
- Systematic and timely information sharing between schools, ICBs, and VCSE partners is critical, and adequate time for this should be built into the planning stage of any initiative. Access to relevant information about children's backgrounds – including SEND, mental health, and family circumstances – enables practitioners to tailor interventions effectively and prevent misunderstandings. Information sharing should follow agreed protocols, use secure digital systems, and include regular briefings or handovers between partners before sessions begin. Roles and responsibilities should be clearly understood by all partners, and information should be shared in a way that maintains children's trust, with safeguarding concerns always prioritised.
- Youth workers should also have formal mechanisms to share relevant information with schools in a way that maintains children's trust – the Team around the Family meetings was an effective way of doing this during the initiative, but not all children will have this support. Non-safeguarding information should only be shared with the child's knowledge, while safeguarding concerns must always be disclosed, and agreed protocols and secure systems should be used.
- Work closely with schools from the outset to clarify eligibility, align expectations, and co-design activities. This helps ensure the right children are selected, reduces confusion for families, and maximises programme impact.
- Endings should be planned and handled sensitively, with clear, repeated communication with children and their families, and coordinated transition plans across agencies, including schools, to help children adjust and maintain the benefits of the programme. Abrupt or poorly managed endings can be especially distressing for children who have experienced loss or instability. Programmes should aim for longer-term, consistent support and tailor the duration and closure of interventions to each child's needs. Where ongoing support is needed, continuity should be ensured through extended involvement or clear links to other services. This flexible approach helps sustain children's trust and stability and protects the progress they have made.

Conclusion

The Friday Fun Club was built around children's voices and priorities. Local children and young people shaped its design, identifying the need and wish for a consistent, safe space – both physically and emotionally – close to home, where they had choice, autonomy, and felt respected. Trusted relationships were formed with adults outside formal teaching or safeguarding roles, who offered tailored, non-judgemental support.

The initiative successfully engaged children who had not previously taken part in out-of-school activities or interventions. Although there were challenges with structured activities, participant selection, endings, and evaluation, children enjoyed attending the club, and many were upset when it ended. The project supported improvements in children's school engagement, behaviour, confidence, self-expression, emotional regulation, and social skills – factors that contribute to positive mental health and wellbeing. It also brought wider benefits for schools, families, and cross-system collaboration.

The positive reception and promising outcomes from this pilot suggest that South Yorkshire ICS could build on this model to create more safe, child-led spaces that promote children's mental health, wellbeing, and engagement with school. There is also potential to embed future delivery across South Yorkshire and beyond within existing frameworks, such as Mental Health Support Teams or neighbourhood health models.

Future initiatives should continue to prioritise co-design with children, support systematic information sharing between schools and delivery partners, manage endings carefully, and use creative, proportionate approaches to evaluation. Any expansion should be supported by a larger, mixed-methods evaluation to capture both outcomes and experiences.

Initiative Profile: Tell Me a Story, Liverpool – Strengthening School Readiness and Family Literacy Through Storytelling

How and why *Tell Me a Story, Liverpool* was developed

School readiness is influenced by a range of interrelated factors. Evidence indicates that socio-economic disadvantage, low parental (particularly maternal) education, and a less stimulating home learning environment have the strongest impact on early development. Poor health and parental employment status also play contributory roles. (REF EPPE). In 2023/24, only 62% of children in Liverpool were ready for school at the end of their school reception year, compared to the England average of 67.7%[11].

Children living in the most deprived areas of Liverpool are gradually improving in Early Years Foundation Stage Profile (EYFSP) communication, language, and literacy, with the percentage of children achieving the expected level increasing from 60.2% in 2021/22 to 62.6% in 2023/24. Children living in the least deprived areas continue to have a higher percentage of children at the expected level, though it has slightly declined, from 80.5% to 79.1%, over the same period. In 2023/24, the gap in the percentage of children at the expected level in communication, language, and literacy between children living in the most and least deprived areas of Liverpool is around 17 percentage points, reflecting some progress but persistent disadvantage. At a national level, in 2023/24, the inequality gap in EYFSP communication, language, and literacy is slightly larger at 19.5 percentage points, but overall percentages of children at the expected level in communication, language, and literacy in Liverpool remain below the England averages, indicating that while the gap is narrowing locally, children in Liverpool still generally perform below national levels and further improvement and sustained investment in early years language, communication and literacy is needed[12].

Families in Liverpool often face poverty, low adult literacy, and other pressures that make activities like reading together more difficult. In 2022/23, 59.7% of teenage pregnancies were to women living within the most deprived decile, compared to 0.24% in the least deprived decile[13]. Young mothers up to the age of 25, are at greater risk of poor mental health, up to 3 years after birth, compared to mothers in older age groups[14]. Parental depression is a well-established risk factor for negative child development outcomes[15] and is thus included as a key driver of child health and wellbeing in the Child Health Equity Framework.

Cheshire and Merseyside ICS carried out a broader review of key areas of concern for children and young people across the region and identified three potential areas for intervention. System partners – including

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[11] https://fingertips.phe.org.uk/
[12] Early years foundation stage profile results, Academic year 2023/24
[13] Internal report - Beyond Programme Board Update: October 2025
[14] Early Years High Impact Area 2: Supporting Maternal and Family Mental Health
[15] Association of maternal and paternal perinatal depression and anxiety with infant development: A longitudinal study; Economic deprivation, maternal depression, parenting and children's cognitive and emotional development in early childhood.

health services, local authorities, public health, VCSE organisations, and CYP health equity champions – came together to review the findings and agree where action was most needed.

In Liverpool, this evidence highlighted the potential of storytelling as a fun and accessible approach to support children's early development, strengthen parent-child attachment, boost parents' confidence, and tackle inequalities by building on local strengths and relationships.

Overview of *Tell Me a Story, Liverpool*

Tell Me a Story, Liverpool, delivered in partnership with Mersey Care NHS Foundation Trust and the Dollywood Foundation, launched on 6 March 2025 to coincide with World Book Day. The pilot gives first-time teenage parents a free letterbox picture-book each month (suitable for the age and development of their child), addressed to their child, through the Dolly Parton Imagination Library. This occasionally comes with supporting tools, such as puppets, for families to use with the books.

Family Nurse Partnership (FNP) nurses and health visitors received training from the BookTrust in storytelling and shared reading, with extra training for FNP nurses through the Peers Early Education Partnership (PEEP) Learning Together programme. This equipped practitioners with the skills and confidence to help parents build their children's language, communication, and literacy at home, and to know where to access further resources or support. The training encouraged practitioners not just to start conversations about reading earlier, but to reframe storytelling for parents – exploring books together, making up stories, helping them understand it is okay to make mistakes, describing pictures rather reading all the words, and pointing things out – rather than simply telling them they "have to read a story." Practitioners also receive copies of the picture book and any supporting tools each month so that they can familiarise themselves with the content before working with families.

The initiative is designed to continue beyond the CHEC programme, supported by Family Hubs. It has started with an enhanced offer for teenage parents and their families but aims to expand to all families over time. In the short term, *Tell Me a Story, Liverpool* aims to boost practitioner support for families, including ensuring that all families receive simple and consistent messages about shared reading and storytelling across all the spaces and professionals they engage with, including libraries, health visitors, FNP nurses, and voluntary sector services. It also aims to improve how literacy programmes work together. In the long term, the initiative aims to improve children's school readiness.

Evaluation approach and limitations

The evaluation of *Tell Me a Story, Liverpool* used a mixed-methods approach. Findings in this profile draw on 14 interviews with 10 stakeholders, including project team members from Liverpool City Council, representatives from BookTrust and the Dollywood Foundation, and FNP nurses, some of whom were interviewed twice.

A bespoke storytelling survey was developed for this evaluation, as standardised measures were considered too broad to capture the initiative's specific focus, although many questions were adapted from existing measurement tools. Of the 79 parents enrolled in the FNP intervention, baseline data was collected for 74 (94%).

Follow-up questionnaires were conducted three months later. By September 2025 – the cut-off for inclusion in this evaluation – 36 FNP-enrolled parents had returned follow-up surveys. No follow-up surveys were returned by the eight parents supported by their health visitor but not enrolled in the FNP.

Broad demographic data was also collected for monitoring purposes. This evaluation reports a pre-post differential analysis based on a matched sample of 36 parents (i.e., those who completed both the baseline and 3-month follow-up surveys, with responses linked). Absolute percentage-point change from baseline to follow-up was calculated for each survey item (response scale: *strongly disagree* to *strongly agree*), with 95% confidence intervals (Cis) used to assess whether changes were statistically significant.

Proportional (relative) change from baseline is also reported where the change was statistically significant — this shows how much the proportion changed compared with the baseline percentage. Where proportional (relative) change is included, this is stated explicitly.

The project team plans to continue evaluation beyond the CHEC programme, including six-month follow-up surveys and interviews with families. Longer-term tracking, managed by health visitors, will include Ages and Stages (ASQ) scores at 2–2.5 years and school readiness outcomes, providing a fuller picture of the initiative's impact over time.

This evaluation has several limitations. No health visitors were available for interview during the fieldwork period, and the FNP nurses who participated were already confident in storytelling and shared reading, making it difficult to detect changes in professional practice.

Survey data were limited: only 36 of the 87 families receiving book subscriptions completed both the baseline and 3-month follow-up surveys. We compared the baseline responses of all parents (n=74) with those of the matched sample who completed both surveys (n=34). Overall, the distribution of responses across items was broadly similar. A small number of parents (1–3) in the full sample selected 'disagree' or 'strongly disagree' on some items; these response options were not represented in the matched sample.

A pre–post design was used. Planned comparisons between Family Nurse Partnership (FNP) and non-FNP parents were not possible due to the very small non-FNP group (n=8) and the absence of follow-up responses. Numbers were also too small to support subgroup analyses (e.g., by age or ethnicity). While Cis were calculated, these were wide due to the low sample size, and findings should therefore be interpreted with caution, as indicative rather than statistically robust evidence of change.

The bespoke storytelling survey is not validated and included some questions about children's development, so changes measured between baseline and three months may reflect children's natural development rather than the contribution of the initiative, although most questions focused on parents' confidence and storytelling skills, which are less affected. Finally, the study provides a snapshot of an initiative designed to continue and evolve beyond the scope of the CHEC programme.

Participant Profile

87 families received monthly picture books through the Dolly Parton Imagination Library as part of this pilot, with the vast majority also enrolled in the intensive FNP programme. FNP in Liverpool provides home-visiting support for first-time mothers aged 19 or under at the start of pregnancy, from early pregnancy until their child's second birthday. A small number (n=8) received books via health visitors (parents who declined FNP).

Parents identified to take part in *Tell Me a Story, Liverpool* were identified through hospital referrals and live in vulnerable or complex households. Most families reside in Liverpool's most deprived areas.

Available demographic data from 36 respondents shows the majority (approximately 85%) of children were of White ethnicity. A small minority were from Black, mixed or other minority ethnic backgrounds. To protect confidentiality, specific numbers are not reported due to the very small group sizes. This is broadly in line with the overall population profile in Liverpool, although specific data for all teenage parents across the city was not readily available. The average age of parents is 20.

FNP nurses highlighted several challenges faced by the teenage parents and children they work with. These children are at greater risk of poorer outcomes, including low school readiness, limited educational achievement, and reduced confidence – sometimes compounded by learning difficulties. Some parents feel embarrassed about reading or have limited experience with books, and high levels of poverty mean many households have few or no books at home. Practitioner interviews also indicated that many teenage parents experience socioeconomic hardship – such as poverty, unemployment, and low income – alongside mental health challenges and early school leaving. One FNP nurse estimated that “at least 75–80% of our teenage parents” are likely to benefit from the initiative, suggesting that these risk factors affect most, though not all, of the parents and children they support.

Emerging benefits for children and families

Analysis of survey data and stakeholder interviews suggests that teenage parents and their families are beginning to benefit from receiving monthly books and support from FNP nurses and health visitors. Children are engaging with and enjoying stories more, homes have more books, daily shared reading is increasing, more families are involving their children in storytelling, and there are early signs of strengthened parent-child bonding.

More children are engaging with and enjoying stories

Early signs indicate that *Tell Me a Story, Liverpool* is helping children enjoy and engage more with books and stories.

Parents reported an increase in their child’s interest during reading or storytelling sessions over the 3-month period. The number of parents who *strongly agreed* that their child shows interest (e.g., looking at pictures, pointing, or making sounds) rose from 12 (34%) at baseline to 21 (58%) at follow-up – a statistically significant net increase of 9 parents (+24 percentage points; 95% CI: 1.53–46.55), equivalent to a 70% relative (proportional) increase over baseline. This increase was accompanied by a decline in parents selecting *Agree*, indicating a shift from moderate to strong observed child engagement. Responses of *Neutral* remained stable, and *Strongly Disagree* responses were unchanged. One survey response at baseline was missing and therefore excluded from this analysis.

Parents also reported changes in their child’s positive emotional responses during reading or storytelling sessions over the 3-month period. The proportion of parents selecting *Strongly Agree* increased from 13 (36%) at baseline to 21 (58%) at follow-up, a net increase of 8 parents (22 percentage points; 95% CI: -0.26 to 44.70), although this change was not statistically significant. The proportion selecting *Agree* decreased from 18 (50%) to 10 (28%), a statistically significant net decrease of 8 parents (-22 percentage points; 95% CI: -44.15 to -0.29). This corresponds to a relative (proportional) decrease of 44% from baseline, suggesting a shift toward stronger observed enjoyment.

Responses in other categories changed minimally (*Neutra*l: 4 to 2; *Disagree*: 1 to 2; *Strongly Disagree*: 0 to 1). This slight increase in parents who *disagreed* or *strongly disagreed* that their child enjoys reading or storytelling at the 3-month follow-up may reflect normal variation rather than a meaningful decline in enjoyment. However, it could also suggest that a few children were less engaged at follow-up, which is an area worth exploring further as the initiative continues.

Increased parent-child interaction through storytelling

Parents are taking a more active role in storytelling, with parents' use of interactive storytelling techniques increasing over the 3-month period. The number of parents who *strongly agreed* that they encourage their child to join in during storytelling (e.g., by asking questions or prompting responses) rose from 11 (31%) at baseline to 19 (53%) at follow-up, a statistically significant net increase of 8 parents (22 percentage points; 95% CI: 0.03–44.41), equivalent to a 73% relative (proportional) increase over baseline. This increase was accompanied by a decline in parents selecting *agree*, indicating a shift from moderate to strong use of interactive storytelling behaviours. *Neutral* responses also decreased (from 6 parents to 2), although this change was not statistically significant.

Practitioners also observed parents starting to use props, sing songs, and talk more during story time, showing greater confidence and a willingness to try new approaches.

Increased daily shared reading and storytelling

Substantially more parents reported finding time each day to look at or read a book together with their child over the 3-month period. The proportion of parents selecting *Strongly Agree* increased from 4 (11%) at baseline to 14 (39%) at follow-up, a statistically significant net increase of 10 parents (27.78 percentage points; 95% CI: 8.83 to 46.73), corresponding to a relative (proportional) increase of 250% from baseline. The proportion selecting *Agree* remained stable at 10 parents. Responses in the *Neutral, Disagree*, and *Strongly Disagree* categories decreased (*Neutra*l: 15 to 9; *Disagree*: 6 to 3; *Strongly Disagree*: 1 to 0), but none of these changes were statistically significant. Overall, these findings indicate that substantially more parents were able to make daily time to share books with their child over the 3-month period.

Promoting bonding between families and their children

Sharing books and stories is helping strengthen bonds between parents and children. One practitioner noted that even very young babies benefit from being introduced to picture books, which in turn helps strengthen the parent-child relationship from an early stage. Survey findings reflect this too: more parents believed that sharing stories and books strengthened their bond with their child over the 3-month period. The proportion of parents selecting *Strongly Agree* increased from 17 (49%) at baseline to 26 (72%) at follow-up – a statistically significant net increase of 9 parents (23.65 percentage points; 95% CI: 1.55 to 45.75). This corresponds to a relative (proportional) increase of 49% from baseline. The proportion selecting *Agree* decreased from 17 (49%) to 9 (25%), a statistically significant net decrease of 8 parents (-23.57 percentage points; 95% CI: -45.35 to -1.79). This corresponds to a relative (proportional) decrease of 49% from baseline and suggests a shift from moderate to strong agreement. Responses in the *Neutral* category remained stable (1 to 1). One survey response at baseline was missing and therefore excluded from this analysis.

Increased access to books and learning resources

Stakeholders observed more books appearing in homes, even in challenging circumstances such as temporary accommodation. Survey data supports this: parents reported changes in the number of children's books in their home over the 3-month period. The proportion of parents reporting 21 to 50 books increased from 4 (11%) at baseline to 12 (33%) at follow-up, a statistically significant net increase of 8 parents (22 percentage points; 95% CI: 3.71 to 40.73). This corresponds to a relative (proportional) increase of 200% from baseline, indicating that more children had access to a moderate number of books at home – far more than could be accounted for by the three picture books received during the evaluation period.

The proportion reporting fewer than 10 books decreased from 14 (39%) to 7 (19%), although this change was not statistically significant (-19.45 percentage points; 95% CI: -39.96 to 1.06). Changes in the other categories were smaller and not statistically significant (10 to 20 books: 16 to 13; more than 50 books: 2 to 4).

Experiences and emerging benefits for practitioners and the wider system

FNP nurses have responded very positively to the initiative, reporting renewed enthusiasm for and confidence in shared reading and storytelling, and feeling inspired by new ideas to engage families more effectively. They described it as a valuable addition to their “toolbox” for supporting families and noted that it has brought storytelling and shared reading to the forefront of their practice, helping them to move out of “auto-pilot” with the shared reading support they offer as standard. Many stakeholders highlighted that the initiative has started to strengthen collaboration between early literacy services across Liverpool, enhancing the support available to families.

How the initiative worked

The early impact of *Tell Me a Story, Liverpool* appears to be supported by a combination of factors, including growing parental confidence, knowledge, and enjoyment; strong partnership working; the free monthly picture books, which provide prompts for practitioners to more frequently engage with parents about shared reading and storytelling; and the regular weekly contact FNP nurses have with families, allowing for repeated, ongoing conversations.

Parental confidence in storytelling

Parents taking part in the programme became more confident in sharing stories and books with their children over the 3-month period. The number of parents who *strongly agreed* they felt confident rose from 18 (50%) at baseline to 26 (72%) at follow-up, a statistically significant net increase of 8 parents (22 percentage points; 95% CI: 0.3–44.2), equivalent to a 44% relative (proportional) increase over baseline. This increase was accompanied by a corresponding decline in parents selecting *agree*, indicating a shift from moderate to strong confidence. No significant change was observed among parents who were *neutral* at baseline.

One parent reported a drop in confidence over the three-month period. The reasons are unclear; it may reflect greater self-awareness of developmental needs or error in questionnaire response. This will be explored further through follow-up conversations at six months, beyond the scope of the CHEC programme.

Parents also reported feeling more confident in how to use storytelling to support their child’s development (fine motor, scaffolding, personal-social, speech) over the 3-month period. The proportion of parents selecting *Strongly Agree* increased from 17 (47%) at baseline to 26 (72%) at follow-up, a statistically significant net increase of 9 parents (25.00 percentage points; 95% CI: 3.09 to 46.91), corresponding to a relative (proportional) increase of 53% from baseline. The proportion selecting *Agree* decreased from 19 (53%) to 8 (22%), a statistically significant net decrease of 11 parents (-30.56 percentage points; 95% CI: -51.78 to -9.34), equivalent to a relative (proportional) decrease of 58% from baseline. This suggests a shift from moderate to strong understanding. Responses in the *Neutral* category increased slightly from 0 to 2 parents.

During the same period, parents described changes in their behaviours – for example, using storytelling techniques more often, and bringing more books into the home. These shifts together suggest a positive pattern that can help support children’s language, literacy, and communication development.

Practitioners similarly noticed a clear boost in parents' confidence. Parents with learning needs or limited experience of books felt more comfortable sitting down to read with their children, while others began using props, singing songs, and talking more during story time – which practitioners felt showed both increased confidence and a willingness to try new approaches. They attributed this to the storytelling aspect of the initiative, which supported families – especially those with children at greater risk of poor communication and language development outcomes – to use books in different ways. One practitioner described how they were able to support families resistant to reading books with their children through storytelling techniques:

> *"It's not about reading what's on the page … you can make up your own story … It's maybe just about looking at the pictures, pointing out certain things, allowing the baby to explore … you don't have to read that story from start to finish … and now [parent] who can't read has been making a bit more of an effort … [they're] not scared now to pick up a book and look at it with [their] child … in case [they] says the wrong word. It's given [them] that confidence, that [they] can just look at the pictures" (FNP Nurse)*

Increased parent enjoyment in storytelling and shared reading

Parents felt substantially more enjoyment in reading or storytelling with their child over the 3-month period. The proportion of parents selecting *Strongly Agree* increased from 12 (33%) at baseline to 27 (75%) at follow-up, a statistically significant net increase of 15 parents (41.67 percentage points; 95% CI: 20.76 to 62.58). The statistically significant increase in the S*trongly Agree* category corresponds to a relative increase of 125% from baseline.

The proportion selecting *Agree* decreased from 21 (58%) to 6 (17%), a statistically significant net decrease of 15 parents (-41.66 percentage points; 95% CI: -61.85 to -21.47), equivalent to a relative (proportional) decrease of 71% from baseline, suggesting a shift from moderate to strong enjoyment. Responses in the *Neutral* and *Disagree* categories remained stable (Neutral: 2 to 2; Disagree: 1 to 1).

Parents' sense of support from the Health Visitor or Family Nurse in using storytelling remained largely stable over the 3-month period. The proportion selecting *Strongly Agree* increased slightly from 19 (53%) at baseline to 22 (61%) at follow-up (8.33 percentage points; 95% CI: -14.46 to 31.12), while the proportion selecting *Agree* decreased slightly from 13 (36%) to 12 (33%) (-2.78 percentage points; 95% CI: -24.76 to 19.20). Responses in the Neutral and Disagree categories remained low (Neutral: 4 to 1; Disagree: 0 to 1), and none of these changes were statistically significant, indicating that parents generally felt supported from the outset and this level of perceived support remained stable.

Parents' knowledge about the importance of shared reading

One stakeholder shared an example of a parent who had not previously been aware of the value of reading and storytelling with very young children. After witnessing their children's enjoyment of a shared book, the parent was both surprised and encouraged – leading them to incorporate regular storytelling into their family routine.

Parents generally believed that storytelling supports their child's language development, and this level of belief remained stable over the 3-month period. The proportion of parents selecting *Strongly Agree* increased from 22 (61%) at baseline to 26 (72%) at follow-up, a net increase of 4 parents (11.11 percentage points; 95% CI: -10.52 to 32.74), although this change was not statistically significant. The proportion selecting *Agree* decreased from 14 (39%) to 8 (22%) (-16.67 percentage points; 95% CI: -37.60 to 4.26), and the *Neutral* category increased slightly from 0 to 2 parents, with none of these changes statistically significant.

Clear, consistent messaging

The training and partnership work around child and family literacy is creating clear, simple, and consistent messages about shared reading and storytelling. By aligning different organisations and support, families are receiving the same messages across settings, making support easier to access and the system work more efficiently.

> *"It's about creating a consistent narrative… if they go to the library, children's centres, or early years providers, we've got the same message throughout. That's the power of this approach" (ICS Project Team)*

Monthly free books as a catalyst

FNP nurses described how providing families with the gift of a free picture book each month acted as a key mechanism for the initiative. It gave them more frequent and earlier opportunities to start conversations about storytelling and shared reading with families, in a non-judgemental way, and to role model how to share books and storytelling with their children.

> *"It's increased the frequency of the conversations about books and sharing stories … when we see [the books] in the house, it gets the conversation started "oh, you've got this month's free book! How was it? How's the baby enjoying it?", it's been really useful for reiterating that" (FNP Nurse)*
>
> *"The books have allowed us to role model to the parents … how they can interact and communicate with their babies using the books… and then they tend to build confidence in themselves to sustain that" (FNP Nurse)*

Families valued receiving the books directly at home, and seeing their children enjoy them encouraged repeated engagement.

Practitioner role and capacity

We heard how FNP nurses are especially well placed to support shared reading because they work with families regularly over a longer period, allowing them to build trust and strong relationships. This gives them the space to introduce storytelling and books in a friendly, approachable way, even with families who may be hesitant.

Building on assets

Tell Me a Story, Liverpool built on existing local strengths rather than starting from scratch. Health visitors and FNP nurses were already sharing Bookstart baby packs and talking with parents about how reading supports children's speech and development. Other local programmes, such as Parents in Partnership Education (PIPE), also gave parents opportunities to engage with books and stories. By linking to these existing efforts, and with partners such as libraries and the National Literacy Trust, the initiative strengthened what was already working, creating a more joined-up and sustainable approach. Practitioners noted that because families now have multiple books at home, along with props such as puppets, because of *Tell Me a Story, Liverpool*, programmes like PIPE are easier to deliver, as resources can stay with families rather than being taken away at the end of each visit.

The initiative was also promoted through the Liverpool Festival of Storytelling, which brought together libraries, family hubs, health visitors, speech and language therapists, and other local services. The festival featured live storytelling, theatre, poetry, and play-based activities, giving families practical ways to explore books and early literacy while learning about local services and support. The festival was designed to be fun, accessible, and inclusive, and reached hundreds of families, including those from disadvantaged backgrounds. It also helped professionals connect, share ideas, and showcase the value of early literacy.

The CHEC as a vehicle for change

Tell Me a Story, Liverpool has begun to show early benefits for children, families, and beyond, partly because the CHEC programme acted as both a platform and a vehicle for change. With senior support through the ICS and from the collaborative, practitioners were given the space and legitimacy to try new ideas and have conversations about child health equity amid busy workloads. The funding contribution of £10,000 – invested in the initial book subscription of up to two years for approximately 100 families – and the relatively short timelines encouraged creativity, prompting teams to build on existing assets, relationships, and partnerships rather than starting from scratch. The approach drew on the dedication, enthusiasm, and motivation of individuals already working within the system.

> *"A lot of the activities were already happening… [CHEC] gave us permission to have the conversations, explore new opportunities, and reconnect with partners… it gave us a new dynamic, a new topic of conversation to reunite or reignite existing relationships." (ICB Project Team)*

Key challenges and lessons learned

Strengthening service links

A key aim of *Tell Me a Story, Liverpool* is to strengthen links between early literacy services. Progress is being made, but some stakeholders noted that partners still often work in silos, and awareness of roles and services varies across local authorities, making it sometimes difficult to contact or stay in touch with relevant teams.

Contacting non-FNP parents

Recruiting families outside the FNP programme proved challenging, with some parents sceptical about the offer of free books.

> *"I've felt like a bit of a cold caller trying to enrol [parents who did not want to take part in FNP]… there's that scepticism, like why is this person offering me free books?" (FNP nurse)*

Maintaining contact after FNP

Some professionals anticipated challenges in continuing to support families, deliver books, or track outcomes once they leave FNP, especially if families move or change address.

> *"There will come a point where we're going to have clients who we graduate from our programme who are going to go into a universal caseload… risk maybe not being able to get in touch with clients if they move address… the books aren't going to be getting delivered to them." (FNP nurse)*

Ensuring equitable support

The pilot was designed with a focus on health equity, supporting teenage parents and their children in areas of higher deprivation, who face an increased risk of poor early language, communication, and literacy outcomes. The monthly books are age-appropriate and chosen by the Dolly Parton Imagination Library to be inclusive and representative of all families. As described in the previous section, FNP nurses are well placed to deliver the programme because of the longer-term relationships they build with families, allowing them to cover a range of topics, and the nurses we spoke with for this evaluation felt confident they could, overall, equitably deliver the intervention. However, supporting families with more complex needs remains a challenge, meaning some children may receive less input on shared reading and storytelling than their peers. Health visitors, who see families less frequently, may face an even greater challenge in reaching higher-risk families.

> *"What the FNPs told me was their time was largely taken up around housing issues, safe sleeping, feeding… it's difficult to then share a story, especially if they're in someone's home… I wonder about training professionals who might already have a really busy role … with limited capacity [they] might think 'Why are you now expecting me to be a storyteller?" (Early Literacy Professional)*

Extra demands made on committed, but over-stretched individuals

While the initiative successfully unlocked local innovation and collaboration, it often relied on the dedication and goodwill of committed, passionate but already stretched professionals. Limited resources and tight timeframes added extra demands on individuals working in challenging circumstances.

> *"It worked to our advantage in terms of we're not here with loads of money… but also that made it incredibly hard in [terms of] the drain on the already busy workloads for a lot of people … It has become all-encompassing and my whole life… not the expectation." (ICB Project Team)*

We heard how, for some stakeholders, implementing the initiative and completing data collection felt rushed, with teams having to set up their own systems for tracking and reporting, which added extra work.

> *"It all felt quite rushed… we very quickly had to create our own local internal system and spreadsheet… one part of it was paper, one part of it was digital… we ended up having to do everything ourselves." (FNP nurse)*

Pressure to demonstrate impact

Some stakeholders felt pressure to quickly demonstrate work or visible outcomes, such as photos or publicity, which sometimes felt at odds with the initiative's longer-term goal of creating meaningful, sustainable change for local children and families. As one practitioner reflected:

> *"There was this pressure to get a picture… it does feel like you're part of something that's about publicity rather than the longevity of making a difference." (FNP Nurse)*

FNP nurses also described the challenge of collecting data and reliable information from families using the bespoke storytelling survey.

> *"We're doing the questionnaires now, and that's the bit I'm finding the hardest to fit in" (FNP Nurse)*
>
> *"It was funny when we did the first questionnaire. Everyone is a marvellous reader and they're all able to do stories, and they're already all able to do voices. But then that wasn't necessarily what we were seeing" (FNP Nurse)*

Library use

Stakeholders reported that they had not noticed much change in parents' use of libraries during participation in *Tell Me a Story, Liverpool*, which is corroborated by survey findings. Parents similarly reported little change in how often they visited the library with their child over the 3-month period. The proportion reporting *never* visiting decreased from 29 (81%) at baseline to 26 (72%) at follow-up (−8.34 percentage points; 95% CI: −27.86 to 11.18), while those reporting *visiting once* increased from 5 (14%) to 8 (22%) (+8.33 percentage points; 95% CI: −9.34 to 26.00). Changes in the other categories were minimal (*2-3 times*: 1 to 2; *4-5 times*: 1 to 0), and none of these differences were statistically significant, indicating that library visit frequency remained largely stable.

Recommendations for future delivery

The evaluation highlights key lessons for Cheshire and Merseyside ICS and other health and care systems to consider when designing and delivering similar initiatives.

- To deliver equitable benefits as the initiative expands beyond teenage parents and their children, a coordinated approach across health, early years, schools, libraries, adult learning, and the VCSE sector is needed. Strengthening and formalising partnerships with VCSE organisations can provide additional support to families at higher risk of poor outcomes, enabling NHS staff to deliver shared reading and storytelling support to all families – a proportionate universal approach. This also ensures children and families receive consistent messages across all the spaces they engage with, including libraries, health visitors, FNPs, and voluntary sector services.

- For a rolling initiative that aims to support new children each year, long-term sustainability is key. This requires embedding the initiative within existing local plans and services – such as the ongoing training of health visitors in shared reading and storytelling – reducing reliance on individual leaders, and ensuring teams and organisations collaborate to provide consistent support for families.

- There are plans to evaluate the programme over the next few years. Future, longer-term evaluations of *Tell Me a Story, Liverpool* could address current limitations by collecting data from practitioners with a wider range of experience, tracking outcomes over a longer period to capture the initiative's full impact, and examining the role of partnership working with the VCSE sector and trained volunteers (e.g., in family hubs) in supporting families and alleviating workforce pressures, which will be key for long-term sustainability.

Conclusion

Tell Me a Story, Liverpool is a pilot initiative that provides teenage parents and their children with free monthly picture books, alongside shared reading and storytelling support from FNP nurses and health visitors. Early findings suggest children are enjoying books more, families have more books at home and are reading more often, and parents feel more confident, supported, and bonded with their children through storytelling. Survey data and practitioner feedback indicate the initiative works by building on trusted relationships, using free books as a catalyst for frequent conversations about shared reading and storytelling, and offering clear, consistent messages across services. Challenges remain in reaching families outside FNP, sustaining support when families leave the programme, ensuring equity for those with complex needs, and managing pressures on already stretched staff. Overall, it shows early benefits and momentum, with promising signs that it may help raise vocabulary levels, particularly in children at greater risk of poor outcomes. The ICB could consider scaling the initiative to reach more families over a longer period, though this will require strong collaboration and sustainable support to deliver long-term impact.

Initiative Profile: Using Social Value and Corporate Social Responsibility in Procurement to Promote Child Health Equity – Lessons from Birmingham and Solihull

How and why Birmingham and Solihull ICS explored using social value and corporate social responsibility in procurement to promote child health equity.

Birmingham and Solihull ICS took a different approach from the other CHEC partners when developing their initiative. Rather than creating a new initiative targeted at a specific underserved group of children, young people, and their families, and focusing on one or a few key drivers of children's and young people's health and wellbeing (as set out in the Child Health Equity Framework), they chose to explore the potential for existing strategic work to be optimised for child health equity. Specifically, they examined how social value (SV) and corporate social responsibility (CSR) in procurement could address the wide range of social determinants of child health and inequalities. This initiative profile shares key findings on the potential and early benefits, challenges, and opportunities of using this approach to support child health equity and an increased focus on the social determinants of child health.

Context

Birmingham is the youngest city in Europe, with almost 40% of its population aged under 25 years old[16], and around 250,000 aged under 16 years old (23.4% of the population)[17]. According to 2022/23 data, the West Midlands has the highest rate of poverty in the UK, at 27%, with some constituencies seeing child poverty rates of over 1 in 2. This includes Ladywood (55%), Hall Green and Moseley (55%), and Solihull North (51%)[18]. The "scandal of child poverty" was the focus of a Birmingham Live commission.[19] Birmingham is also one of the UK's first "super diverse" cities, where citizens of ethnic minority backgrounds make up more than half of the population (51.4%), and higher among those aged 0-15 (67%)[20]. The layering of poverty, ethnicity, and other characteristics such as having a learning disability, means that health outcomes for local children and young people, and of their families, are not equal across different groups. Compared with Richmond-upon-Thames in London, which has one of the highest healthy life expectancies in the UK (68.9 years for women and 70.2 years for men), women in Birmingham and Solihull have 8.7 and 3.2 years less HLE respectively, and men in Birmingham have 11 and 2.8 years less HLE respectively[21].

Tackling the social determinants of health is a system-wide task, with significant contributions by community and voluntary organisations, and local authorities are a key source of funding. However, this landscape has been changing in recent years, with grants and other forms of funding available to charities diminishing, and Birmingham City Council effectively declaring itself unable to balance its budget in 2023.

Background: Embedding social value and CSR in procurement, and the role of the CHEC

Birmingham and Solihull had already begun a major programme of work to embed SV/CSR into procurement for public good. This included activity such as aligning procurement with the ICS's 10-year health inequalities strategy, planning a Social Value Conference, and increasing the SV weighting in contracts from 10% to 20%,

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[16] Breaking Down Barriers - Working Towards Birmingham's Future Supporting Younger People into Employment
[17] Birmingham: A Child Poverty Emergency
[18] UK Poverty 2025
[19] Birmingham: A Child Poverty Emergency
[20] Why Birmingham's super-diversity is a strength, and not a surprise
[21] Map of healthy life expectancy at birth

alongside new monitoring processes. The core idea for exploring the potential of embedding SV and CSR into procurement for public good is that it represents an untapped resource for promoting health and reducing inequalities. By aligning supplier contributions with locally defined needs, the ICS could enable voluntary and community organisations to deliver community-based solutions that address the social determinants of health. At the same time, the approach is expected to “help voluntary and community organisations gain resources and capacity, while giving suppliers opportunities to increase their local impact and strengthen employee engagement.” (ICB Project Team)

The above activities were led by Birmingham and Solihull ICS and were not created by or for the CHEC, but they provided an important foundation for Birmingham and Solihull ICS’s aim as part of the CHEC – to explore if and how maximising and embedding SV and CSR into procurement could promote child health equity and increase focus on the social determinants of health. The goal is to align supplier commitments with local child health equity priorities so that children and families in the most deprived areas of the city receive more support.

Within this context, the CHEC programme added a more targeted focus on children and young people. The £10,000 CHEC investment was used to support Health Equity Champions to help shape and develop projects that align with the Child Health Equity Framework. A dedicated ICS lead, supported by CYP engagement and data specialists, worked closely with procurement leaders, and community and voluntary partners to explore the potential of using procurement to release social value for child health equity.

In the sections that follow, we set out:

- The research approach and limitations
- The benefits observed so far for children, young people and their families – where procurement activity is directly or indirectly promoting child health equity or addressing the social determinants of health
- The key enablers and mechanisms – how the embedding of SV and CSR in procurement is making this possible
- The challenges – what risks or barriers may limit impact
- The recommendations – insights for Birmingham and Solihull and for other local health and care systems wishing to replicate this approach.

Research approach and limitations

This study used a mixed-methods approach. Findings are drawn from 13 interviews with 10 stakeholders, including ICB project team members, the procurement lead, VCSE representatives, leaders, and a CYP engagement lead (some interviewed twice).

A short documentary review was also carried out, using case studies of collaborations between voluntary organisations and suppliers, as well as information on the CYP Champions. In addition, data from the Match My Project (MMP) platform - which connects suppliers with third-sector organisations delivering support and services in the local community - were extracted in July 2025 and analysed. The data included details of each project, any resources or funding requested, project outcomes, and whether support was offered or accepted.

A key limitation of this study is the short timescale, which meant it was not possible to measure the impact of linked supplier/community organisation projects on the health of CYP and their families. No direct feedback was gathered from CYP or families themselves, although health outcomes are being measured by the ICB over a longer period.

While the number and types of projects successfully matched on the MMP platform were recorded, the potential number of beneficiaries was not quantified, and the geographical distribution of the linked projects has not yet been determined. Changes to the MMP data extracts, including the removal of some long-term unfunded projects, may have led to undercounting of total projects. Some projects also requested multiple resource categories (e.g., funding and items), which could have resulted in duplication or overcounting.

Finally, as the social value approach within Birmingham and Solihull is still in its early stages of implementation, financial proxy values have not yet been assigned to in-kind activities (e.g., volunteering, apprenticeships, or donated goods), and the MMP system is not currently configured to capture or monetise these types of contributions.

Benefits for children, young people and their families

This section briefly explores the tangible benefits being seen for children, young people, and families through Birmingham and Solihull's efforts to embed SV and CSR into procurement practices. These include both direct support - such as resources for CYP-focused projects - and indirect benefits, such as supplier contributions that help address stressors and the wider social determinants of child health.

In the July 2025 data extracted from MMP, over half of all projects listed on the platform (102 out of 200) were directly related to children and young people. VCSE-led child and family services submitted CYP-related projects requesting a total of £1,303,825 in support. Of this, £30,200 was successfully backed, representing around 32% of all successfully funded projects.

Following the Social Value Conference, 112 new projects were listed, 26 of which were successfully matched, with CYP-related projects receiving £15,200 in support during this period (approximately 16% of total successfully backed projects). While this represents a meaningful investment in children and young people and the wider determinants of their health, it also highlights a gap between the support requested and what was provided - a challenge that is explored further in a later section.

Increased support for VCSE-led child and family services and organisations

Suppliers are now providing more meaningful and sustained support to voluntary and community organisations working with children and families. Stakeholders described how many suppliers used to support CYP through smaller and more tokenistic gestures, such as toy donations, and this has now developed into more substantial contributions, including the funding of outreach initiatives, fixing broken water supplies for youth programmes and providing vans for logistics.

Support that addresses stressors and the broader social determinants of child health

Many of the projects listed on MMP as being directly relevant to CYP, provide essential items, funding, and volunteer support to address stressors such as poverty and financial hardship - important social determinants of child health.

For example, the 'Safe Sleep Scheme' for children and babies in temporary accommodation, saw a private sector organisation donating beds, moses baskets, and cots to a voluntary sector organisation for distribution. Another example includes a sports programme in a more deprived area of Birmingham and Solihull where a supplier sponsored all kit and equipment. Suppliers also supported schools with career days, visits, and guaranteed interviews for school leavers, helping address broader educational and economic opportunities for children and families.

Some projects addressed health equity more indirectly, for example by donating laptops, workspace equipment, furniture, and office fit-outs for frontline workers and volunteers in organisations supporting CYP with learning disabilities, other additional needs, or who had experienced rape and sexual violence.

Support for health services

Stakeholders described how a contractor appointed to extend Birmingham Children's Hospital was the first to actively engage with the programme, embedding social value into a major development directly linked to child and family health. As part of their successful tender for the Front of House Project, their social value offer included two T-Level Apprentices from University College Birmingham; workshops and flexible work placements for older patients; six weeks of work experience for local school students; 500 hours of workforce volunteering; and guaranteed interviews for care leavers and other groups with protected characteristics. One stakeholder noted that, without the Social Value Conference and the launch of Birmingham and Solihull ICS's social value process, these contributions would not have been made.

Faster access to support

Embedding SV/CSR in procurement has helped children, young people, and families get help more quickly. Across all projects, the average time from listing to backing was 91 days. After the Social Value Conference in September 2024, this dropped to 22 days.

Wider system benefits

Analysis of data and stakeholder interviews suggest that Birmingham and Solihull's social value initiative has contributed to some wider system benefits.

Stronger partnerships

Some stakeholders described how Birmingham and Solihull's SV initiative has strengthened partnerships across sectors. This includes partnerships between the ICB and key stakeholders, helping focus social value activity on the areas of greatest need for children and families; between private sector and VCSE organisations, enabling voluntary organisations to proactively influence the support they receive; and between private sector organisations themselves, where there is now a greater focus on collaboration instead of competition.

Raising the profile of child health equity

The initiative has increased awareness and focus on child health equity across a wide range of stakeholders, including public, private, and voluntary sector organisations, as well as within the ICB itself.

Enabling Child Health Equity: Key Mechanisms and Drivers

By embedding SV and CSR requirements into procurement processes, the system can direct resources and support toward children, young people, and their families - without requiring additional public spending. This section outlines the specific features of the system, platforms, and processes that appear to drive these impacts, or that have the potential to do so.

Structural consolidation

Merging six NHS trust procurement teams into one gave Birmingham and Solihull a single lead managing £1.3 billion in annual spend. This has made it easier for them to work with suppliers strategically and secure commitments that could benefit the whole system.

Leadership support

Embedding SV/CSR in procurement is supported at the highest levels within the ICS, with a board member focusing on health equity, and senior leaders, including the ICB Chair and Chief Financial Officer, actively backing these efforts. Anchor organisations, such as the ICB, play a central role in championing social value and child health equity. The CHEC programme has reinforced this by highlighting health inequalities and social determinants of health, with dedicated leads advocating for child health equity. Senior leaders working to make child health equity more visible have raised awareness across the ICS and among public, private, and voluntary sector stakeholders, attracting attention from policymakers, the media, and the public, and helping inform wider efforts to address child poverty and inequality.

Child poverty is a strategic priority in Birmingham and Solihull

The focus on child poverty in Birmingham has helped create momentum for child health equity work. The Birmingham Mail's major 2024 investigation raised public and policy awareness, giving the issue visibility and advocacy that supported wider engagement with related initiatives[22].

Relational activity

Human relationships have been central to the success of embedding SV and CSR in procurement. Stakeholders described to us how meaningful engagement, stories, and face-to-face connections are often more effective at getting supplier support than formal contracts or digital tools alone. Relational activity operates across three main levels:

- Between leaders and decision-makers - connections formed at health equity events helped create momentum for change. For example, a senior procurement lead, frustrated with the limited impact of previous SV efforts, approached the CHEC team to explore a new approach. We also heard how champions have had some influence with the procurement agenda by linking it with child health and poverty outcomes, leading to a shift in mindset among senior procurement figures.
- Between the ICB and suppliers/VCSE organisations - The ICB encouraged suppliers to think practically about SV and CSR in procurement, such as by participating in community events, and engaging directly with VCSE organisations, rather than seeing it primarily as a tick box exercise. The procurement lead has regular communication with suppliers, puts on live events, and develops interactive forums with suppliers to ensure meaningful engagement.
- As a broker between suppliers and VCSE organisations - Procurement introduces suppliers to voluntary organisations so “they can see needs first-hand, see what they do and how they can help them” (Community Sector Leader). These visits often lead to multiple projects, from toy drives to logistics support, turning small contributions into more meaningful and longer-term partnerships. “They went with one thing in mind and left … with about 20 different projects they started doing … and this was a company that wasn't sure what to do at first” (Procurement Lead)

Stakeholders saw these relational levers - bringing people together, sharing real-life stories, and creating chances for direct engagement - as essential for using SV/CSR in procurement to most benefit children, young people, and their families.

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[22] Birmingham: A Child Poverty Emergency

Co-production of projects

Stakeholders described how working closely with organisations to understand their real needs - asking “what do you need?” rather than “what can we give?” - ensures projects are designed effectively.

The Child Health Equity Framework

Although the procurement strategy was developed independently, it was later informed by the Child Health Equity Framework, which stakeholders have said is helping to focus support on the drivers of children’s and young people’s health and wellbeing. Although further work is still needed (see challenges section).

Role of the Social Value Conference

The Social Value Conference – “a sort of speed-dating event” - acted as a catalyst for child-focused engagement within the ICB-led approach. By showing the value of SV in procurement, promoting the MMP platform, and showcasing local organisations that work with and for CYP, the conference encouraged local community and voluntary organisations to submit projects that help children, young people, and families. It also brought people and organisations together, creating new collaborations and commitments. As a result, projects were listed and matched faster, delivering support to CYP and their families more quickly.

Enhanced contractual weighting and monitoring

Stakeholders believed that increasing the SV weighting in procurement contracts from 10% to 20% had encouraged more suppliers to create and submit projects that support the health and wellbeing of children and young people.

The Match My Project (MMP) platform

The MMP platform allows suppliers and local community and voluntary organisations to connect, list projects, request resources, and receive support quickly. It tries to ensure that procurement commitments deliver tangible benefits by centralising information and enabling efficient “matchmaking”. Stakeholders reported that suppliers value the clear structure and accountability, while community organisations gain access to new resources and relationships. But there are challenges with the platform, which we described later in this profile.

CYP voice

Most stakeholders said that hearing directly from CYP with lived experience was the most powerful way to encourage them to tailor support and contributions to local needs. Health Equity Champions sharing their own stories and those of their peers about how inequalities affect them, has been a motivator for private sector organisations and the ICB, as has voluntary sector organisations sharing the challenges that their clients face and the benefits of private sector support.

Shared learning

Interim findings from this initiative have been shared with various bodies, including NHS England’s Net Zero/Social Value team, the Health Service Journal’s Health Inequalities Conference, and other ICBs, further strengthening buy-in within Birmingham and Solihull.

Passionate individuals

Stakeholders highlighted the dedication of key figures, particularly the ICB's procurement lead and the CHEC leads, whose commitment drove the initiative forward and helped bring partners on board.

Challenges

Findings indicate several challenges in embedding SV and CSR in procurement, particularly when aiming to promote child health equity and address the social determinants of child health.

Projects not yet matching the scale of need

While projects supported through MMP are providing valuable support, the number and scale of these initiatives remain small compared to the extent of child poverty in Birmingham and Solihull. This highlights both the potential for impact and the ongoing gap between local needs and current levels of activity. Early contributions have helped individual children or families but have not yet had a meaningful impact on child health inequalities or the broader determinants of child health.

Competing priorities

Procurement processes must address multiple high-need areas across the ICS. Ensuring that children and families remain prioritised alongside other urgent social and health needs continues to be a challenge.

> *"How do you put young children, young people first and foremost…how do we make this a good city to grow up in?" (VCSE Leader)*

Limited CYP voice

Most stakeholders described how children and young people were not consistently or meaningfully involved in shaping projects, limiting their influence on priorities and the relevance of interventions. While some engagement occurred through training or panels, some stakeholders described a lack of systematic approach to embed CYP perspectives. Early advisory panels did not gain traction, and engagement is now largely being discussed as the responsibility of local voluntary and community – for them to involve CYP when developing projects to put forward to suppliers. Stakeholders noted that a plan to strengthen CYP involvement is currently being developed by the Children's Board within the ICS, but it is not yet widely known across the VCSE sector.

Relational activity is resource-heavy and can be fragile

Building the relationships necessary to drive SV/CSR in procurement takes time, effort, and sustained leadership. Stakeholders highlighted the head of procurement's hands-on engagement with VCSEs as essential and said that such relational work cannot be replaced by digital platforms or events alone. Some stakeholders expressed concern that possible over-reliance on key individuals makes the work fragile, because if they leave, retire or priorities shift, momentum and strategic focus may be lost.

Limitations of the Match My Project platform

VCSE representatives told us that MMP can be hard for some VCSE organisations to use. We also heard that some partnerships between VCSE organisations and companies happen outside the platform, so it is harder to track their impact. Stakeholders stressed that MMP on its own isn't enough - human support and relationship-building are essential. Without this, the platform risks becoming “a form-filling exercise with no heart”, reducing the impact of Birmingham and Solihull’s work to embed SV/CSR in procurement for public good.

Misalignment of expectations - limited funding uptake with more in-kind support

A key challenge for Birmingham and Solihull is the mismatch between the type of support most sought by VCSE organisations and that most often offered by suppliers. VCSE organisations typically request cash funding to support their projects, while suppliers more frequently provide in-kind support such as staff volunteering, training, or donated goods and equipment.

Data from the MMP platform show that VCSE organisations requested a total of £2.5 million in funding (median £5,000; range £150 to £900,000), yet the total value of projects backed was £94,513.

The reasons for this gap are not yet fully understood. One explanation may be that VCSE organisations prefer cash because it offers flexibility to cover core costs and sustain services. In contrast, suppliers may find it easier to offer and account for in-kind contributions, which are more visible to others and easier for suppliers to record and report as social value. Cash funding, once spent, can be harder to track and may go towards less visible operational costs.

Interviews with stakeholders also revealed differing assumptions about what social value would look like in practice:

> *“Walking around Birmingham and Solihull, you should be bumping into social value activity quite a lot of the time… there is no way that there is £200 million worth of spend [i.e. 20% of the ICB’s total annual spend of £1 billion] going into Birmingham and Solihull every year around social value… it’s very unlikely to materialise as cash.” (VCSE Leader)*
>
> *“We were always clear that this was likely to be ‘in-kind’ support… but that doesn’t mean that others were too.” (Project Manager)*

Birmingham and Solihull has not yet assigned financial proxy values to in-kind activities such as volunteering or apprenticeships. This is largely because the social value approach is still in its early stages of implementation, and the MMP data systems are not yet configured to capture or monetise these types of contributions. This means that Birmingham and Solihull cannot yet fully measure or show the impact of social value activity within its contracts, which makes social value less visible and points to the need for clearer communication and shared understanding among partners. There are, however, plans to introduce this in the future.

Without consistent definitions, agreed methods for quantifying in-kind activities, and robust tracking, expectations are likely to remain misaligned - with VCSE organisations seeking funding, suppliers offering in-kind support, and the ICB focused on measurable community-wide benefits that may not align with partner priorities. These challenges may be further compounded by the ongoing clustering of Birmingham and Solihull ICB with the Black Country ICB.

Formal procurement processes in development

Some stakeholders thought that much of the SV and CSR activity has been achieved informally through relationships, rather than embedded in formal procurement processes, with more work needed to create the infrastructure to carry the work forward.

Lack of follow-up and accountability

Another challenge is that providers are not consistently held to account for their SV pledges in contracts. Without dedicated resources to monitor SV delivery, suppliers may promise initiatives during tendering but fail to implement them fully - or at all - and there is little systematic tracking or evaluation, although there are plans for this in the future.

> *"The main thing that needs to happen is that somebody needs to follow up with the private sector organisations [to check] have they done it? To what degree have they done it? Can you give me a figure which says you have invested this much time or [achieved] this much impact … It's very loosely managed from a contractual point of view…We've given you a £15,000,000 contract and you've delivered £2,000 worth of activity" (VCSE Lead)*

Recommendations for future delivery

The research findings point to important things for Birmingham and Solihull ICS and other health and care systems to consider when embedding SV/CSR into procurement with an ambition to promote child health equity and the social determinants of child health.

- Make SV/CSR in procurement a long-term, system-wide priority by embedding it into ICS strategy, governance, and procurement processes. Establish sustainable infrastructure, dedicated leadership roles, and clear accountability so progress is not dependent on a few individual champions. Ensure all contracts include outcome-focused social value requirements, supported by robust monitoring and reporting, so that suppliers' commitments are consistently delivered, tracked, and translated into measurable impact for local children, young people, and families.
- Develop a practical, cross-sector social value framework and toolkit that defines what counts as social value in Birmingham and Solihull (including cash and in-kind contributions), sets out priorities linked to the social determinants of child health[23], and explains how activity will be recorded, valued, and communicated. Engagement with VCSE organisations and suppliers can help the toolkit reflect the reasons behind differing preferences for cash versus in-kind support and provide guidance on how to balance these preferences in practice. Provide consistent messaging through supplier briefings, VCSE engagement, and procurement documentation.
- To maximise the potential of social value in procurement to address local need, link procurement with NHS organisations and the ICB, public health, children's and adult's services, social care, housing and other local authority teams, Health Equity Champions and VCSE organisations to create a more joined-up response to health inequalities. Establish shared governance, data-sharing agreements, and aligned reporting so all partners can plan and deliver social value activity that meets local needs and promotes child health equity.
- Shape social value projects using local data and the lived experience of children and families, ensuring activity meets the right needs, in the right areas, and at the right scale. Involve children and young people consistently so their views help set priorities, shape design, and guide reporting. Encourage and support both suppliers and VCSE organisations with guidance on how to develop and test solutions with children and young people, not just for them.
- Help smaller VCSE organisations access opportunities by working through umbrella organisations that can broker relationships, share information, and support capacity building. Continue to provide structured networking and support opportunities so private sector suppliers and VCSE organisations can meet, build relationships, and collaborate more effectively.

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[23] Social value, procurement, and tackling the social determinants of health for CYP at ICS level

- Improve the tracking and reporting of social value. Expand the use of MMP to capture both cash and in-kind contributions; and consider adopting a recognised valuation framework such as National TOMs (Themes, Outcomes and Measures) to do this. Collect stories and case studies that highlight the real impact for children and families, especially for VCSE organisations and suppliers that prefer relational approaches and are not on MMP. One stakeholder also suggested using simple branding or “badging” for supported projects to increase awareness of social value activity across Birmingham and Solihull and encourage engagement.
- As SV/CSR work develops, keep children, young people, and families at the heart of decision-making. Establish a network of child health equity champions across organisations to maintain momentum and a focus on children, young people, and their families, over time.

Conclusion

Birmingham and Solihull’s work to embed SV and CSR into procurement shows clear potential to promote child health equity and address key drivers of children’s and young people’s health and wellbeing. It has already delivered tangible benefits, including essential items and new opportunities for education and employment, supported by strong leadership, partnerships, and tools such as the Match My Project platform. However, the scale of support remains too small for the level of local need, young people’s voices are not consistently included, and supplier commitments are not always followed through, with progress dependent on a few individuals. To build a strong, sustainable system, the ICS and partners need to embed SV/CSR into strategy and governance, strengthen cross-sector collaboration, consistently involve children and young people in decision-making, and improve tracking, reporting, and accountability across suppliers and projects. Despite current challenges, the approach shows promise as a model that other health and care systems could adapt and build on.

Findings - Objective 3

Improving the monitoring and use of key child health equity data.

Context

Access to quality data on issues pertaining to child health equity at a local level is vital. However, many local areas lack validated, comprehensive datasets that capture the full picture of children's health and its social determinants. This makes it hard to compare across regions or track progress over time. Data is often siloed across health, education, and social care, making it hard to get a full picture of a child's circumstances.

Role of the CHEC

The data workstream was designed to play a foundational role in supporting the Child Health Equity Framework and guiding the development of pilot interventions. Its primary aim was to enable effective monitoring of child health equity across regions. By doing so, it hoped to support ICSs to identify local priorities and evaluate the impact of their interventions.

To achieve its goals, the workstream had set out several objectives:

- To develop a basket of indicators that aligned with the domains of the Child Health Equity Framework with a particular focus on the social determinants of health and equity.
- To conduct child health equity assessments using a combination of quantitative and qualitative data.
- To establish baseline data and create robust monitoring plans.
- Finally, to produce replicable protocols and evaluation tools that could be used across different ICS sites to ensure consistency and sustainability.

Outcomes

The below discussion presents evidence from a range of sources to determine the extent to which key outcomes aligned to this objective have been achieved. After discussing the evidence of outcomes, we consider what it was about the CHEC programme that led to those outcomes (referred to as mechanisms) and the contextual factors that supported or hindered the achievement of the outcomes.

Current gaps within health system data are highlighted and understood, with plans in place to fill them.

We found strong evidence that gaps in health system data were highlighted and understood, although some gaps remain.

We found several documents that referenced efforts across the three ICS areas to identify (and fill) gaps in health care data. While some of this work pre-dated the CHEC, particularly around addressing health inequalities at a broader level, most documents referred specifically to the work of the CHEC programme. For example, we found reference to the work that each ICS has been undertaking to improve child health equity data (as part of the CHEC) in the minutes of an ICB meeting (2025). This suggests the CHEC has been a key factor in ICSs addressing gaps in child health equity data.

Similarly, in interviews with key personnel, including data leads, ICS leads and strategic leaders, we found clear evidence that all three areas have worked to improve access to local data on child health equity. In one ICS, a CYP transformation programme, focussing on health inequalities, was set up just prior to the CHEC. The transformation programme had a dedicated data scientist with a specialist in this area and a data architecture that links data across health services in the ICS. These factors meant that providing an evidence base for reporting to the CHEC was easier at this ICS.

The other two ICSs have created new dashboards to bring together existing health data on child health equity (with one now including aggregated LA data that is in the public domain). The two new dashboards bring together around 100 indicators for CYP health (for example, hospital admissions for asthma), and the data can be disaggregated by ethnicity, deprivation and geography. While these dashboards largely bring together data they already had, they allow new ways to analyse child health equity data at the local level. Ultimately, as one participant described, the CHEC created an opportunity to identify gaps in data and provided a justification to push for new datasets and investment in bridging gaps:

> *“While it can be a negative that we’ve got a gap… we can use this programme to say here is the gap, and how can we bridge that gap?” (ID24, ICS, P2)*

However, there were still gaps in these data sets that are important to highlight. Only one ICS has been able to fully link with primary care data, another has partial access, while the third has limited access. All three ICSs have struggled to integrate LA data, with only one area having access to identifiable data, and another using aggregated data in the public domain. Furthermore, in one ICS, a strategic leader commented on the fact that challenges remain in linking data to outcomes, particularly in complex systems with long lead times.

> *"Still difficult to prove clear cause-and-effect." (ID13, ICS, P2)*

This suggests that while there has been clear progress made in relation to this outcome, there are persistent challenges (see context section below).

ICSs understand data on the social determinants of children’s health and their impact on CYP

We found good evidence that ICSs understand data on the social determinants of children’s health, but this was variable across ICS areas.

Given the efforts across the three ICS areas to fill gaps in child health equity data, we were keen to understand whether this had started to be used in practice. Data leads in all three areas felt there had been shifts in how their ICSs used and interpreted data because of the CHEC programme. For example, they described a move from primarily tracking health inequalities to also analysing the underlying social determinants of health, including indicators related to education, housing, and emotional wellbeing, to better understand what drives disparities in outcomes.

> *"It’s really the social determinants of life… emotional health and well-being is not about have you been referred to CAMHS, it’s about how are you in yourself." (ID4, ICS, P2)*

Others commented on how the CHEC programme had helped to raise awareness of inequalities within their ICS, with data being presented ‘at the highest level’:

> *"We are providing that information to people and that is in theory going to the highest levels of the ICB to see how is the ICB doing.” (ID36, ICS, P2)*

This was reiterated by some ICS leads:

> *"The data work has definitely had an impact because the board's able to see information it has by a different set of metrics, so recognising deprivation, recognising protected characteristics." (ID38, ICS, P2)*

Another commented on how data had become embedded in strategic documentation and discussions:

> *"It's become something that people now see. So, health and welfare social determinants, it's threaded through all of our documentation." (ID24, ICS, P2)*

Interviews with participants in two of the ICSs were less clear on the extent to which access to data was informing strategic decisions (at this point in time):

> *“I'm not sure what action is ultimately coming off it.” (ID36, ICS, P2)*

> *“I haven’t been able to clearly see it being used in decision making.” (ID20, ICS, P2)*

We were keen to understand if strategic leaders in the three ICSs were aware of the improvements to child health equity data. Leaders in one ICSs area were familiar with the new dashboards and had examples of using them in practice:

> *"I think it's [CHEC] raised awareness of what's available and how it can be used... It’s the first time we'd used data really purposefully..." (ID29, ICS P2),*

> *"There's a few we've regularly discussed-child obesity data, child death data, disabilities, as well as asthma and the quality of air..." (ID28, ICS, P2)*

However, in another area, there was limited awareness of access to credible data:

> *"I don't have instant access to robust, comparative data… there isn't a single version of the truth." (ID13, ICS, P2).*

The evidence suggests a mixed picture regarding the extent to which ICSs are currently using available data on child health equity. However, this is not surprising given the recency of the dashboards being available. The fact that one area has clear examples of how it has used data, and the increasing prominence being given to data on the social determinants of health suggests that, in time, there will be greater understanding of child health equity data across all levels in the ICSs.

VCSE partner data is captured and accessible to all partners and improved understanding of VCSE partner held data.

We found no evidence that VCSE partner data was captured and accessible to all partners.

An important aim of the CHEC programme was for VCSE sector data to be available and accessible to all partners. It was hoped that data from organisations outside of the health service could improve understanding of child health equity and help focus efforts to reduce inequalities. Unfortunately, as the programme developed, it became clear that this would not be achievable. This was primarily due to the practicalities and legalities of sharing data on child health equity:

> *"I think there was just this kind of conceptual idea that if everyone was willing it would just happen and the practicalities and legalities of it hadn't necessarily been thought through" (P11, project team, P1)*

Reflecting on the initial aim of the data workstream, some ICS respondents (in phase 1) felt that the initial aims of the CHEC were over ambitious, in the context of the nature and quantity of data available. They reported having had to reach a compromise based on available data.

> *"The master plan was that we'd have one architecture that just ran in CHEC that did it all. But because we can't share the data and CHEC can't access the data, that's just not feasible with where we are the moment." (P18, ICS, P1)*

This resulted in a shift in the aim of the data workstream which changed to ongoing monitoring of child health equity over time, without VCSE sector data being included. While this outcome could not be achieved in the life of the CHEC programme, it is still an important ambition for ICSs to work towards. In collaboration with the CHEC project team, Barnardo's Data and Insights team have been working on a document called "What Good Child Health Equity Data Looks Like and how the Voluntary, Community and Social Enterprise Sector can Contribute". Within this document, there is a description of data that Barnardo's collects to make the case for the value that VCSE organisations can bring to child health equity data. It is hoped this will support integration of VCSE sector data into NHS and LA data. The document is being published alongside the other learning products from the programme, which you can find on the Barnardo's website.

Mechanisms

The development and refinement of data infrastructure across the ICSs were underpinned by several mechanisms, each specific to their local context but sharing common goals of improving data quality, accessibility, and utility.

Strategic use of dashboards

A key mechanism was the effort taken to improve data visualisation, particularly through the development of dashboards. Strategic leaders in one ICS were actively involved in shaping these tools to ensure they were meaningful and actionable.

> *"We had loads of different views of the dashboards, but which one is actually going to help. So, part of that was that conversation, so we could use the data. What's the purpose?" (ID34, ICS, P2)*

This reflects the importance of presenting data in accessible and engaging formats in order to influence decision-making.

Shift to longitudinal tracking

In one ICS, a significant shift occurred from event-based data (which is about healthcare events as they happen) to longitudinal tracking of individuals. This approach enabled deeper insights into population health over time.

> *"So, what's helped us, is a focus on events and focusing on people longitudinally. So, it's moving the mindset away from we've had these data sets for ages about events, but moving from an event which happens like bang, into an idea of looking longitudinally at people. So that is the real change." (ID35, ICS, P2)*

This evolution was supported by dedicated analyst capacity through the CHEC programme.

Embedded Information Governance

In another ICS, embedding an Information Governance (IG) lead within the data workstream was a key mechanism. This ensured ethical and secure data use while facilitating innovation.

> *"We've used information governance as a lever to entice change and really make sure we're doing the right thing with additional data sources." (ID4, ICS, P2)*

This mechanism helped to address some of the key challenges in this workstream in terms of information governance and legal protections (discussed in the context section below).

Specialist input from IHE

The final mechanism relates to the specialist advice and support offered by IHE. In their reflective diary, they describe conducting a rapid review of indicators and identified gaps to create a list of priority and secondary indicators aligned with the Child Health Equity Framework. They also developed a master Excel tool to help ICS data leads capture insights from local authority discussions on data quality and availability.

Supporting contexts

In one ICS, it was suggested that the COVID-19 pandemic had acted as a catalyst for improving data-sharing infrastructure and fostering cross-system collaboration. Commenting on how things had changed after the pandemic, one participant explained:

> *"The biggest benefit to all the data sharing was unfortunately COVID… as a result we now have really good data sharing in place across many of our services." (ID4, ICS, P2)*

The urgency of the pandemic was felt to have created momentum that enabled rapid infrastructure development - thereby supporting the data workstream.

Constraining contexts

Based on interviews with ICS participants and the project team, there were numerous structural, and technical barriers that slowed progress and limited the effectiveness of the data workstream. These contexts hold valuable insights for ICSs who wish to embed a focus on child health equity data in future.

Persistent data gaps

Across regions, there were significant gaps in child development, health, wellbeing, and income indicators which undermined efforts to build comprehensive datasets and monitor outcomes effectively. These gaps then caused delays in dashboard development. This hindered the ability to visualise and act on data insights in a timely manner.

Competing priorities

In IHE's reflective diary, it was noted that competing priorities diverted attention from data initiatives. This was particularly the case when ICS leads and data teams were focused on evaluating their interventions, which left limited capacity for broader data work.

Data literacy challenges

During some interviews, participants reflected on low levels of data and analytical literacy among partner organisations which further constrained progress:

> *"We're still working with organisations which aren't the greatest for [data] literacy." (ID35, ICS, P2)*

This made it difficult to use data effectively, even when it was available.

Information Governance and technical barriers

Across all ICSs, navigating IG requirements and addressing technical integration constraints were recurring problems.

> *"So first and foremost is complying with the law. Do we have a legal duty to share that data? Do we actually have a legal duty for using the data for that purpose?" (ID35, ICS, P2)*

> *"Significant issues remain with data sharing… NHS data sharing often relies on pseudonymised information… differing systems and infrastructure." (ID29, ICS, P2)*

> *“We’re struggling to influence councils to go through all the IG hoops to give us access.” (ID20, ICS, P2)*

These barriers slowed data-sharing agreements and limited access to critical datasets and those from LA partners.

Good practice highlights

Data Tool Development

Context - Data on children's health often fails to capture the wider social determinants, such as housing and financial pressures, or to present inequalities in an accessible way. All three ICSs used the CHEC programme as a platform to strengthen their data infrastructure, though they started from different positions. Cheshire and Merseyside already had relatively mature data systems in place, which gave them a head start in linking health datasets. NHS South Yorkshire focused on building the Cherish tool to provide nuanced equity analysis, while NHS Birmingham and Solihull developed dashboards and an outcomes framework to monitor children's priorities, though their work was shaped by greater challenges around data sharing and literacy.

Action South Yorkshire designed the Cherish tool as a dedicated dashboard for children's health equity analysis. It incorporates:

- Trend data to track progress over time.
- Breakdowns by Index of Multiple Deprivation (IMD) and ethnicity to ensure inequities are visible.
- A standardised template that has since been adopted across other local dashboards.

> *"We built the Cherish tool for the programme, which is our sort of deep dive analysis of what's happening in children's health and by designing that we came up with quite a nice way of presenting the information. So, we made sure we always presented the trend, we always presented a breakdown by IMD and by ethnicity. So that has become a template for all our kind of dashboards now." (ID20, ICS, P2)*

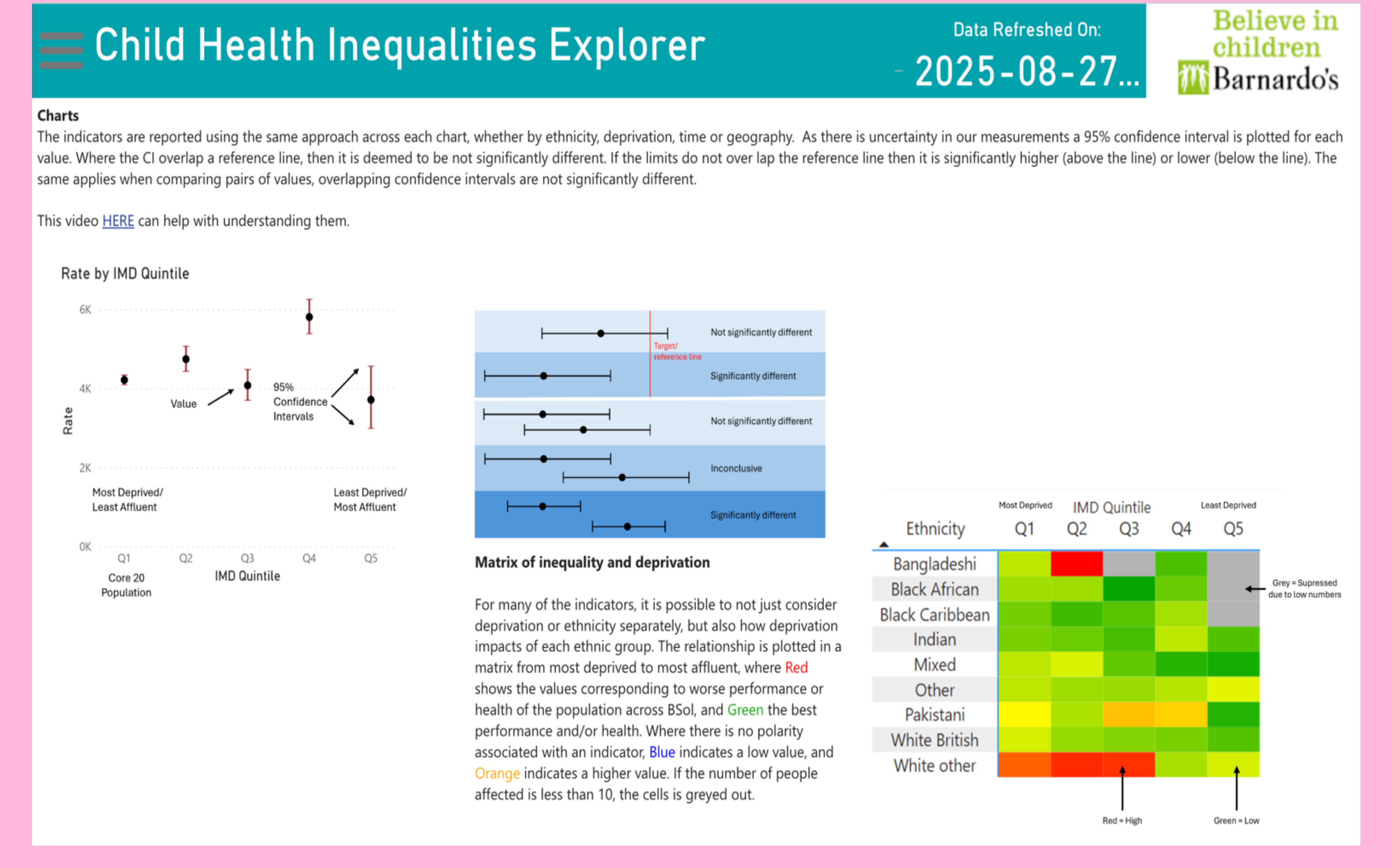
NHS Birmingham and Solihull developed an outcomes framework and dashboard structures to report on children's priorities, with indicators broken down by ethnicity and deprivation. They also invested in a "metric engine" and central data model to strengthen reporting pipelines and are planning a Single View of the Child system to integrate health, education, and care records. However, this work faced barriers including low organisational data literacy, fragmented datasets, and difficulties linking GP and council data.

Impact

- In NHS South Yorkshire, the Cherish tool has provided a clear, consistent way of presenting equity-focused data and has shaped evaluation work by embedding systematic pre/post analyses. It is becoming an established tool beyond the CHEC programme, with ambitions to make it publicly available.
- In NHS Birmingham and Solihull, dashboards and reporting pipelines increased awareness of inequalities and ensured that children's outcomes are now monitored at ICB level. While their direct impact on practice is still emerging, they represent an important step towards embedding children's health into system-wide data structures.

Learning - Together, these examples show both the potential and the challenges of embedding equity-focused data into ICS monitoring. NHS South Yorkshire demonstrates how a standardised, replicable tool can make inequalities visible and support decision-making. NHS Birmingham and Solihull highlights the technical and governance barriers that must be overcome, particularly around linking datasets and building analytical literacy. Taken together, they illustrate that progress on child health equity data requires both innovative design and ongoing investment in system capability.

Figure 1 - NHS Birmingham and Solihull dashboard



Child Health Inequalities Explorer

Data Refreshed On:
2025-08-27...

Believe in children
Barnardo's

Charts

The indicators are reported using the same approach across each chart, whether by ethnicity, deprivation, time or geography. As there is uncertainty in our measurements a 95% confidence interval is plotted for each value. Where the CI overlap a reference line, then it is deemed to be not significantly different. If the limits do not over lap the reference line then it is significantly higher (above the line) or lower (below the line). The same applies when comparing pairs of values, overlapping confidence intervals are not significantly different.

This video HERE can help with understanding them.

Matrix of inequality and deprivation

For many of the indicators, it is possible to not just consider deprivation or ethnicity separately, but also how deprivation impacts of each ethnic group. The relationship is plotted in a matrix from most deprived to most affluent, where Red shows the values corresponding to worse performance or health of the population across BSol, and Green the best performance and/or health. Where there is no polarity associated with an indicator, Blue indicates a low value, and Orange indicates a higher value. If the number of people affected is less than 10, the cells is greyed out.

Findings - Objective 4

Actively engaging decision-makers by raising their awareness of child health equity and the social determinants of child health to support informed decision-making.

Context

Decision-makers, particularly those within ICSs, are central actors in shaping health equity outcomes. The CHEC emphasised the need for system-wide action and cross-sector collaboration, which inherently involved those in leadership and policy-making roles.

Role of the CHEC

The CHEC sought to involve decision-makers in several ways:

- External communications activity targeted ICS leaders across England, local authority decision-makers, and healthcare leaders in devolved nations. The intention was to position the CHEC and its partners as thought leaders in child health equity, to share learning nationally, and to contribute to the commissioning conversations that ICS operational leads said the programme had begun to open up, particularly around how investment and resources affect outcomes for children and young people.
- In the Intervention workstream, ICS programme leads, and Senior Responsible Officers (SROs) were directly involved in shaping and approving interventions. They presented ideas to the Children and Young People's Health Equity Board for feedback, led planning and mobilisation efforts, and were responsible for signing off interventions both locally and at the programme level.
- The Health Equity Champions workstream highlighted the importance of decision-makers listening to, and acting on, the insights of Health Equity Champions. Efforts were made to ensure that the Children and Young People's Health Equity Board, which included key decision-makers and integrated CYP voices in every meeting, reinforcing the programme's commitment to participatory governance.
- Finally, evaluation activity was overseen through a steering group that included decision-makers and ICS leads. This structure ensured alignment between programme-level and intervention-level evaluations, facilitating communication and consistency across the system.

Outcomes

The below discussion presents evidence from a range of sources to determine the extent to which key outcomes aligned to this objective have been achieved. After discussing the evidence of outcomes, we consider what it was about the CHEC programme that led to those outcomes (referred to as mechanisms) and the contextual factors that supported or hindered the achievement of the outcomes.

ICSs understand the social determinants of CYP’s health

We found strong evidence that ICSs understand the social determinants of CYP’s health.

We asked all participants in phase 2 to describe the social determinants of CYP’s health, and all responses suggested a clear and consistent understanding of the concept. In several ICSs, this understanding reflected work already underway to address children’s social determinants of health. As one participant explained, CYP and child social determinants were already a strategic priority within their system, and the CHEC programme aligned with existing initiatives such as Healthier Together and Core20PLUS5:

> *“Outcomes for children is one of the top priorities for our ICP… it was like pushing on an open door with CHEC.” (ID1, ICS, P2)*

This suggests a foundational understanding of social determinants of health, with the CHEC reinforcing rather than initiating strategic focus. However, in other areas, the CHEC was described as helping move social determinants of health from conceptual awareness into tangible strategic planning:

> *“We’ve been able to thread it and embed it into many, many conversations at quite a high level.” (ID25, ICS, P2)*
>
> *"It's given us a platform to have the conversation in a more nuanced way than we have before." (ID24, ICS, P2)*

This reflects a growing institutional understanding of how social, economic and environmental factors shape child health outcomes. Similarly, in another ICS, the CHEC contributed to board-level engagement with social determinants of health, prompting reflection on data and strategic priorities:

This participant explained how ICB boards began reviewing metrics by socioeconomic disadvantage and protected characteristics, indicating a more nuanced understanding of health inequalities.

We also found several examples in the desk review of strategic documents that demonstrate understanding of the social determinants of CYP’s health. In NHS Birmingham and Solihull, their Joint Forward Plan (2025) references their work with the VCSE sector to address food insecurity, mental health, family support and community safety. In NHS Cheshire and Merseyside, their NHS Joint Forward Plan (July 2024) explained how they had designed programmes targeting mental health, oral health, neurodiversity, and edge-of-care, reflecting a broader focus on the social and environmental factors influencing wellbeing and developmental outcomes. In South Yorkshire, their NHS Joint Forward Plan (March 2025) outlined how they had embedded CYP voices in planning for family hubs, mental health services, and oral health, targeting key social determinants.

> *“CHEC has contributed to making social determinants of children’s health a more visible and strategic focus within the ICS.” (ID38, ICS, P2)*

There is greater prioritisation of CYP within population health management plans for ICSs

Strong Evidence

We found strong evidence that some ICSs had increased prioritisation of CYP in health management plans as a result of the CHEC. In the third ICS, CYP were described as already being prioritised prior to the CHEC.

In two ICSs, the CHEC was described as having played a key role in increasing attention on CYP’s health:

> *“Since CHEC’s introduction, CYP have become a key priority in both the five- and ten-year ICS strategies.” (ID30, ICS, P2)*

> *"It's probably just put more of a spotlight on that as part of all the other programmes of work that we do." (ID34, ICS, P2)*

In the third ICS, where children’s health equity was already a strategic priority, the CHEC aligned with ongoing work and provided a useful framework:

> *“It is not causal for the changes that we’ve made… what I will say was that it came along at a really brilliant time.” (ID1, ICS, P2)*

The CHEC was described by one interviewee as catalysing structural and cultural change within ICSs, embedding child health equity more firmly into strategic priorities and enabling new accountability mechanisms.

> *“Structurally it has added weight to stimulating an infrastructure around CYP, which has been a catalyst... There was a resounding kind of consensus at the board that we absolutely needed to continue… and I think that’s a fantastic legacy.” (ID43, Project Team, P2)*

However, there is a potential disconnect between strategic awareness and concrete action. For example, in an ICS where the CHEC was felt to have prioritised CYP, a strategic leader commented that while it had influenced spending conversations, it had not yet resulted in changes to budgets:

> *“Obviously, we're all very strapped by finances. So, I can't say that the programme has directly influenced the way that we spend our money, but I think it has had a secondary influence. What we tend to think about when we're discussing our budgets - I couldn't point, you know, to this budget shifted in the favour of a social determinant, but I would say it underpins all the conversations we're having because we can't spend anything now without it having a clear outcome for children and families and the health determinants are part of those outcomes for children.” (ID28, ICS, P2)*

One participant cautioned that without sustained commitment, there is a real risk of regression.

> *“If that didn’t continue and it didn’t continue to be supported by the organisation, there would be a huge loss of momentum… the statistics nationally will just continue and the health inequalities with CYP will just continue to get worse and worse and worse.” (ID43, Project Team, P2)*

Overall, interviews with key personnel suggest that ICSs are increasingly (or were already) prioritising CYP within their population health management plans. Interviews suggest this is starting to be reflected in strategic documents, governance structures, budgeting decisions, and planning processes. However, progress is uneven, with some ICSs still facing structural and financial barriers to fully embedding CYP as a population health priority.

Population health management approaches give proportional support for underserved communities.

We found limited (but emerging) evidence of population health management plans giving proportional support for underserved communities.

We reviewed JFPs in each of the ICSs. ICSs have a statutory responsibility to tackle inequalities in outcomes, experience and access. In NHS Birmingham and Solihull, their JFP (2025) referenced their locality model to focus support in areas of high deprivation and poor service/support access, although CYP are not cited as a key aspect of this approach. In NHS Cheshire and Merseyside, their JFP (2024) is rooted in their 'All Together Fairer: Our Health and Care Partnership Plan' which explains how they are focusing on addressing inequalities across the wider system. In respect of CYP specifically, they explain that in order to address health inequalities they will focus on poverty. In NHS South Yorkshire, their JFP (2025), identifies groups most affected by health inequalities, including ethnic minority communities, asylum seekers, people with disabilities or long-term conditions. They reference the importance of improving health outcomes for underserved communities, with some focus on CYP directly (e.g. improving access to mental health services for different ethnic groups).

In NHS South Yorkshire and NHS Cheshire and Merseyside's JFPs, there is evidence of a focus on underserved communities, with the CHEC programme being referenced as an example of how NHS Cheshire and Merseyside are tackling health inequalities in their area. These two plans suggest a commitment to addressing the needs of underserved communities. Moreover, in interviews with key personnel in one ICS, there was evidence to suggest an increasing focus on proportional support for marginalised communities. In this ICS, strategic leaders we spoke to were clear on the importance of focusing attention on underserved communities:

> "We regularly discuss data on child deaths, disabilities, asthma, and air quality… including sickle cell in Afro-Caribbean families." (ID28, ICS, P2)

> *"We're really concerned about issues on maternity services. Lots of maternity organisations have been raising concerns for years around the inequalities Black and Brown women face, and the rates of women who are dying in hospitals. That's one of the things that we did as a board, was to look at the data around maternity services." (ID30, ICS, P2)*

Yet those close to the data workstream in this ICS felt that data poorly reflects health issues for underserved or marginalised children, as key information like learning disabilities is often missing, thereby limiting understanding of equity and service access:

> "We've got no idea if our services are equitable for disabilities. Until we get primary care data where it's recorded, we have no knowledge of that. (ID35, ICS, P2)

Based on the evidence available to this evaluation, there is emerging evidence that ICSs are beginning to give proportional support to underserved communities, and in the case of NHS Cheshire and Merseyside, the CHEC is cited as a mechanism for doing this.

Mechanisms

There were some key mechanisms that were felt to have contributed to actively engaging decision-makers on issues surrounding the social determinants of children's health.

Awareness raising events

Evidence from the reflective diaries, the desk review and interviews showed how the programme team and ICS areas worked to raise the profile of the CHEC programme (with a view to influencing decision-makers at a regional and national level). The CHEC team have been actively involved in a wide range of consultations, forums and events. These include presenting to the Health Select Committee, the King's Fund Conference, the NHS Confederation Expo, the NHS Providers Conference, the Health Devolution Commission and the Health Equity Network Conference. Team members have written articles detailing the progress of the CHEC and contributed to the Health Devolution Commission Meeting briefing materials. The CHEC approach was subsequently advocated by the Health Devolution Commission in its consultation response to the NHS Long Term Plan, where it recommended that all ICSs adopt the Child Health Equity framework to strengthen their focus on children's health equity.

As a result of these awareness raising activities, the CHEC has been mentioned in several high-profile reports, including that of the Health Policy Influencing Group (HPIG) which examined how well ICB strategies and joint forward plans represent the needs of CYP. The CHEC was also mentioned in the Health Devolution Commission submission to the NHS 10 Year Health Plan for England. This recognition highlights the extent to which awareness raising efforts have reached strategic leaders at a national level.

At a local level, the CHEC has been discussed at numerous events across the three ICS areas. In one ICS, the CHEC programme was represented at the Child Health Poverty Summit, with the aim of sharing learning with strategic leaders and partners. In another, the CHEC was featured in a workshop at an annual conference and two Festival of Storytelling events which engaged over 300 families and helped to promote both literacy and the CHEC initiative. In addition, the Barnardo's project team recorded several events and awareness-raising activities, including materials that were presented at the NHS Providers Conference (supported by CYP from one ICS), and held virtual webinars for ICSs.

Centring CYP's voices

Connected to the mechanism of awareness raising is the fact that the CHEC sought to centre CYP's voices throughout the programme. This included inviting CYP to present at conferences and events (e.g. the King's Fund event in 2023), co-producing videos with CYP, inviting them to Children and Young People's Health Equity Board meetings and inviting them to Parliament. The focus on CYP's voices was described by a participant in one ICS as being central to their decision-making:

> *"At the beginning of every standard improvement meeting, we have a message from a young person describing their lived experiences of services. Good, bad, indifferent - it's in my mind all the time about how practice can be improved to really recognise the lived experiences of young people, to make sure that we're hearing what their lived experience actually is and not what we would like it to be. (ID2, ICS, P2l)*

Similarly, a strategic leader in another ICS reflected on some of the co-produced conferences in their ICS area, describing them as:

> *"…hugely positive in terms of really hearing that first hand young person's voice, about what they need and want from the health and care system. I think there is something hugely positive about that engagement that kind of transcends some of the data, just about an awakening in terms of how important this agenda is." (ID13, ICS, P2)*

This indicates that prioritising the involvement of CYP has played a key role in effectively engaging decision-makers.

Profile and impact

A key mechanism in engaging strategic decision-makers was the profile of the CHEC and its partners (Barnardo's and IHE). The fact that the CHEC was designed as a collaboration with Barnardo's and IHE was seen as important because it provided legitimacy to the programme and ensured that all parties were coming from a strong foundation and shared vision.

The credibility and visibility of the people and organisations leading the initiative was a draw for all three ICSs:

> *"The opportunity for some national visibility I'm sure was helpful as well and the credibility of being backed by someone like Sir Michael Marmot, you know that helps." (P28, ICS, P1)*

Having Barnardo's and Professor Sir Michael Marmot was one of the reasons the ICSs wanted to be involved in the CHEC initially, with some suggesting that their continued involvement helped keep CYP on the agenda.

Supporting contexts

A key context that was felt to have supported the outcomes described above was strong, supportive leadership and political will. In one ICS, the presence of a committed ICP chair helped maintain focus on child health equity:

> *"We've got a really strong chair of the ICP. And he's really interested in this agenda and keeping us honest on it. So that feels hugely beneficial." (ID13, ICS, P2)*

Similarly, in another ICS, collaboration with their local Mayor was felt to have aligned health and youth-focused initiatives (ID30, ICS, P2). These examples suggest that leadership buy-in, particularly with political leaders, can elevate child health equity within strategic agendas.

Constraining contexts

Yet there were several contexts that were seen to have hindered the outcomes under this objective.

Financial constraints

Interviews suggested that severe budget pressures across the NHS and local government limited capacity for strategic engagement. Decision-makers were often forced to prioritise immediate service delivery over long-term equity goals:

> *"It does feel like a really constrained funding environment… I'm more in the frame of how do I keep the lights on." (ID13, ICS, P2)*

This financial strain made it difficult to sustain attention on child health equity, even when awareness was present.

Systemic fragmentation and leadership gaps

Frequent structural changes within ICSs and lack of senior ownership disrupted continuity and diluted strategic focus. In one ICS, participants felt that leadership instability hindered programme coherence.

> "As soon as you've got nothing left and no focus on it, things start to dissipate… that's a concern I have." (ID32, ICS, P2).

These dynamics made it harder to embed child health equity into sustained decision-making processes.

Statutory limitations of the NHS

The NHS's narrow statutory remit restricted its ability to act on broader social determinants of health, which are central to child health equity. In one ICS, this limitation was explicitly acknowledged:

> *"We recognise it's important, but it's not quite our job in terms of the statutory silo of health." (ID13, ICS, P2)*

This structural constraint often required cross-sector collaboration, which was not always feasible or prioritised.

Overall, engaging decision-makers in child health equity has been shaped by a mix of enabling and constraining contexts. While strong leadership and political will have helped raise awareness and drive strategic focus, financial pressures, fragmented systems and statutory limitations have often hindered sustained engagement. Addressing these contextual factors will be key to embedding child health equity more deeply within ICS decision-making.

Good practice highlights

High profile events

Context - A key aim of the CHEC was not only to influence local ICSs but also to shape national conversations on child health equity. High-profile events were identified as an important mechanism for raising visibility, sharing learning, and amplifying the voices of CYP.

Action – the CHEC and its partners convened and contributed to a number of national platforms, including:

The King's Fund: Time for action - addressing health inequalities for CYP (March 2024)

- 307 delegates registered, 268 attended.
- Delegate mix: 37% VCSE, 25% NHS provider, 8% NHS commissioner.
- 45 speakers, including 10 young people.
- High-profile contributions from Dame Rachel de Souza, Professor Sir Michael Marmot, Prof Bola Owolabi, Rukshana Kapasi, Dr Priya Singh, Marie Gabriel, Professor Simon Kenny, Dr Prasad Nagakumar, Kath Evans, Baroness Anne Longfield, and Dr Camilla Kingdon.
- Sessions covered: tackling CYP health inequalities; ICS roles in addressing wider determinants; cost of living and pandemic impacts; outcomes for CYP from ethnic minority backgrounds; early intervention in schools; digital support; and future policy directions.

NHS ConfedExpo 2025

- **The ICS leads from all three areas, Barnardo's and IHE** took part in a panel discussion, sharing insights and learning from the programme's implementation and impact across regions.
- Focus on collaborative models between statutory services, VCSE partners, and young people.

Evidence from the CHEC fed into the Health and Social Care Select Committee and the Health Devolution Commission.

Over 300 CYP's views shared with policymakers, shaping Barnardo's national policy initiatives on neighbourhood health and belonging, and decision making at ICB level.

Parliamentary and policy forums

- At a national level, the CHEC influenced policy conversations through advocacy at events, parliamentary committees, and publications, creating a ripple effect beyond the initial three participating ICSs.

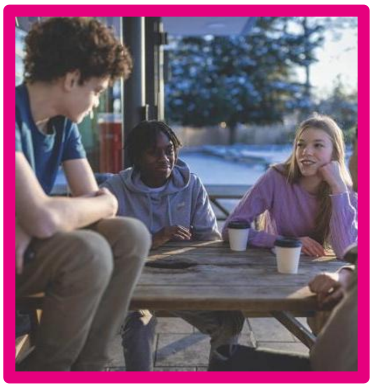
Impact - These high-profile events gave the CHEC a national platform to showcase its work and raised awareness of the valuable role that the VCSE sector can play in addressing the social determinants of health for children and young people. Through its role in the collaboration, Barnardo's helped to elevate the visibility of VCSE partners as key contributors to system change, while also reinforcing the importance of embedding CYP voice in health equity agendas.

Learning - Strategic convening is a powerful tool for systems change. By combining expert debate with lived experience, the CHEC influenced practice and policy simultaneously. Future programmes should build on this model, ensuring CYP remain visible in national debates and that local learning is consistently shared on high-profile platforms.

Findings - Objective 5

Establishing or strengthening formal mechanisms for capturing, integrating, and acting on CYP's priorities and insights within ICS strategic planning processes.

Context



The CHEC aspired to promote the vision for all children to enjoy good health and positive wellbeing. Both Barnardo's and IHE, alongside the three ICS areas, firmly believe that involving CYP ensures that solutions are relevant, inclusive, and equitable, especially for those most affected by health inequalities.

Role of the CHEC

There were two keyways in which the CHEC established mechanisms for capturing, integrating and acting on CYP's priorities and insights. The first was through the development of the Child Health Equity Framework, the second was through the creation of the Health Equity Champion role.

- **The Child Health Equity Framework** - The framework was grounded in the WHO's Social Determinants of Health. It was adapted for the CHEC following input from children and young people to reflect themes identified by CYP, such as education, home, and community. In total, over 300 CYP from across the three ICS areas took part in the framework consultation. You can find further information on the Barnardo's website.
- **The Health Equity Champion role** - Health Equity Champions played a central role in ensuring that CYP's voices were meaningfully embedded within the programme. They advised on the approach to voice and influence across the collaborative, worked with their peers to gather and reflect perspectives, and provided feedback to decision-makers on programme activities and priorities.

Their involvement included attending induction sessions and regular bimonthly meetings with ICS and Barnardo's leads. Champions also supported the development of the CHEC locally by commenting on proposed interventions, advising on outcome measures, and helping to socialise the Child Health Equity Framework within wider CYP networks. Additionally, they contributed ideas to the evaluation approach and advised on how best to involve CYP in the evaluation process.

Outcomes

The below discussion presents evidence from a range of sources to determine the extent to which key outcomes aligned to this objective have been achieved. After discussing the evidence of outcomes, we consider what it was about the CHEC programme that led to those outcomes (referred to as mechanisms) and the contextual factors that supported or hindered the achievement of these outcomes.

The issues that matter to CYP inform ICS strategic planning.

There was good evidence regarding the extent to which the issues that matter to CYP inform ICS's strategic planning.

In one respect, there was clear evidence that CYP's perspectives had informed strategic planning - through the development of the Child Health Equity Framework. To ensure the framework reflected the lived experiences of CYP, a consultation exercise was carried out during June and July of 2023.

> *"The aim was to hear directly from CYP about their views on health and health inequalities, allowing them to describe these issues in their own words." (P1, project team, P1)*

The consultation was described in positive terms, not least because it reached over 300 CYP, but also because of the way in which it was conducted:

> *"The conversations I had were good. It was very much about treating the young people that were talked to… with autonomy and sort of saying this is what we're trying to achieve. What are your views and letting them be quite autonomous in their response." (P6, project team, P1)*

This was echoed by an ICS respondent, who felt that creating the framework, with its deep involvement of CYP, was a great success.

> *"That was great. It's being done on a national scale. I think it's very impactful. There's not a lot of programmes that can say they've interacted with hundreds of children to influence this." (P22, ICS, P1)*

The Child Health Equity Framework has ultimately influenced all activities undertaken as part of the CHEC programme and can therefore be seen to have influenced strategic planning. However, beyond their involvement in developing the framework, evidence of CYP's impact on strategic planning was more mixed.

Reference to CYP in strategy documents

In the desk review, we found some evidence that ICSs are committed to listening to CYP's voices in their strategic plans (and the role of the CHEC in facilitating this). In NHS South Yorkshire, their JFP (2025) outlines several ways in which CYP have been consulted, primarily through the CYP Alliance, with activities including a 'what matters to you' campaign and the involvement of CYP to co-design services. The CHEC programme is also cited as a mechanism for CYP involvement. In NHS Cheshire and Merseyside, their JFP (2025) discusses several ways in which CYP have been consulted in the development of their approach. This includes a dedicated CYP committee and the CHEC Champions programme. In NHS Birmingham and Solihull, their JFP (2025) outlines a clear commitment to involving CYP through a three-stage community engagement framework, although there is no reference to the CHEC specifically.

CYP influence on strategic priorities

Interviews with key personnel in ICSs suggested that CYP's voices were increasingly shaping strategic priorities, though the depth and consistency of their influence vary. In one ICS, CYP engagement was described as strongly embedded in strategic spaces. Here, Health Equity Champions produced a manifesto that aligned with regional leadership priorities, including the Mayor's Health Equity panel. Their contribution to the framework was seen as particularly important because it raised the issue of 'safety' which CYP felt was key to their health. This was described by one strategic leader as being an important message that came up regularly when engaging with CYP:

> "They've influenced most kinds of strategic conversations where we're able to see, this is what's important, and the highlights around feeling safe, feeling loved, those types of things." (ID24, ICS, P2)

In this ICS, CYP involvement extended to co-producing sessions and presenting at system events, influencing both delivery and evaluation:

> "We had a conference about six weeks ago and the Health Equity Champions were invited to that, not just invited to attend, but invited to be part of the key speaking. I mean they're involved in the whole organisation of it and actually involved in the whole day, so they weren't just part of the audience". (ID25, ICS, P2)

In another ICS, there were differing perspectives on the extent to which CYP's voices were informing strategic planning. One participant felt their ICS was less mature at involving CYP compared to other regions at the point of joining the CHEC, but that this was starting to improve (ID38, ICS, P2). However, another participant from the same ICS felt differently, reflecting that despite engaging young people in a range of activities, when it came to communicating how their involvement had impacted the ICS:

> *"I've got nothing to give them." (ID40, ICS, P2)*

In this ICS, strategic leaders could not point to concrete examples of how CYP's input had influenced strategic planning in the context of the CHEC specifically. However, they were able to offer other examples of where CYP insight had shaped service design, such as incorporating CYP's perspectives into redefining "school readiness" and developing a new Healthy Child Programme model.

In the third ICS, youth engagement was described as strong at the outset, particularly in selecting their intervention, but did not extend into development or delivery. This was felt to have limited their strategic influence (ID7, ICS, P2). Despite this, there was recognition of the power of youth voice in shaping conversations:

> *"The amplification of the voices of young people… has been really powerful. I hear now regularly in conversations back to me, well, what about what matters to kids?" (ID1, ICS, P2)*

These perspectives suggest that the issues that matter to CYP have begun to inform ICS strategic planning because of the CHEC, but that this varies considerably between areas. Where co-production was embedded and youth voices were sustained across programme stages, their influence was more visible and impactful. However, some areas struggled to move beyond initial engagement, highlighting the need for more consistent integration of CYP perspectives into strategic decision-making.

CYP feel like their input matters and will be acted on.

There was good evidence from across the three ICSs that Health Equity Champions felt their input mattered, however, this was more mixed in terms of having confidence it would be acted on.

The nature of Champions' involvement in the CHEC can be broadly categorised into two key themes. The first is direct involvement in campaigns/initiatives, the second is through attending events and meetings. Champions in phase 2 described a range of different campaigns/initiatives they had been involved in, on topics such as anti-hate crime, oral health, domestic abuse, obesity, organ donation and mental health. Champions in both phases of the evaluation described attending a wide variety of meetings and events, including a number of high profile conferences such as The King's Fund conference in 2023, a CHEC breakfast session held at the NHS Providers conference in 2024, a networking event with the Reporter's Academy, a meeting with the NHS Youth Forum and attending the National Children's Hospital Alliance to talk about the work of the CHEC, and share their views on it.

There was a consensus between Champions (in both phases of the evaluation) that their contribution was valued:

> *"I don't usually feel listened to… this shows we actually are important and my thoughts do matter." (Champion, FG1, P2)*
>
> *"Actually being able to give my opinion and having people listen" (Champion, FG1, P1)*
>
> *"Actually having an audience and people listen to you, taking notes about what you're saying, it just, it's sort of amplified how important your voice was". (Champion, FG2, P1)*

In one ICS area, Champions had concrete examples of how their input had been acted on. For example, they consulted on a mental health campaign seeking to encourage young people to ask for help. The Champions were directly involved in the design of the campaign and had seen their suggestions become reality across their local area. Even in phase 1 of the evaluation (prior to any specific activities/campaigns), Champions in this ICS area felt their input would be acted on:

> *"So, it's been really great to kind of have that continuous sort of feedback loop and hear back from, from the professionals and the ones that are kind of like, trying it out and implementing it, kind of seeing where it's going and then you know, potentially asking for advice from us and throughout." (Champion, FG1, P1)*

Mixed feelings on impact

However, in the other ICS areas, Champions described a disconnect between their input and subsequent action:

> *"We've learned a lot… but there's nothing I can actually say, hey, this is what we've worked towards and this is what we've done." (Champion, FG2, P2)*
>
> *"In the moment, [we] definitely [felt heard] … but if we could see the end product… that would be enough". (Champion, FG2, P2)*

The impact of not having these feedback loops was described by one participant, who suggested that their involvement often felt "*pointless because… no one's going to do anything because their hands are tied, they haven't got any money to do it, or they don't want to do it*." (Champion, FG1, P2). Champions recognised the potential challenges of translating their advice into action, but felt that even an acknowledgement of their suggestions would be enough to validate their contribution:

> *"Even one line in the action plan… would be enough just to know that we're being taken seriously." (Champion, FG1, P2)*

These quotes highlight the importance of Champions being updated on what has come from their involvement to feel truly valued.

VCSE partners suggested that challenges remain in embedding youth voices systemically. One interviewee observed that while there were regular meetings between Barnardo’s and ICS leads, these often leave little time to showcase youth-generated insight:

> *“We’ve got regular meetings where each ICS lead comes together with Barnardo’s… but we don’t have much opportunity in those times to say what we’ve been doing. I’ve got a heap of reports and things that they’ve done that they haven’t probably seen.” (ID22, ICS, P2)*

They suggested a shared resource bank would make it easier to collate and access evidence across the pilot.

The Health Equity Champions identified several areas where the model could be strengthened at a local ICS and programme transition level. A recurring theme was the desire for equity in access to support spaces, with Champions calling for safe networks to be available to all CYP rather than limited to certain groups.

Champions reflected that access to opportunities often depended on background and networks. Some described how having parents in professional roles, e.g. their local council, or families with higher levels of education, had encouraged or enabled their participation. They recognised this as a form of privilege that is not widely shared and noted that it results in limited representation of CYP from less advantaged circumstances.

Champions also expressed the need for clearer role definitions and progression pathways, tailored to different ages and levels of experience. As one explained:

> *“There’s no quiet transition from one stage to the other… you need to stratify us a little bit more and individualise our roles.” (ID2, CYP, P2).*

To ensure their contributions are valued, Champions emphasised the importance of feedback and follow-through. They suggested action plans explicitly linking what young people said to actions taken, alongside sharing tangible outcomes to evidence the influence of their input.

Finally, Champions highlighted the need for stronger preparation for external events, including clear agendas and introductions, to reduce anxiety and support more confident participation.

Benefits to CYP directly

Good Evidence

There was good evidence that being involved in the CHEC as a Champion had direct benefits to CYP.

An additional (unintended) outcome has been positive impacts on CYP who became Health Equity Champions. These positive impacts came in many forms, with several Champions describing increased confidence:

“I’m quite a shy person and I think being able to do that [speak at The King’s Fund event] and pushing myself to do it was so great. Kind of being able to reflect back on that and then getting people saying like it was amazing hearing you speak you know, your insight it’s been great to hear and kind of being able to take that with me when I do public speaking in the future as well like it kind of just gave me more confidence" (Champion, FG1, P1)

For others, being part of the programme helped their own mental health:

> *"If it wasn't for being a Health Champion, I don't think I'd be able to discuss these things in my normal life… it helps my mental health." (Champion, FG3, P2)*

Champions in phase 1 of the evaluation reflected on the value of the training and development they received as part of the role:

> *"It felt like we were learning about things that actually mattered and that actually like impact everyone around us rather than just like the things that you're gonna do a test about and then forget afterwards." (Champion, FG1, P1)*
>
> *"It was a really good way of me kind of being introspective about kind of my social determinants. And then kind of looking at my friends and my family and loved ones and then kind of different communities, it just like kind of broaden[ed] my perspective a lot." (Champion, FG1, P1)*

In one ICS area, a Champion's experience led to them being employed by a VCSE organisation that is part of the CHEC programme. Another Champion has since been employed by Barnardo's to coordinate Co-op's youth-led volunteering initiative, demonstrating the longer-term professional and leadership opportunities emerging from their involvement. These positive impacts on CYP were also noted by those working in the ICS areas:

> *"These kids have been amazing… they've grown in self-confidence, ability to articulate themselves, pose an argument, present to people, health professionals, public health professionals and make a case." (ID32, ICS, P2).*

A participant in phase 2 summed up one of the key benefits of being part of the CHEC:

> *"These people in this group, I can confidently say, are some of my closest friends… it just does feel like a family." (Champion, FG3, P2)*

Overall, Champions across the regions were clear that being involved in the CHEC programme had been a positive experience for them personally. However, as explored earlier, for these young people, personal benefit was not their aim, they wanted to help change the wider system for future generations of young people.

Mechanisms

During our analysis we identified some key mechanisms that help explain how CYP voices were effectively integrated into the CHEC programme.

Non-negotiable involvement of CYP

Some participants referenced that Barnardo's brought expertise in CYP engagement, particularly appreciating their strong line on CYP involvement:

> *"The key bit has been Barnardo's non-negotiable stance on CYP engagement: 'This is how we do things. We always start with children and people's voice. We always do what matters to them.' … Which I think is great and I absolutely stand by. … I've really valued that." (P21, ICS, P1)*

This expertise was seen as a key mechanism for raising the profile of CYP's voices and supporting the development of effective engagement plans.

CYP given meaningful opportunities for engagement

We found evidence across the reflective diaries, desk review and interviews that CYP had been given several meaningful opportunities in their role as Healthy Equity Champions. While these roles varied according to the ICS area, there were some common aspects, with the nature of involvement changing over time:

- Onboarding and early engagement - Champions received training on their role and had a clear induction process. This was led by the Voice and Influence team at Barnardo's, with strong support from systems partners.
- Regular meetings with other Champions - these were generally held locally, with some meetings bringing Champions from the three areas together (particularly in the earlier stages of the programme).
- Providing input - for committees, events, workshops, conferences and newsletters (about the CHEC programme and their lived experiences).
- Consulting on campaigns, policies, and the CHEC interventions.
- Taking a leading role by acting as guest speakers, facilitators and conference organisers.

The shift in the nature of the role was commented on in one of the phase 2 focus groups. They explained how previously, professionals designed resources and CYP would be asked to review them. However, this had since changed to co-development, which they appreciated:

> *"We're not just reviewers… don't give me the boring admin stuff" (Champion, FG1, P2)*

Champions in this focus group valued how this sort of experience contributes directly to CVs, college applications, and employability. In another focus group, Champions from a different ICS reflected on the value of events they would attend:

> *"[Name of engagement lead] would take us to different conferences… not necessarily designed for students, but actually that turned out to be a much larger learning event. (Champion, FG2, P2)*

The importance of designing meaningful opportunities was commented on by one of the engagement leads:

> *"They want to be taken seriously and listened to and be given opportunities to engage in true problem solving in the system." (ID40, ICS, P2)*

This extended to Champions who noted the importance of being interested in their role:

> *We wouldn't be able to do our best work if we weren't actually interested in it." (Champion, FG3, P2)*

This suggests that effective engagement with CYP requires the creation of meaningful opportunities and is something that both Barnardo's and the ICS engagement leads worked hard to do.

Effective communication, structured support and regular opportunities

It was clear in both phases of the evaluation that Champions valued clear, regular communication and structured opportunities for involvement. In phase 1 of the evaluation, Champions valued regular meetings: "*It's just been generally kind of great to meet other like-minded young people*." (Champion, FG1, P1), but felt they didn't happen often enough:

> *“But I feel like they should have been more frequent meetings, even if it was OK right. Quick update this is what’s happening. This is what’s not happening etcetera.” (Champion, FG2, P1)*

Champions in phase 1 of the evaluation also described a desire for clear communication about what the role entailed:

> *“But what I would have liked to [have] seen was like, even if they were like pencilled in and sort of dates and in your diary like what events there were?...What was gonna happen communication wise or throughout the Health Equity Champion programme? ” (Champion, FG2, P1)*

And as the programme progressed, others felt that more regular communication and updates between events would have been helpful:

> *“And so I think having like, even if it’s just an email with a reminder saying like we’ve been working on this part of the project this month, I think that would be helpful to kind of just keep everyone in the loop and make sure that like even if the Champions aren’t contributing anything at that time, it’s still nice to know what they’re doing.” (Champion, FG1, P1)*

By phase 2 of the evaluation, Champions in two of the ICS areas described effective communication with their engagement leads, with one rating the communication as 10/10. In the other ICS, Champions explained how their engagement lead organises logistics, provides food and looks after wellbeing, and structures sessions with breaks (acknowledging neurodiversity).

Champions felt safe and supported

An important mechanism was the creation of a safe and inclusive space for CYP to feel confident to share their views and experiences. In phase 1 of the evaluation, Champions described how facilitators (including ICS engagement leads and Barnardo’s staff) created a welcoming and supportive environment in online and in-person programme meetings:

> *“It was like a very welcoming environment and it was just made so that everyone felt comfortable, and it was very like collaborative as well.” (Champion, FG1, P1)*
>
> *“But whenever I did share anything, everyone, like people, would listen to what I was saying”. (Champion, FG1, P1)*

In phase 2 of the evaluation, Champions in one ICS area (who do a lot of in-person activities) highlighted the importance of informal, welcoming spaces (sofas, food, games) that encourage openness compared to clinical settings. They explained how they had a say in the design and layout of the space they used regularly to make it feel safe (including quiet rooms, therapy rooms, and sensory toys, offering options for young people who may not want to be in a group).

The importance of creating a safe space was reiterated by engagement leads in terms of how they planned CYP engagement, as one explained:

> *“It’s not just a matter of taking two young people in front of a room full of very important people… we would arrange for a couple of members of the committee [to be introduced to the Champions ahead of time] so they felt comfortable when they walked into that space. (ID5, ICS, P2)*

The role of trusted partners

Engagement leads in two of the ICS areas commented on the importance of recruiting Champions through established organisations who had relationships with CYP. This was particularly important for ensuring the

Champions had support. In one ICS, the engagement lead commented on the fact that recruiting long-term Champions was only possible where high levels of trust existed, and hence they recruited most of their Champions through projects and organisations with whom they had existing links.

In the third ICS area, CYP engagement was managed by a specialist VCSE partner. Based on the focus groups we held with Champions (in phases 1 and 2 of the evaluation), this approach was the most effective in recruiting and retaining Champions, with CYP offering nothing but praise for the charity they were working with as part of the CHEC.

> *"If it wasn't for [name of organisation], and more specifically [name of staff]… we would not have been able to do any of the things we've done." (Champion, FG1, P2)*

During the evaluation, Champions explained how this organisation made them feel valued, created safe and welcoming spaces (that were inclusive) and created meaningful opportunities that resulted in tangible outcomes, as one participant explained:

> *"They're not coming to us for plans, they're coming to us for actions that we can do." (Champion, FG1, P2)*

Supporting contexts

We identified some contexts that were felt to have supported the extent and impact of CYP engagement in the CHEC.

Strategic support

The first of these relates to strong strategic backing. In one ICS, a newly formed CYP's Committee, chaired by the ICB Chair, signalled commitment to involving CYP across the system. This was felt to have created a shared aim across the ICS with all partners wanting to improve CYP engagement. As one participant explained:

> *"When participation requests go out, ICS partners respond quickly and supportively". (ID5, ICS, P2)*

Existing commitment to involving CYP

On a related point, engagement leads in two of the ICS areas discussed an existing commitment to including CYP voices prior to the CHEC. In one ICS, while there had been intent to involve CYP, it was not until the CHEC that this became a reality. The CHEC was described as a catalyst for CYP engagement, providing a tangible framework for participation and systems change. In another ICS, they were already engaging with young people through projects before the CHEC, but the programme gave further structure and focus for that work. In the third ICS, where engagement is managed by a VCSE partner, CYP involvement was well established at the point of joining the CHEC. This suggests that despite ICS areas being at varying stages of CYP engagement at the point of joining the programme, there was at least a commitment to working in this way, which ultimately made the process more straightforward for engagement leads.

Constraining contexts

There were several contexts that were felt to have hindered meaningful involvement of CYP.

Practical challenges of retaining Champions

In reflective diaries for two of the ICS areas, they cited challenges of maintaining Champion engagement in the long term. This was particularly the case during exam periods and the summer holidays. In some cases, Champions moved on to college, university or work, impacting their ability to stay involved in the programme.

Lack of senior leadership engagement

In one ICS, a lack of senior leadership engagement was described as a key barrier to effective CYP engagement (however, this was not the view of all participants from this ICS). One participant explained that ICSs need to genuinely want youth engagement, co-design the approach, integrate it into governance, and ensure feedback is collected and acted upon, something they did not feel had been achieved to date.

Staffing changes

The final context was raised in Barnardo’s reflective diary and related to staffing changes, particularly the Voice and Influence manager, which created gaps in programme level activities for Champions. However, it is important to note that ICS engagement leads continued to meet after this point, with numerous events and activities being organised.

Good practice highlights

Chilypep - Meaningful CYP engagement

Context – A common challenge across ICSs is ensuring that CYP's engagement is not tokenistic or short-lived. While many initiatives consult CYP, fewer create the conditions for sustained involvement where young people feel their voices are valued and see evidence of their contributions making a difference. In South Yorkshire, the CYP Alliance commission Chilypep to lead their voice and influence work, which has proven a particularly effective approach.

Action – Chilypep (CYP's Empowerment Project), a voluntary sector organisation in South Yorkshire, has become a prime example of how to lead CYP engagement effectively within the CHEC programme and beyond. Their approach is rooted in youth work principles and includes:

- Sustained engagement with young people over extended periods, enabling trust, continuity, and deeper influence.
- Providing a wide variety of opportunities for CYP to participate, from local consultations to national events.
- Supporting CYP to shape interventions directly, co-producing activities and reviewing strategic priorities.
- Creating regular spaces where CYP input is shared back with decision-makers, ensuring feedback loops are visible.
- Acting as a trusted intermediary between ICS structures and CYP, building relationships that statutory services often struggle to establish and maintain.

Impact – Chilypep is a clear example of the value of VCSE partnerships for ICSs. By bridging the gap between systems and young people, Chilypep has facilitated collaboration and ensured that CYP contributions are not only heard but acted upon. Young people reported feeling valued, respected, and confident that their voices made a difference. Evidence from NHS South Yorkshire shows that their input directly influenced interventions, strengthened ICS decision-making, and ensured CYP priorities were embedded in strategic processes. Chilypep's role has also raised the visibility of youth voice within ICS governance, positioning it as a model for how voluntary sector expertise can add distinct value to system transformation.

Learning – The Chilypep experience illustrates that lasting impact relies on three elements: consistent resourcing to sustain engagement over time, youth work approaches that prioritise relationships and trust, and formal mechanisms to show CYP how their input shapes outcomes. This combination creates a feedback loop where young people not only contribute but also see tangible evidence of their influence—strengthening both individual empowerment and system accountability. It is clear that partnering with experienced VCSE organisations like Chilypep is critical to embedding authentic CYP engagement into system-level change.

Conclusions

What has the CHEC achieved?

The CHEC programme has provided a critical proof of concept for how ICBs, LAs, VCSE organisations, and CYP can work together to address the social determinants of health. It has raised the visibility of child health equity, built stronger cross-sector partnerships, and piloted new tools for data and participation. These contributions show what is possible when prevention, equity, and CYPs voices are placed at the centre of system design.

Extent to which objectives have been achieved

Across the evaluation, evidence shows that the CHEC made meaningful progress against its programme objectives:

- **Strengthening partnerships** – The CHEC built on and extended existing relationships, while also catalysing new ones. Governance structures and alliances (such as the NHS South Yorkshire CYP Alliance) embedded children's health within ICS priorities, though consistency varied by area. In NHS South Yorkshire, closer collaboration with Rotherham United Community Trust (RCUT) enabled the Friday Fun Club intervention, while in NHS Cheshire and Merseyside, the CHEC further developed partnerships with organisations such as the Dolly Parton Imagination Library, BookTrust, and the Family Nurse Partnership.
- **Delivering interventions to address the social determinants of children's health** - Evaluation of the CHEC pilot initiatives – ranging from targeted interventions with underserved families in Cheshire and Merseyside and South Yorkshire, to a study of the potential for SV/CSR in procurement to address wider social determinants of health in Birmingham and Solihull – highlights how initiatives guided by child health equity principles can begin to improve child health outcomes, with the potential to reduce inequalities. Early findings from the targeted interventions suggest benefits for the at-risk groups engaged, while in Birmingham and Solihull, emerging partnerships between suppliers and community organisations show promise in strengthening support for local children and families.
- **Improving data use** – The CHEC facilitated the creation (or refinement) of child health equity tools, dashboards and indicators, allowing ICSs to understand and address the social determinants of health moving forward. This increased focus on data has helped to embed child health equity as a key priority within ICS areas.
- **Engaging decision-makers** – The CHEC raised visibility of child health equity at senior levels, influencing ICS strategies and achieving national recognition (e.g. references in the Hewitt Review).
- **Embedding CYP voice** - Champions and the Child Health Equity Framework gave CYP a platform to shape strategy. While depth of influence was uneven, their perspectives informed frameworks, campaigns, and events.
- **Learning and system influence** – The CHEC has generated transferable tools and insights now being shared across ICSs, including VCSE sector organisations, demonstrating clear potential to inform future system-wide practice. Beyond the three participating ICSs, the programme has also contributed to national system learning, influencing discussions on children's health equity and informing wider policy and commissioning approaches.
- **Developing a proportionate universal approach** - Across the CHEC initiatives, local areas are demonstrating elements of a proportionate universal approach. This approach is essential for improving health and wellbeing for all children, reducing health inequalities through action on the social determinants of health, and improving outcomes for children and young people from underserved communities - core aims of the CHEC programme.

Taken together, these outcomes show that the CHEC achieved most of its intended objectives within the evaluation timeframe, while also surfacing challenges, particularly sustaining youth influence and embedding equity in mainstream commissioning, which remain priorities for the future.

Priorities for the future

Looking ahead, the challenge is not only to sustain these achievements but to build on them. The evaluation highlights several areas for next steps, many of which align with the NHS 10 Year Health Plan for England[24] and its commitment to prevention and neighbourhood health:

- **Structural reform** - ensuring children's needs are prioritised within commissioning, governance, and accountability processes, rather than overshadowed by adult services.
- **Data and evidence** - investing in data infrastructure and analytical capacity to track inequities and use evidence to inform decisions.
- **Voice and influence** - embedding CYP engagement as a core principle of ICS working, moving beyond one-off consultations.
- **Strengthening VCSE partnerships** - continuing to value VCSE organisations as critical connectors between systems and the communities most affected by inequality.

Systems change

The evaluation could not fully evidence long-term system change within its timeframe. However, it does provide clear starting points for the future. The CHEC has seeded frameworks, tools, and governance mechanisms that can be scaled and adapted. Its national visibility has created momentum, with child health equity now more prominent in strategic plans and policy debates.

Moreover, evaluations of the three interventions demonstrate how local systems can combine targeted interventions for those with the greatest need with initiatives that benefit all children, underpinned by system-level approaches to ensure sustained investment - a necessary foundation for a proportionate universal approach.

- **Targeted support -** South Yorkshire delivers a small-scale, highly targeted initiative providing after-school mental health support to a defined group of children with specific needs.

- **Targeted with potential for universal reach -** The storytelling and book-giving initiative in Cheshire & Merseyside is targeted initially at teenage parents, with plans to extend and embed resources for all families, demonstrating a move towards universal access.

- **System-wide, sustainable mechanisms -** In Birmingham and Solihull, the SV/CSR procurement initiative is exploring innovative, system-level ways to generate sustained resources for child health equity initiatives, helping provide lasting support for all children, and extra support for those who need it most.

Together, the initiatives also show that strengthening collaboration between the ICB, schools, health services, suppliers, and community and voluntary organisations can lead to more joined-up, creative, and sustainable forms of support that help reduce child health inequalities over time.

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[24] Fit for the future: 10 Year Health Plan for England

Looking forward

The impact of the CHEC lies in demonstrating that system-level action on the social determinants of children's health is both necessary and achievable. To realise the programme's final objective, informing future system-wide approaches, ICBs, (who have strategic commissioning responsibilities[25]) in collaboration with other ICS organisations, will need to take forward these lessons, consolidating the gains made and addressing the barriers identified. The task now is to embed this learning into routine practice, so that children and young people's health equity and the social determinants of health are no longer treated as an add-on, but as fundamental principles shaping how health systems support CYP.

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[25] making-commissioning-strategic.pdf

Recommendations

The following recommendations draw on insights from across the evaluation. While grouped according to where the learning emerged, many of the recommendations have wider relevance across ICBs, VCSE and LA partners, and national policy contexts. The recommendations draw on learning from the CHEC programme but are not prescriptive to its delivery model. They are intended to inform how future initiatives, can strengthen children's health equity through similar principles of collaboration, participation, and system alignment.

For improving youth participation and co-production

- **Ensure programmes are co-designed with CYP** - Embed CYP involvement at every stage of programme design, delivery, and evaluation to ensure initiatives reflect their lived experiences, priorities, and ideas for change. Co-design should move beyond consultation to genuine collaboration, with CYP recognised as equal partners in shaping outcomes.
- **Apply learning from the CHEC model** - Areas seeking to strengthen children's health equity should establish a local Health Equity Champions (CYP) model to embed youth voice in system design, commissioning, and evaluation. The model has demonstrated value in improving engagement, developing leadership skills among young people, and ensuring that children and young people's perspectives inform local priorities.
- **Broaden and equalise access to support spaces** - Future programmes should widen recruitment routes for CYP and provide consistent access to safe spaces for all CYP, ensuring they have access to support. This would ensure that engagement reflects the diversity of local populations rather than reinforcing existing inequalities.
- **Develop structured roles and progression pathways** - Introduce tiered roles with clear expectations and pathways for progression. This would allow CYP to transition smoothly between roles, strengthen their skills, and sustain their engagement over time.
- **Strengthen feedback loops and evidence of influence** - Implement a transparent process to show how CYP's input shapes decisions. For example, action plans explicitly linking "young people said X" with "we implemented Y." Tangible outputs should be shared to demonstrate how their contributions lead to change.
- **Enhance preparation and communication for events** - Provide pre-event briefings with agendas, objectives, and introductions to key people to reduce anxiety and enable Champions to participate with confidence in external engagements.

The Health Equity Champions model created meaningful opportunities for CYP to engage with health equity agendas, participants also identified several areas where the model could be strengthened at a local ICS and programme transition level. A recurring theme was the desire for equity in access to support spaces, with Champions calling for safe networks to be available to all children rather than limited to certain groups.

Champions reflected that access to opportunities often depended on background and networks. Some described how having parents in professional roles, e.g. their local council, or families with higher levels of education, had encouraged or enabled their participation. They recognised this as a form of privilege that is not widely shared and noted that it results in limited representation of CYP from less advantaged circumstances. Champions also expressed the need for clearer role definitions and progression pathways, tailored to different ages and levels of experience.

For improving data and evidence regarding CYP's health inequalities

- **Improve data sharing across organisations -** include access to GP datasets, to strengthen the ability of systems to understand and respond to children's health needs.
- **Strengthen information governance and organisational connections** – develop clear protocols and trusted contacts to enable safe, timely use of data across agencies.
- **Develop centralised, linked data systems** - for example, a "Single View of the Child" that integrates health, education, and care data to provide richer, joined-up analysis. This approach is aligned with forthcoming legislative changes in the Children's Wellbeing and Schools Bill, which will mandate use of the NHS number as a single unique identifier for children's services, thereby supporting improved data linkage across sectors.
- **Secure sustained infrastructure and capacity** - invest in dedicated roles and resources to maintain progress on data improvement for child health equity beyond the programme.
- **Build representative, multidimensional datasets** - incorporate demographic factors such as ethnicity, disability, and socioeconomic status to ensure equity analyses are comprehensive and granular.
- **Involve CYP in making sense of their data** - Data leads recognised the potential to engage schools, community groups, and young people directly in interpreting and contextualising data, so that children's perspectives inform both the evidence collected and the way findings are communicated.

The CHEC programme highlighted the importance of dedicated data leadership across ICSs and the value of collaboration. Data leads jointly developed a practical "*cookbook*", a set of guidance and code templates adaptable to different local data systems, supporting a more coherent, system-wide approach to monitoring child health equity. They emphasised the need to establish clear baselines and translate data into accessible, meaningful insights. As one data lead noted: *"Having good baselines for understanding the inequities, actually setting the baselines and saying right, this is what the inequity is." (ID35, ICS, P2).*

Achieving this requires granular, disaggregated data that reveal inequalities otherwise hidden by broader averages. Data work, they stressed, "*is not a one-off piece. It is a constant kind of collaboration and conversation that would need to happen." (ID20, ICS, P2).* Finally, data leads saw opportunities to engage CYP directly in making sense of data, ensuring that children's perspectives inform both evidence and communication. As one reflected: *"We don't collect big data about what a child thinks is important… It should be a national conversation." (ID20, ICS, P2).*

For operational leads seeking to embed action on child health equity

- **Use the CHEC as a blueprint for commissioning** - apply tested approaches to identify areas of greatest impact for CYP within population health, adapting and scaling the model across different partners.
- **Disseminate tools and resources widely** – actively promote and support the practical use of key outputs such as the CYP Voice and Influence Engagement Tool; Child Health Equity Monitoring Framework; What good child health equity data looks like and how the voluntary, community and social enterprise sector can contribute; Child Health Equity Readiness Tool and the Children and Young People's Health Equity Collaborative Evaluation Report.

- **Leverage national frameworks** - finalise and promote procurement toolkits and embed social determinants of health within ICS accountability and inspection processes.
- **Encourage wider system adoption** - use structured evaluation and learning frameworks to promote uptake in ICSs less engaged with child health equity.
- **Strengthen local delivery and governance clarity** - provide practical, on-the-ground support and establish clearer lines of accountability and coordination between the NHS, local authorities and VCSE partners to ensure effective local implementation.
- **Simplify programme scope** - reduce the breadth of objectives and focus on clear, achievable outcomes to make delivery and evaluation more manageable.
- **Address structural barriers to integration** - consider employment models that embed delivery staff within a range of ICS organisations to improve influence, visibility, and sustainability.
- **Enhance youth engagement models** - invest in more effective approaches to ensure CYP's voices are consistently embedded in operational decision-making.

Strategic leads viewed the CHEC as a valuable blueprint for commissioning frameworks centred on CYP's outcomes. They saw potential to use its learning to shape strategic commissioning and identify areas of greatest impact within population health. As one explained, such approaches could be *"hooked in"* once commissioner roles for CYP are more clearly defined (ID1, ICS, P2). Others reflected that tested models like Youth Health Champions could inform longer-term service design: *"Then thinking about strategically what can you take out of the learning from CHEC that you want to keep building on, which would be how we think about commissioning services going forward." (ID24, ICS, P2)*. Consolidated evaluation findings were seen as strong foundations for scaling and adapting approaches across systems: *"Once all the reports and evaluations are sort of in black and white… here's a framework." (ID25, ICS, P2)*.

Leads also identified practical lessons for embedding the CHEC learning, from disseminating tools nationally and linking procurement to social determinants, to strengthening governance between NHS and local authorities. Barriers included limited on-the-ground delivery support, broad programme scope, and delivery staff being positioned outside ICBs. Participants also emphasised the importance of strengthening youth engagement models so that CYP's perspectives are consistently embedded in operational decision-making rather than treated as an add-on.

For strategic leaders seeking to create systems change

- **Advance progressive devolution and joint working** - pursue devolution deals that mandate closer integration of health, education, VCSE, and social care resources at neighbourhood and population level.
- **Prioritise CYP in commissioning and planning -** recognise CYP as a distinctive population cohort in strategic decision-making, elevating their needs to equal priority alongside adult services.
- **Use population health data to drive decisions** - establish clear baselines for inequities and embed data-driven approaches into commissioning to ensure resources are targeted where they can achieve the most impact.
- **Secure senior ownership and accountability** - appoint committed leaders with responsibility for delivering agreed objectives and embed clear accountability structures to sustain focus and system-wide integration.
- **Align local initiatives with national policy** - ensure that local programmes are explicitly linked with national health policy priorities, raising the visibility of child health equity and securing longer-term sustainability.

Insights from strategic leaders highlighted that sustaining the progress of the CHEC will require strong leadership, structural reform, and closer alignment between local, regional, and national agendas. A key priority was advancing joint working and devolution to better integrate health, education, and social care:

> *"I genuinely think we've got to get into what is a far more progressive set of devolution deals that absolutely forces you at a local neighbourhood and population level to work jointly on this stuff." (ID13, ICS, P2).*

Leaders stressed that CYP must be prioritised within commissioning and planning, noting that children's health is often an *"afterthought"* in systems dominated by adult services (ID29, ICS, P2). They also emphasised the importance of data-driven decisions, clear accountability, and senior ownership to maintain visibility and integration. One participant reflected: *"It would have been really helpful to have seen this as a joint programme initiative rather than sitting in the ICB." (ID32, ICS, P2).*

Finally, aligning local work with national strategies was viewed as essential to sustain progress and legitimacy. At the point of publication, new NHS planning guidance and the forthcoming 10-year health plan provide an opportunity to embed this alignment more systematically.

For designing and delivering child health equity initiatives

Local health and care systems when planning, designing and implementing child health equity initiatives focussing on the social determinants of health should aim to:

Secure long-term support for child health equity initiatives

- Local health and care systems should prioritise the long-term sustainability of child health equity initiatives by securing both funding and resources through innovative mechanisms - such as social value and corporate social responsibility in procurement, pooled budgets, cross-sector partnerships, and philanthropic support - to supplement limited central and VCSE funding. This approach should support both targeted and universal interventions, enabling small-scale initiatives to be scaled, embedded, and effectively evaluated over the long term.
- Prioritising interventions to address health inequalities is a core function and activity for ICBs as they move into their formal roles as strategic commissioners for population health and to grow their functions in prevention and tackling health inequalities26.

Understand local needs and priorities

- Assess the key drivers of health inequalities among CYP.
- Assess what children, young people, and their families need locally so initiatives provide the right support where it's needed most.
- Emphasise early support to give children the best start in life and reduce future demand on services.
- Use the Child Health Equity Framework and its indicators to gather and analyse data. Combine this with insights from practitioners, partners (including community and voluntary organisations), and the lived experiences of children, young people, and families to guide the development of new or existing initiatives.

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[26] Model Integrated Care Board - Blueprint v1.0

- The national blueprint for a model Integrated Care Board (ICB) highlights the use of population health data and analytics as areas for ICBs to develop. (19)

Engage children, young people, and families

- Involve children, young people, and families from the outset to understand what success means to them – what they want to experience and achieve. This engagement helps ensure initiatives are relevant, accessible, and impactful.
- Actively involve children, young people, and families in planning and decision-making to ensure initiatives reflect real needs, improve engagement, promote equity, and strengthen outcomes. Involvement can include advisory groups, co-design workshops, surveys, and feedback loops that show how their input shapes initiatives.

Build on local assets

- Map local assets and programmes linked to the Child Health Equity Framework and the issues identified by children and young people, to identify gaps, strengths, and opportunities to better align and leverage existing evidence-based and innovative initiatives for the benefit of children, young people, and families.

Strengthen partnership working

- Build and maintain partnerships that bring together complementary skills, resources, and networks across healthcare, voluntary and community organisations, local authorities, and corporate partners. Evidence from the CHEC initiatives shows that strong partnership working should:
    - Use existing programmes, relationships, and services to avoid duplication and create a stronger, system-wide impact.
    - Share clear, simple, and consistent messages across organisations so families receive coherent support, and services are easier to access.
    - Prioritise face-to-face connections, storytelling, and shared experiences to build trust, encourage collaboration, and sustain commitment.
    - Involve partners in planning and delivery to ensure initiatives are relevant, practical, and responsive to local challenges.
    - Use partnerships to share workforce expertise, connect initiatives with wider services, and ensure long-term support for children and families.

Align initiatives with existing local plans, services, and partnerships

- Design child health equity initiatives so they connect with existing local strategies, services, and partnerships. This helps reduce reliance on individual champions and strengthens the system's ability to provide lasting and equitable support for all children and young people. ICSs should focus on building the skills and capacity to work across sectors, tackling the social factors that affect children's health, and making sure initiatives are joined-up, embedded, and sustainable.

Adopt a proportionate universal approach

- Provide support for all children and young people, while offering extra help to those with the greatest needs or who are likely to benefit most.
- Local systems should ensure that enhanced services do not unintentionally widen inequalities by primarily benefiting children and families with fewer or less complex needs.

- Develop strategies to proactively reach underserved groups, drawing on the expertise of community networks and voluntary sector organisations. Ensure support is accessible, relevant, and tailored to those most at risk of poor health and wellbeing outcomes.

Implement shared, long-term monitoring and evaluation

- Use validated measures where possible to track outcomes for children and families over time.
- Wherever possible, aim for shared monitoring and evaluation across local services and partners to support learning, coordination, and continuous improvement.
- Use creative and accessible evaluation methods, co-designed with children, young people and their families, to understand how they experience and benefit from initiatives, and how services can be improved.

Systems change and learning for the future

A Framework for Change

The CHEC has demonstrated what is possible in embedding equity-focused, child-centred approaches within complex health systems. Its legacy lies in four main areas:

Proof of concept – The CHEC showed that upstream, preventative approaches to children's health equity can be delivered in the NHS context, despite structural and financial pressures.
"It's difficult for the healthcare system to do. They don't do this kind of programme routinely. It's really important and it demonstrates what's possible and how it might look." (ID43, Project Team, P2)

CYP's influence - By embedding CYP as Champions, co-producers, and advocates, the CHEC demonstrated the value of sustained youth involvement in shaping both interventions and strategic conversations. While their influence on formal decision-making is still emerging, the programme has created structures and expectations for CYP voice to be an ongoing part of system planning.

Sustainable tools and partnerships - Dashboards, governance structures, and VCSE partnerships developed through the CHEC are continuing beyond the programme. These provide a foundation for ICSs to integrate children's health equity into mainstream planning.

National influence and learning - The programme has informed wider policy debates, highlighted the importance of children's health equity at a national level, and left behind a body of learning that other ICSs can adopt.

The CHEC programme has played a unique role in elevating child health equity within ICSs and at a national level. Across the evaluation, stakeholders emphasised that while structural barriers remain, the CHEC has acted as a catalyst for change, raising visibility, embedding new ways of working, and creating foundations that can be sustained beyond the life of the programme.

One of the most consistent impacts reported was the way the CHEC raised the profile of the social determinants of children's health. Strategic leaders described how issues such as housing, poverty, and school attendance are now more visible in long-term ICS strategies, giving children's health equity greater prominence within systems traditionally dominated by adult services.

> *"It's put it on the map at a national level and mainstreamed certain areas at system level." (ID42, Project Team, P2)*

The CHEC also influenced system priorities and governance. In several areas, the programme contributed to the creation of new boards and partnership structures that embedded children's issues alongside adult health priorities. This included direct influence on areas such as housing regeneration, where system leaders noted the way children's needs had been brought into focus.

> *"They've really come to the forefront. It's not just the ICS, it's working with the Council and with the Housing Directorate. We've been able to influence housing decisions." (ID28, ICS, P2)*

Alongside governance, the CHEC has also left a legacy of data infrastructure that is likely to endure. Data leads developed tools and dashboards that are already supporting decision-making. In NHS South Yorkshire, the Cherish dashboard has become a template for wider data reporting. These developments demonstrate how the CHEC seeded sustainable and transferable models for monitoring equity.

Importantly, the CHEC made a valuable contribution to embedding co-production practices, building on existing partnerships with VCSE organisations and amplifying their role in shaping children's health equity. Examples such as Chilypep, highlight how sustained engagement can provide young people with a genuine voice in decision-making, showing not only that their contributions are valued but that they can see evidence of their impact. Across the programme, CYP's perspectives were heard more consistently and began to influence both local initiatives and Barnardo's national policy priorities.

Finally, the CHEC's impact was amplified by its national visibility. Referenced in the Hewitt Review and parliamentary committees, the programme was positioned as an example of good practice, lending credibility to local activity and helping to secure senior buy-in. This profile reinforced alignment with wider system priorities and ensured that lessons from the programme contributed to broader policy conversations about the future of child health equity in England.

While systems change is incremental and fragile, the CHEC has shifted the conversation, created tangible infrastructure, and left a clear legacy of how children's health equity can be prioritised within ICBs (as future strategic commissioners). The challenge now is ensuring this momentum is sustained, so the gains made are not lost once programme-specific activity ends.

Appendices

Appendix A - Realist Evaluation

The essence of realist evaluation is that social programmes do not bring about change, instead it is the resources they generate and the conditions they create for people to act, that generates change.

As Ray Pawson (one of the co-founders of realist evaluation) explained:

“Interventions work when the resources on offer (material, cognitive, social or emotional) strike a chord with programme subjects. This pathway from resources to reasoning is referred to as the programme ‘mechanism’. Realist evaluation is thus fundamentally about unearthing and inspecting vital programme mechanisms”.[27]

In Realist evaluation it is assumed that programmes and the measures they introduce will trigger different mechanisms depending on the local context. Context is therefore important in realist evaluation because it will either help or hinder mechanisms from leading to outcomes. We view Realist evaluation as being the most appropriate approach for the CHEC evaluation because you have three different contexts in which the collaborative is working. It is somewhat inevitable that things will work differently, and the ICSs will take slightly different approaches to implementation. This means that we need to understand what it is about how they work, who they work with, and in what contexts, if we want to understand how outcomes were achieved (or not). This approach is also important if we want to share learning about the CHEC with other ICS areas. If an evaluation doesn’t identify what it was about a programme of work that led to outcomes, and the contexts that facilitated this, it is very difficult for another area to implement the approach and reach the same outcomes.

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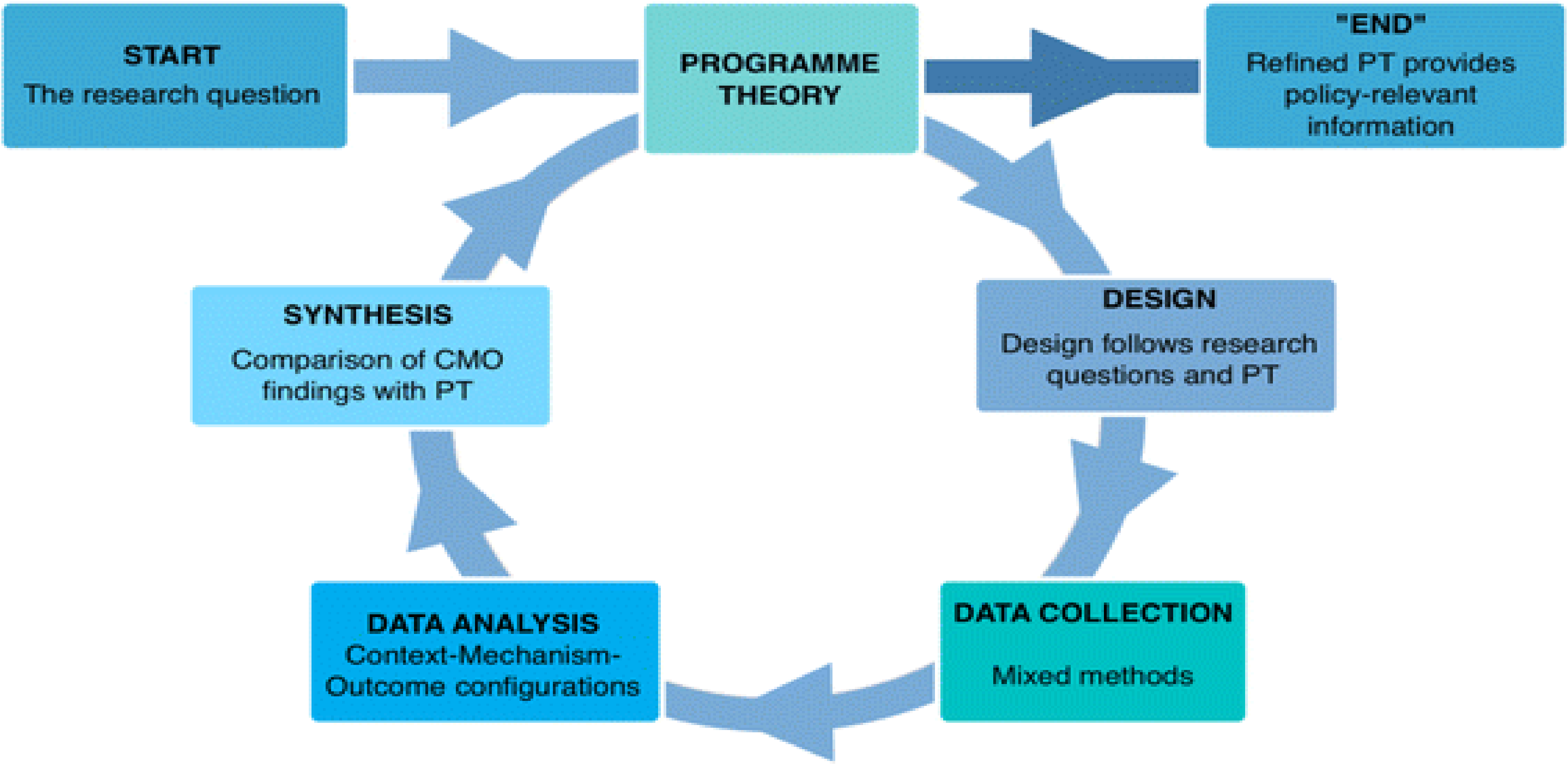
[27] Pawson, R. (2003) Nothing as Practical as a Good Theory. **Evaluation**. 9 (4): 471-490.

Figure 2 - The Realist Evaluation Cycle (Belle and Rifkin, 2017) adapted from Marchal et al (2012)



START

The research question

PROGRAMME THEORY

"END"

Refined PT provides policy-relevant information

DESIGN

Design follows research questions and PT

DATA COLLECTION

Mixed methods

DATA ANALYSIS

Context-Mechanism-Outcome configurations

SYNTHESIS

Comparison of CMO findings with PT

Appendix B – Initial Theory of Change

Context Why is this project needed?	The gap in healthy life expectancy is 19 years between the least and most deprived areas of England.[28] Children growing up in deprived areas often suffer disadvantage and poorer health outcomes throughout their lives.[29] It's important to understand the **social determinants of health** which describe the social and environmental conditions in which people are born, grow, live, work and age, which shape and drive health outcomes. Factors that determine how the social determinants of health conditions are experienced across societies include the distribution of power, money and resources. Unfair distribution of these resources creates avoidable health inequalities. While most social determinants lie outside the healthcare system, there is much that the healthcare system can do by acting on these social determinants of health, providing advocacy and leadership for such action as well as by ensuring equitable access to healthcare services.
Aims What are the overall goals of the project?	The CHEC programme aims to improve health equity for children and young people by working in new, innovative ways across the voluntary sector, academic partners, and healthcare systems. Programme ambitions are: For Integrated Care Systems to give equal weight to children and young people's health creation, as to their health and care service integration. In focusing on health creation, to incorporate the role of the Voluntary Community Social Enterprise (VCSE) sector in understanding and acting on the wider determinants of health.
Objectives How the aims will be achieved?	Each ICS is responsible for meeting the CHEC ambitions through combined activities that: - Strengthen local partnership working. - Deliver an intervention that will support child health equity by being informed by children and young people's insight and acting on a social determinant of health. - Increase system focus on child health equity through enhanced monitoring of child health equity indicators and an increased awareness of child health equity at decision-making level.

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[28] Office for National Statistics, 'Health state life expectancies by national deprivation deciles, England and Wales: 2015 to 2017' ↩

[29] Chapter 6: social determinants of health - GOV.UK (www.gov.uk)

Inputs The resources delivering the programme	- Academic, public health and voice and influence expertise provided by Barnardo's and the IHE in the design of the CHEC, including the Framework and associated narrative and indicator set and a Children and Young People's Insight report based on engagement work with over 300 children and young people. - Leadership and support to ICS data leads to create local child health equity assessments, advice and guidance on evaluation metrics and co-design of novel methods to incorporate VCSE insights with statutory quantitative child health equity data (including a data plug-in for two-way sharing of information). - Leadership, content knowledge and financial resource to support intervention planning and evaluation. - Ongoing support to plan and conduct engagement work, recruitment and induction of Health Equity Champions and co-design of Champions workplan (provided by Barnardo's Voice and Influence team provide). - Comms strategy to support awareness of the CHEC within ICS partner organisations and further afield, including a quarterly child health equity newsletter and maintaining a child health equity web page on the IHE Health Equity Network. - Governance and oversight provided by a Children and Young People's Health Equity Board jointly chaired by Rukshana Kapasi (Director of Health, Barnardo's) and Professor Sir Michael Marmot (Director of the UCL Institute of Health Equity). - Programme support by a core project team within Barnardo's which comprises a consultant in Public Health and 2 programme managers. - Temporary support (of varying length) provided since August 2023 by 2 Specialist Registrars in Public Health and a data analyst. - Local ICS programme leads who are supported by a senior data analyst. - Monthly operational groups chaired by Barnardo's.

Outcomes	Mechanisms	Contexts
Short-term impacts/outcomes - ICSs understand CYP health inequalities and their drivers within their health system - ICS's understand wider determinants of health data and their impact on CYP - The issues that matter to CYP and their health inform ICS's strategic planning - Current gaps within health system data are highlighted and understood, with plans in place to fill them - VCSE data is captured and accessible to all partners - Improved understanding of VCSE held data	- **A collaborative approach** - The CHEC facilitates ICBs, VCSEs, LA's and CYP to come together to understand and address different perspectives on wider determinants of health. (through monthly operational groups, 12 weekly Children and Young People's Health Equity Board, intervention planning, bi-weekly data workstream meetings, event days, Champions, Champions workplan) - **A foundation of evidence and expertise** - the expert support, guidance and advice from Barnardo's and IHE supports ICSs to understand and begin to address health inequalities and drivers within their health system (through framework development, indicators, local child health equity assessments, guidance on intervention development, Children and Young People's Health Equity Board etc)	Enabling contexts - Addressing health inequalities is one of four priorities for all ICSs to take action on - Levelling up White paper seeks to address geographic difference in life circumstances or wider determinants of health - CORE20PLUS5 health inequalities strategy for CYP launched in 2022 - Marmot places (Cheshire is one). - Requirement for ICPs to work in partnership and share data with

- ICSs have developed effective partnerships with their LA and VCSE partners to understand and address CYP health inequalities. **Medium-term impacts/outcomes** (some of which may be measurable within the evaluation timeframe) - Data parity for CYP - and the VCSE sector - in population health management within ICSs. - Children and young people feeling like their input matters and can make real long-lasting change - Raise the status of the VCSE sector contribution. - Culture of parity between the statutory and voluntary and community sectors. - CYP prioritised with population health management plans for ICSs. - Population health management approaches give proportional support for marginalised communities. - Wide adoption of the CYP health equity framework across all 42 ICSs. - Improved capacity and resource planning, involving whole systems partners to act on health issues. - ICSs think and act differently about support interventions, e.g. to include a tier through the social determinants of health, to build on assets and VCSE partnerships.	- **Localised practical support** - the practical, financial and technical support provided by Barnardo's and IHE enables ICSs to operationalise key priorities in their area for addressing the wider determinants of health (monthly operational meetings, programme support and temporary support) - **A foundation of lived experience** - there is a commitment to CYP system actors driving change. The inclusion of CYP in developing the framework and the involvement of Champions helps ICSs to make strategic planning decisions based on the lived experiences of CYP (Champions, CYP insight report, engagement with CYP through voice and influence team, Champions meetings, funding for CYP involvement and co-production, 20k per area). - **Raising awareness and understanding** - the CHEC facilitates raising awareness and understanding of the importance of addressing the wider determinants of health both within the three ICS areas and beyond with a view to bringing 'warm' contacts back in. (Comms planning, comms meetings, website, newsletter and engagement with 'warm' contacts through in-person days). - **Profile and impact** - The CHEC is seen as a national programme - ICSs wanted to be part of this work as it has implications for national policy and practice, meaning they have a chance to influence wider policy. There is also external interest in the programme and high visibility. Both factors help keep up momentum and commitment to the CHEC. - **Local Champions/empowered actors** - The CHEC enables local leaders, politicians and practitioners who are committed to improving the health of CYP to implement change in their area of work. The CHEC essentially gives people with expertise, passion and political will the license they need to make change happen.	VCSE partners - *(introduced after the CHEC was established)*. Constraining contexts - Cuts in funding to ICS's - Disparities White paper no longer going ahead - Covid 19 - Cost of living crisis - Health deterioration - Political instability due to election year.
Long-term impacts	- All children to be guaranteed a basic state of health and wellbeing. - Improved health outcomes for CYP from deprived and marginalised communities. - Reduction in health inequalities for CYP	

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Mental Health Aware MHFA England

IQCS Interviewer Quality Control Scheme

UK Evaluation Society

AQR Association for Qualitative Research

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