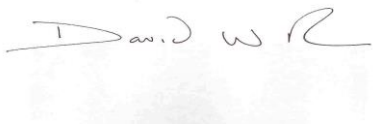
Public Document Pack

Health and Wellbeing Board

Wednesday, 12 October 2016 2.00 p.m.
Bridge Suite, Halton Security Stadium



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 18 January 2017

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 6 July 2016 at The Halton Suite - Select Security Stadium, Widnes

Present: Councillors Polhill, Chair , Wright and Woolfall and N. Bunce, P. Cooke, T. Hill, M Larking, E. O'Meara, A. McIntyre, D. Parr, M. Reaney, C. Samosa, M. Sedgwick, S. Semoff, H. Sheldrick, R. Strachan, H. Teshome, L. Thompson, T. Tierney, S. Wallace-Bonner and S. Yeoman

Apologies for Absence: Councillor T. McInerney and S. Banks, D. Lyon, H. Patel and M. Pickup

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB1 MINUTES OF LAST MEETING

The Minutes of the meeting held on 9th March 2016 having been circulated were signed as a correct record.

HWB2 PRESENTATION BY MIKE LARKING, CHESHIRE FIRE AND RESCUE SERVICE

The Board received a presentation from Mike Larking, Cheshire Fire and Rescue Service, which provided information on expanding the current home safety assessments to support identified health issues. The presentation provided Members with details on the Fire Prevention in the Home Policy and the impact of a sustained programme of fire safety activity over the last five years in Cheshire.

The Board was advised that a Cheshire and Mersey Health and Fire Summit had been held on the 15th July 2015 and a number of issues had been identified to be considered and worked up which were designed to deliver a consistent and impactful intervention and support to NHS across the whole of Cheshire and Merseyside. Using Exeter health data, the service would continue to focus on those most at risk from fire but would work with Health partners to identify

those households which also faced additional health risks. In 2016/17, the Service would re-launch its Home Safety Assessment Programme as Safe and Well Visits, with fire fighters and advocates carrying out additional basic health checks. The Service planned to increase the current level of 25,000 home visits a year to around 40,000.

RESOLVED: That the report be noted.

HWB3 PRESENTATION - MEETING THE NEEDS OF CHILDREN AND YOUNG PEOPLE WITH SPECIAL EDUCATIONAL NEEDS AND/OR DISABILITIES - ANN MCINTYRE

The Board received a presentation from Ann McIntyre, Operational Director – Educational, Inclusion and Provision, which provided information of how effectively Halton met the needs of and improved the outcomes of children and young people who had special educational needs and/or disabilities as defined in the Act and described in the Special Educational Needs Code of Practice: 0 to 25 years.

The Children and Families Act 2014 gave each Clinical Commissioning Group (CCG), a statutory duty to co-operate with the Local Authority in a co-ordinated assessment of the needs of individual children or young people assessed as having special educational needs. They also were required to agree a single outcome focused Education, Health and Care (EHC) Plan. The role of the Health and Wellbeing Board and the Halton profile in comparison to neighbouring local authorities, North West local authorities and the national average was detailed in the presentation.

In addition, Members were provided with an update on the current position and areas for development with regard to children and young people who had a special educational need or disability in Halton.

RESOLVED: That the presentation be received.

HWB4 HALTON HOUSING TRUST - DIRECTOR OF HOUSING AND WELLBEING

The Board considered a report which provided an update on the expansion of Halton Housing Trust (HHT) Director of Housing role to include Health and Wellbeing. This expanded role reflected on-going discussions between HHT, NHS Halton Clinical Commissioning Group (CCG) and Halton Borough Council's Director of Public Health, to

develop a role with joint housing and health responsibilities. This strategic role would enable further development of the positive joint working approach developed over the last few years. The report highlighted the Director of Housing and Wellbeing responsibilities, the initial agreed shared priorities for Halton, and a number of ways that HHT, Halton CCG and Public Health, could work more cohesively to achieve shared objectives.

It was noted that Halton CCG had agreed to make an initial contribution of £10,000 towards the cost of this role. This would be reviewed after an initial 12 month period.

RESOLVED: That the report be noted and that the Board supports the creation of a Director of Housing and Wellbeing.

HWB5 FINANCIAL RECOVERY AND SUSTAINABILITY PLAN

The Board considered a report of the Chief Officer of Halton CCG, which outlined the actions being undertaken by NHS Halton CCG to achieve financial recovery and sustainability. Over the three previous financial years NHS Halton CCG had managed to deliver a balanced year end budget and a 1% surplus.

It was reported that the next five years would be challenging and would involve some difficult and potentially contentious decisions about what services NHS Halton CCG chose to commission or decommission and what partnerships and activities could be invested or disinvested in. The initial figures over the next five years suggested NHS Halton CCG would need to find a cumulative total of £55.6m.

At its meeting of the Governing Body of NHS Halton CCG on the 7th April 2016, it was agreed that based on the forecasts, a financial recovery and sustainability plan was required by July 2016 to deliver recurrent savings over the next five years and to deliver more efficient and effective health and care services. The plan would explore four areas of action:-

- Improving health care;
- Improving value for money;
- Reducing costs by reviewing existing services; and
- Considering more difficult decisions.

On 2nd June 2016, the Governing Body agreed some core principles and a process for decision making on cost improvement identification to contribute to financial

sustainability. The process that was agreed would ensure that the impact of any commissioning decisions, whether about investment or disinvestment, took into account quality and equality issues and were taken forward following engagement with interested parties.

RESOLVED: That the report be noted.

HWB6 PUBLIC HEALTH ANNUAL REPORT ASSESSING NEEDS AND TAKING ACTION

The Board considered a report from the Director of Public Health, which provided Members with information on the 2015/16 Annual Report: Assessing Needs and Taking Action. The Annual Report would be available in July 2016 in hard copy and on line at www.halton.gov/PHAR.

The Board was advised that this year's Annual Report focussed on the work of the Public Health Evidence and Intelligence Scheme. The topic had been chosen to highlight some strategic pieces of work, their key findings and how they had been used or would be used by Halton Borough Council and its partner organisations. The pieces of work highlighted in the report where:-

- Children's Joint Strategic Needs Assessment (JSNA);
- GP JSNA;
- JSNA on Long Term Conditions; and
- Older People's JSNA.

RESOLVED: That the contents of the report be noted and the Board supports the recommendations.

HWB7 BETTER CARE FUND 2016/17

The Board considered a report of the Director of Adult Social Services, which provided information on the submission of the Better Care Fund 2016/17. It was reported that much of the 2016/17 submission remained a continuation of the successful approach in 2025/16 and initial feedback suggested that Halton would be approved unconditionally. This would be confirmed by 30th June 2016.

RESOLVED: That the report and associated documents be noted.

HWB8 WELL NORTH PROGRAMME

The Board considered a report which provided an update on the Well North Programme for Halton. Well North

was a Department of Health response to the Due North Report published in 2015, which highlighted the disparity in health outcomes between the north and the south of England. The development of the Well Halton Programme, under the auspices of Well North, had been conducted in partnership between NHS Halton CCG and Halton Borough Council. The Health and Wellbeing Board reviewed and approved the initial proposition and had received a progress report with a further report due in July. Regular updates and opportunities for engagement in the development of the Well Halton proposition had also been offered across the two organisations and community partners.

It was reported that three schemes had been agreed for Well Halton in the following areas; Windmill Hill, Halton Brook and Widnes.

An initial narrative had been developed for each area and the next steps were that each scheme would require a clearly identified governance structure, a project initiation document and clear leadership team to progress the schemes. Details of the membership for each scheme were outlined in the report.

RESOLVED: That

(1) the report be noted;

(2) the initial work programme for Well Halton be agreed; and

(3) the resources required to support Well Halton be agreed.

HWB9 HEALTH AND WELLBEING BOARD STRATEGY 2017-2022

The Board received a report from the Director of Public Health, which provided an update on the development of the new Halton Health and Wellbeing Strategy (2017/2022). One of the key responsibilities of the Health and Wellbeing Board was to develop a Health and Wellbeing Strategy to meet the needs of the local population. Halton's first Health and Wellbeing strategy covered the period 2013–2016 and set out the vision of Health and Wellbeing in Halton. As the current strategy finished in 2016, a new Health and Wellbeing Strategy would be developed to build on successes and to make further improvements.

Members were advised that it was important that the Strategy recognised:

- the agreement between the Government and the leaders of the Liverpool City Region (LCR) to devolve a range of powers and responsibilities to a Combined Authority;
- the NHS five year forward view; and
- the five-year Sustainability and Transformational Plan (STP).

Whilst the new Health and Wellbeing Strategy needed to reflect current priorities from elsewhere in the system, it would maintain a local focus that was evidence-based and reflected local people's views. Priorities identified within the new Strategy would be aligned with LCR Devolution and "One Halton" areas of focus. Those currently being discussed included:-

- Child development;
- Community immobilisation, health eating and exercise;
- Long term conditions CVD and cancer;
- Mental health; and
- Disabilities.

In addition, the new Strategy would include an updated Health and Wellbeing profile for Halton, outline the progress made since 2013 and the challenges that remained, provide an overview of priorities and how and why these were chosen, outline a system at scale to make a difference and outline how success would be measured.

Following consultation with public and key stakeholders, a draft of the new Strategy would be presented to the Health and Wellbeing Board for comment in October, with a final version submitted for approval in January 2017.

RESOLVED: That the Board provide leadership and oversight for the development of the new strategy and help inform its chosen priorities.

HWB10 DISCUSSION PAPER ON THE MANAGEMENT OF LETTINGS WITHIN THE BOROUGH AND THE IMPACT ON OLDER PEOPLE

The Board considered a report which highlighted the impact that some housing lettings could have on the health and wellbeing of older people within the Borough. In order to

ensure that the health and wellbeing of older people in housing lettings was improved and maintained, it was proposed that the Board consider the following:

i. to adopt a National Pensioners Convention (NPC) Dignity Code;

ii. to consider putting forward a recommendation to the Property Pool Plus to adopt the NPCs Dignity Code; and

iii. discuss how the health and wellbeing of older people within the housing lettings could be brought to the fore and draw attention to so that other older people did not have their lives affected by inappropriate lettings.

RESOLVED: That

1) the report be noted;

2) the Board discuss the issues under Options for Change and develop a system-wide approach; and

3) the Board adopt the National Pensioners Convention Dignity Code.

Meeting ended at 3.50 pm

REPORT TO: Health and Wellbeing Board

DATE: 12 October 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: Adult Health and Social Care – Accountable Commissioning System

WARD(S): Borough Wide

1.0 **PURPOSE OF REPORT**

1.1 The report presents a Project Initiation Document (PID) to the Health and Wellbeing Board, which outlines a proposal and associated mechanisms of how the further alignment of systems and services across Health and Social Care Services will improve the quality and efficiency of services provided to Adults in Halton.

2.0 **RECOMMENDATION: That the Board note the contents of the report and associated appendices.**

3.0 **SUPPORTING INFORMATION**

Background

3.1 There have been many national changes to health and social care policy over the years, but one significant vision has remained: that is for the closer working of health and social care services. Over time, national policy has been designed to remove barriers between these two areas moving from partnerships, to formal joint working and, in some instances, fully integrated services with pooled funding. Over the last 15 years, legislation has been introduced that gives local organisations more scope to progress joint working. These powers were updated by the NHS Act 2006 which introduced "Health Act Flexibilities" (HAFs), to foster partnerships between health and social care agencies and to bring down the barriers between health and social care. The aim for partners is to join together in designing and delivering services around the needs of users, rather than worrying about the boundaries of their organisations.

3.2 In May 2013, the Government announced it's biggest ever commitment to making co-ordinated health and care a reality and published plans that aim for us working together to put people first (Integrated Care and Support: Our Shared Commitment (2013).

The Health and Social Care Act 2012 brought in the most wide-ranging reforms of the NHS since it was founded in 1948. On 1 April 2013 the main changes set out in the Act came into force, and most parts of the NHS were affected in some way. One of the duties within the Act is the promotion of integration. In support of the integration agenda, in June 2013's spending review the Government announced the introduction of the Integrated Transformation Fund from 2015/16 (subsequently renamed the Better Care Fund (BCF)) as a catalyst to ensure that the integration agenda is progressed, services improve and value for money is ensured. Recent guidance has clarified that this is to continue.

Local Context

3.3 In Halton, Adult Services have a long history of collaboration and integration, and began its journey of joint working/integration back in 2003 with a pooled budget and integrated teams within Intermediate Care Services. Attached at ***Appendix 1*** are examples of Joint Working/Integration in respect of the Adult Services.

The focus on joint working and pooled resources has developed and strengthened over the years; we now have a pooled budget in excess of £42 million pounds. Both NHS Halton Clinical Commissioning Group (CCG) and the Council are committed to further developing our integrated approach to service delivery and transformation to improve the Health and Well-Being of Halton residents. Although we are working towards operating as a system, there does continue to be barriers to fully realising the benefits of a truly integrated approach, and as a result some of the improved outcomes for users of our services and opportunities to deliver value for money are missed.

3.4 The management of the pooled budget has been extremely successful, improving outcomes for individuals in addition to moving from a position of overspend for both organisations to financial balance. It should be noted that HBC and NHS Halton CCG have entered into a new Joint Working Agreement which runs until 31st March 2019.

3.5 There is no single definition for integrated care, and the integration of services can take place in various forms and at different levels. For example, services may be integrated at the level of a local or regional population, for a particular care or age group, or at an individual level, or indeed may involve more than one of these approaches. However there is clear evidence that when it comes to delivering benefits, the integration of clinical teams and services is far more important that the integration of organisations; organisational integration in itself is no guarantee of improved outcomes.

Proposal/Project

3.6 However with the introduction of the Better Care Fund from April 2015, which builds upon the Joint Working Agreement and associated pooled budget arrangements introduced in April 2013 between HBC and NHS Halton CCG for the commissioning of services for people with Complex Care needs, both HBC and NHS Halton CCG believe it is an appropriate time to review current arrangements in place in respect of joint working and align organisational structures, leadership and governance arrangements across Adult Social Care and Health, in order to deliver more effectively on the desired outcomes for the residents of Halton.

It should be noted that the approach being taken in Halton supports the national drive towards the concept of 'Accountable Care Organisations' (ACOs). ACOs consist of providers who are jointly held accountable for improving the quality of care and reducing costs, largely by working together more efficiently.

As the basis for the current Joint Working Agreement, the pooled budget and this proposal/project is primarily concerned with the commissioning of services, as both organisations are working towards the same goals – quality improvement, costs savings and working together more efficiently both HBC and NHS Halton CCG feel that this approach is in line with the concept of ACOs but would refer to Halton's current direction to that of an 'Accountable Commissioning System'.

3.7 Attached at ***Appendix 2*** is a detailed PID which outlines the aim of the project, rationale,

expected outcomes, process to be undertaken etc.

A Project Board has been established to take forward this Project; called the 'Integration – Joint Steering Group'. This Project Board is chaired by the Director of Adult Social Services, HBC.

Membership of the Board is as follows:-

- Operational Director, Commissioning & Complex Care, HBC
- Director of Transformation, HBC & NHS Halton CCG
- Chief Nurse, NHS Halton CCG
- Director of Service Delivery, NHS Halton CCG
- Director of Public Health, HBC

The Project Board have met on a number of occasions so far to develop the attached PID and will continue to met on a monthly basis and report progress through to Chief Officers Management Team – HBC and Executive Management Team – NHS Halton CCG on an ongoing basis.

3.8 Commissioning Services for Children and Families will continue to be progressed through the Children and Families Commissioning Partnership Board of the Children's Trust. This allows partners to focus on jointly identifying how the needs of children and families are met and ensures that positive outcomes for children, young people and families are at the heart of the strategic planning and commissioning process. Recent reviews of support to children and young people with special educational needs and disability have identified opportunities for Adult and Children's Services to align more closely and work in an integrated way in areas such as transition and equipment.

NB. A report outlining this proposal and associated PID was presented to the Children's Trust in April 2016 for comment.

3.9 As with Children's Services above, although the focus of this project is on Adult Services, the Integration – Joint Steering Group will ensure that where there are opportunities for further integration/alignment with Public Health then these will be activity explored. This is supported by the inclusion of the Director of Public Health onto the Integration – Joint Steering Group.

<u>Conclusion</u>

3.10 There are increasing challenges for the Health and Social Care economy within Halton to be able to respond effectively to people's needs and provide high quality services within limited and reducing resources. Therefore we need to examine how we can do things differently to not only ensure value for money, but ensure that they are affordable.

3.11 The aim of this project is to facilitate the further alignment of systems, to support the existing pooled budget which will not only improve effective and efficient joint working, but more importantly improve the pathways and outcomes for individuals who use our services, thus setting the scene for the future sustainability of meeting the current and future needs of people with complex needs.

It is anticipated that the model developed as part of this project will provide us with the necessary infrastructure and a sound basis to build upon when moving forward on the integration of front line services and the commissioning of services to support community hubs.

3.12 In summary this project will achieve:

- A joint market position statement - There is the potential to manage the market more effectively, utilising more robust procurement processes in order to manage/contain the general increase in costs;
- Ensure value for money contract prices, to ensure quality provision and that adults are appropriately safeguarded;
- An integrated commissioning plan for Halton Adult Services;
- Delivering high quality care closer to home;
- Reduce the need for unnecessary hospital admission and readmission;
- Ensure the appropriate use of crisis intervention and short term support to promote independence;
- Promote the use of a range of technologies to support independence and the management of risk;
- Ensure the proportion of placements in long term residential care are maintained at an appropriate level;
- Realise placements in Borough with Out of Borough placements being the exception;
- Improve the quality of care in the community and residential placements;
- Identify other opportunities for external partnership/integrated working arrangements; and
- Identify further opportunities to pool additional funding.

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 At this stage it is difficult to accurately assess what the project will deliver in respect of actual efficiencies however what the project will do is provide us with the opportunity to manage resources as a system more effectively which in turn is anticipated to generate efficiencies.

This can be borne out of the fact that we have moved from a position of overspend for both organisations to financial balance as outlined earlier on in the report.

6.0 OTHER IMPLICATIONS

6.1 None identified at this stage.

7.0 RISK ANALYSIS

7.1 Any risks associated with the implementation of this project will be managed via the Integration – Joint Steering Group.

7.2 As part of the development of the PID a risk analysis has been completed by the Joint Steering Group and is included within the PID under section 3.6 ‘Known Risks’.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified at this stage.

Appendix 1

Joint Working/Integration between Health Services and Halton Borough Council (Adult Services): Examples

Examples include the Rapid Access Rehabilitation Service (RARS). This team undertake specialist assessments and interventions, within a community setting and within Intermediate Care Beds. The team is made of professionals from three organisations (HBC, Bridgewater and Warrington & Halton Hospital NHS Foundation Trust) working under HBC management direction. In addition, it supports the falls service, providing specialist therapy and nursing and has an assessment function. RARS also operates a crisis intervention or rapid response element of service provision. RARS is also the 'single point of access', for all Intermediate Care Services in the Borough. Anyone can be referred to the RARS Team, by a Health or Social Care Professional or Practitioner, by the Voluntary Sector or by the Patient themselves or their Relative(s).

Within Halton, although the NHS Halton Clinical Commissioning Group (CCG) is both responsible and accountable for urgent care services for the local population and anyone present in Halton, NHS Halton CCG recognises that urgent care cannot be commissioned in isolation of social care and therefore works in partnership with HBC and neighbouring CCGs and Local Authorities to discharge their statutory responsibilities with regards to urgent care. The Director of Adult Social Services is the Chair of Halton's System Resilience Group and the Director of Transformation, HBC and CCG is Vice Chair, whilst the Operational lead for Urgent Care within Halton, working across both HBC and CCG is the Divisional Manager, Urgent Care, HBC. The System Resilience Team includes other representatives from the CCG and HBC in addition to the Clinical Lead for Urgent Care from the CCG. The team proactively provide leadership, operational input/support, ensure appropriate communication and direct resources into the Urgent Care System to respond to particular pressures in the system on an ongoing basis. One area of work that has been key for the Team over the past 18 months has been the development of the two new Urgent Care Centres within Halton which provide new and expanded diagnostic services, medical and nursing capacity for the management of ambulatory and sub-acute conditions and minor illness and injury.

Another example is that of HBC and NHS Halton CCG entering into a 3 year Joint Working Agreement (hosted by HBC) from April 2013 (Section 75) for the commissioning of services for people with Complex Care needs. This Agreement provides the legal framework in which HBC and NHS Halton CCG work together in order to achieve their strategic objectives of commissioning and providing cost effective, personalised, quality services to the people of Halton. As part of the Joint Working Agreement, HBC and NHS Halton CCG entered into a Pooled Budget arrangement, totalling just under £33 million. This pool contained the expenditure on delivering care and support services for adults with complex needs. During 2014, partners within Halton worked collaboratively, within the national guidance and framework to develop Halton's BCF. It was agreed that the BCF should be incorporated into the existing Pooled Budget arrangements between HBC and NHS Halton CCG; the pool now stands at £42 million.

This Joint Working Agreement has led to changes to the delivery model, including the transfer of Continuing Health Care (CHC) Nurse Assessors from the North West Commissioning Support Unit to the Social Care Complex Care Teams. Since the transfer of the CHC Assessors to HBC in July 2014, review rates for CHC packages have improved. Other examples include the development of a Joint Direct Payments Policy and Procedure between HBC and the CCG for dealing with Personal

Budgets, the development of a Joint Contract for the provision of day, residential and nursing home care and the development of the Integrated Adults Safeguarding Unit to improve the delivery of a flexible and responsive multi-agency service, with a focus on the more complex cases within institutional settings.

Halton's Better Care Fund (BCF) Plan outlines in detail the vision for health and social care services within Halton up to 2018/19. The plan outlines the changes that will need to be delivered over the next 5 years and how services will need to be reconfigured in order to deliver on this vision, in addition to what difference these changes will make to patient and service user outcomes.

Halton's BCF Plan outlines that choice, partnership and control will continue to be developed based on integrated approaches to needs assessment and utilising the diversity of mechanisms that enable individuals and communities to self-direct agreed health, social care and community resources.

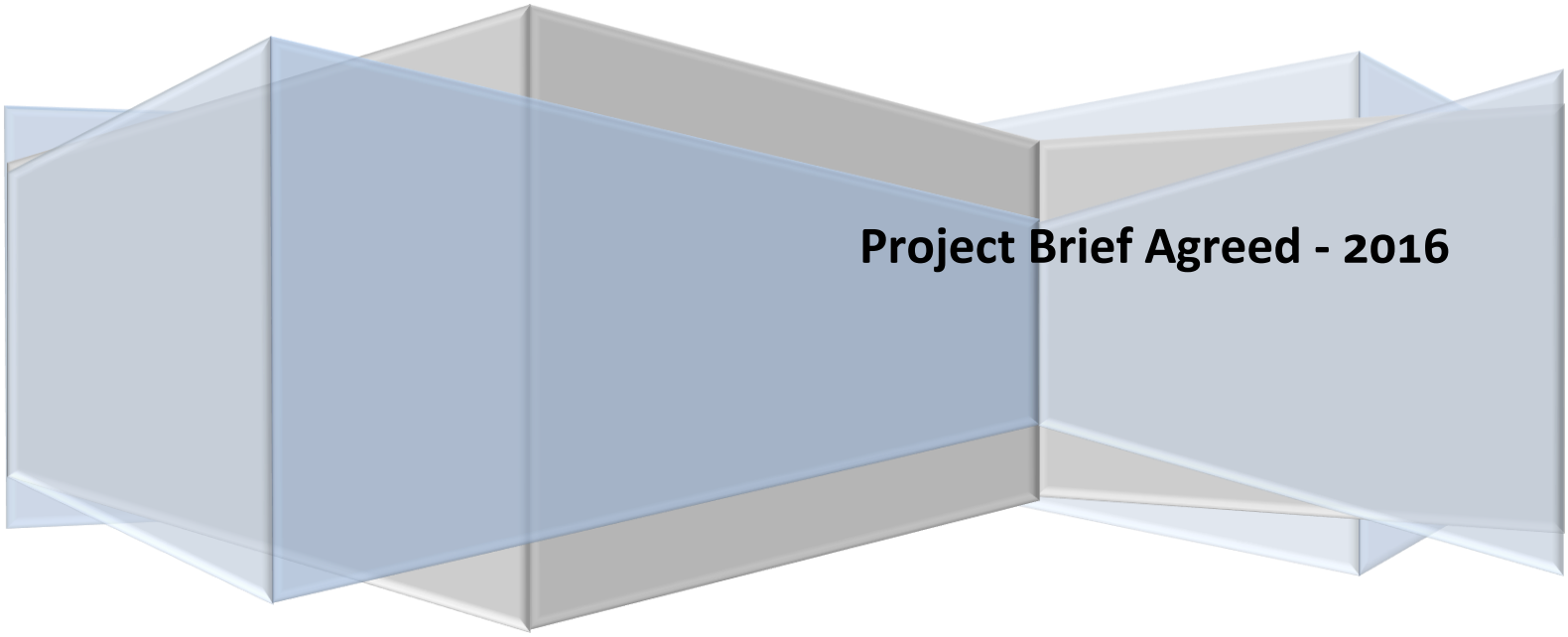
The aim is to ensure that the numerous schemes outlined within the BCF Plan will:

- Improve outcomes;
- Improve health and wellbeing of individuals in our community;
- Support independence;
- Manage complex care and provide care closer to home;
- Integrate our approach to commissioning;
- Improve quality of care; and
- Intervene at an earlier stage to support people with mental health problems in the community.

Halton Clinical Commissioning Group

Adult Health and Social Care – Accountable Commissioning System

Project Initiation Document



Project Brief Agreed - 2016

Contents

1. Introduction

1.1 Overview of Project

Halton began its journey of joint working/integration back in 2003 with a pooled budget being established for Intermediate Care and Equipment services, in addition to specific grant allocations.

Following the emergence of NHS Halton Clinical Commissioning Group (CCG) further work has progressed to establish/consolidate joint working arrangements between Halton Borough Council (HBC) and NHS Halton CCG, underpinned by the Statement of Intent developed between HBC and NHS Halton CCG in May 2013.

Even before the Government announced its biggest ever commitment to making co-ordinated health and care a reality back in May 2013, within Halton there was already an excellent track record in working in partnership/collaboratively to deliver on Halton's strategic approach to the commissioning and provision of services for adults with complex needs. Halton had already introduced dynamic, challenging and innovative integrated change programmes involving both commissioning processes and the delivery of services which have already helped drive forward real change within Health and Adult social care and achieve success in a complex and changing environment.

However with the introduction of the Better Care Fund from April 2015, which builds upon the Joint Working Agreement and associated pooled budget arrangements introduced in April 2013 between HBC and NHS Halton CCG for the commissioning of services for people with Complex Care needs, both HBC and NHS Halton CCG believe it is an appropriate time to review current arrangements in place in respect of joint working and align organisational structures, leadership and governance arrangements across Adult Social Care and Health, in order to deliver more effectively on the desired outcomes for the residents of Halton.

The approach being taken in Halton supports the national drive towards the concept of 'Accountable Care Organisations' (ACOs). ACOs consist of providers who are jointly held accountable for improving the quality of care and reducing costs, largely by working together more efficiently.

As the basis for the current Joint Working Agreement, the pooled budget and this project is primarily concerned with the commissioning of services, as both organisations are working towards the same goals – quality improvement, costs savings and working together more efficiently both HBC and NHS Halton CCG feel that this approach is in line with the concept of ACOs but would refer to Halton's current direction to that of an 'Accountable Commissioning System'.

1.2 Distribution of Project Initiation Document

This document has been distributed to:-

Name	Title	Date of Issue
Sue Wallace Bonner	Director of Adult Social Service - HBC	Draft - 12.1.16 V2 – 29.1.16 V5 – 13.5.16
Paul McWade	Operational Director, Commissioning & Complex Care – HBC	Draft - 12.1.16 V2 – 29.1.16

		V5 – 13.5.16
Jan Snoddon	Chief Nurse – NHS Halton CCG	Draft - 12.1.16 V2 – 29.1.16 V5 – 13.5.16
Dave Sweeney	Director of Transformation – NHS Halton CCG/HBC	Draft - 12.1.16 V2 – 29.1.16 V5 – 13.5.16
Leigh Thompson	Director of Commissioning & Service Delivery – NHS Halton CCG	Draft - 12.1.16 V2 – 29.1.16 V5 – 13.5.16
Eileen O'Meara	Director of Public Health – HBC	V5 – 13.5.16

1.3 Version Control Table

Version	Date	Date Issued	Amendment
1	5.1.16	12.1.16	Document Created
2	25.1.16	29.1.16	Amendments to draft PID discussed at Integration – Joint Steering Group on 25.1.16
3	10.2.16	N/A	Addition of Network Management definition – Page 6
4	9.3.16	N/A	• Amendment to paragraph in respect of support provided by Corporate Services and the Commissioning Support Unit – Page 6 • Addition reference made to Paragraph 3.3 – Page 9 • Addition to Membership of the Board – Page 12 • Amendment made to reference to Public Health – Page 9
5	12.5.16	13.5.16	• Amendment to timescale for completion of Phase 1 – Page 6 • Amendment to the need to develop a business case for a finance post – Page 6 • Amendment to the need to develop a business case for a finance post – Page 13

2. Why is the Project Taking Place?

2.1 Project Aims

The overall aims of this project will be to:-

- expand upon the existing pooled budget arrangements and integrated teams in place;
- further align systems and integrate functions to reduce duplication;
- improve our overall approach to system commissioning;
- demonstrate value for money; and
- improve the pathways and outcomes for individuals who use our services.

The outcomes from this project will provide a sound basis for ensuring that both HBC and NHS Halton CCG will have the ability to meet the current and future needs of people with complex needs.

2.2 Business Case

The outcomes of having the Joint Working Agreement and associated pooled budget arrangements in place since 2013 have been extremely successful, improving outcomes for individuals in addition to moving from a position of overspend for both organisations to financial balance.

There are increasing challenges for the Health and Social Care economy within Halton to be able to continue to respond effectively to people's needs and provide high quality services, within limited and reducing resources. Therefore there is a need to examine how things can be done differently to not only ensure value for money, but ensure that they are affordable.

Both NHS Halton CCG and the Council are committed to further developing its integrated approach to service delivery and transformation to improve the Health and Well-Being of Halton residents. Although already working towards operating as a system, there does continue to be barriers to fully realising the benefits of a truly integrated approach, and as a result some of the improved outcomes for users of services in Halton and opportunities to deliver value for money are being missed.

The rationale for this project includes:

- Closer working relationships will deliver positive health and social care outcomes for individuals within Halton;
- Secure efficiencies and drive service improvement;
- Opportunities to look beyond traditional boundaries and assess ways of doing things differently;
- Opportunities to jointly influence the future shape of health and social care within Halton;
- Move away from a reactive, unplanned and episodic approach to care and deliver integrated long term care;
- Identify further opportunities for pooling resources;
- Promote independence, empower users and allow them to take control of their lives; and

- Provide the most intensive care in the least intensive setting.

2.3 Project Scope

It should be noted that there is no single definition for integrated care, and the integration of services can take place in various forms and at different levels. For example, services may be integrated at the level of a local or regional population, for a particular care or age group, or at an individual level, or indeed may involve more than one of these approaches. However there is clear evidence that when it comes to delivering benefits, the integration of clinical teams and services is far more important that the integration of organisations; organisational integration in itself is no guarantee of improved outcomes.

With this and the overall aims of project, as outlined in paragraph 2.1, in mind, the project will focus on the bringing together of the functions outlined below under a single unit, with a single line management function. This new Integrated Commissioning Hub (ICH) would introduce a wider skill mix and play a key role in shaping, assessing and delivering innovative and untested business transformation solutions within a highly complex multi-stakeholder environment.

- Performance Management (to include analytical support)
- Commissioning/Commissioning Support
- Policy Support
- Customer Care (Complaints/Compliments)
- Contracting (to include all contracting arrangements i.e. secondary and primary care, residential and nursing etc.)
- Financial Management
- Quality Assurance

Note: The Staffing budget associated with the Teams outlined above across HBC Adult Social Care and NHS Halton CCG will be incorporated into the current pooled budget arrangements at the appropriate time.

2.4 Project Priority

Due to the complexities involved the development if the ICH, its development will be progressed in two phases as outlined below:-

2.4.1 Phase 1

The first phase will require HBC Adult Social Care to redesign its existing teams; this would enable HBC to align more closely to the NHS Halton CCG structures. Currently within Adult Services, there are two separate teams as outlined below:-

- Commissioning Team
- Policy and Performance Team

The work areas of these two teams often overlap, and at times operate in silos which results in fragmentation and duplication.

Within the existing structure there is the additional complexity of how it is best to incorporate operational/professional input into the commissioning model. Therefore Phase 1 of the Project would also include the identification of an Executive, Clinical and Practice Leads for each work area from across Adult Social Care and NHS Halton CCG e.g. Urgent Care, Learning Disabilities, Older People etc. dependent on their skills and expertise.

It has been identified that additional support is provided to NHS Halton CCG by the Commissioning Support Unit and from HBC Corporate Services to support the pooled budget arrangements etc. such as Finance and Procurement Services and as part of this Project work will need to be undertaken to identify this support with a view to determining whether there are any areas of duplication and make recommendations to the appropriate Boards to either resolve these issues of duplication or whether the support should be aligned into the new ICH.

Finally as part of Phase 1, a review of the financial management support to the pool budget/joint working arrangements across HBC and NHS Halton CCG will take place. The introduction of further joint/integrated working arrangements will result in an extension to the current pooled budget arrangements and as a result the pooled budget will need to be managed robustly. As outlined in paragraph 3.6 of this document, 'Known Risks', financial fragility has been identified as a risk across both HBC and NHS Halton CCG and ensuring that appropriate financial management processes are in place will be key.

Phase 1 of the project will be completed by the end of May 2016.

2.4.2 Phase 2

Phase Two of the Project will be the full development of the ICH, whereby we would align the HBC Adult Social Care and NHS Halton CCG teams, to function under a network management approach.

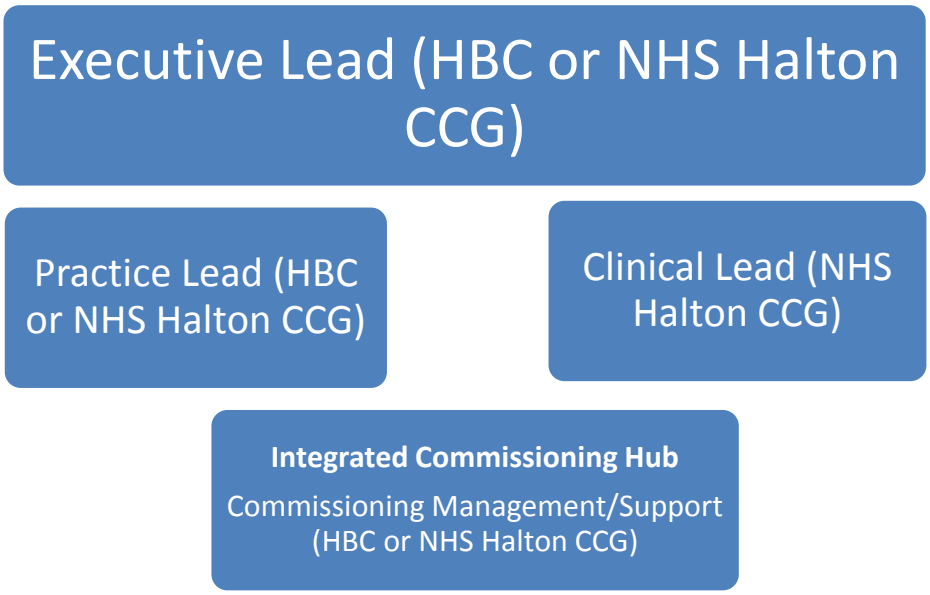
NOTE: As each Commissioning area will have an Executive Lead and support staff employed from either HBC or NHS Halton CCG, there will be no clear hierarchy at which the Executive Lead is 'at the top' whom staff are formally accountable to. Therefore the role of the Executive Lead for each area will be to bring staff together from across both organisations in order to achieve an agreed consensus in respect to developing, implementing and monitoring actions/work associated with Halton's Health and Adult Social Care Commissioning intentions.

The ICH team members will operate within specified commissioning areas, for example Learning Disability, Urgent Care and Older People.

As outlined above in paragraph 2.4.1, each commissioning area will have an identified:-

- Executive Lead (which would be Director Level from either HBC or NHS Halton CCG);
- Clinical Lead; and
- Practice Lead (which would be either at Divisional Manager, HBC or Head of Service, NHS Halton CCG level)

and be provided with identified support from within the ICH, thus ensuring a whole system/multiagency approach to commissioning; see below:-



The Commissioning Management/Support provided via the ICH to each commissioning area could potentially consist of performance management, policy support, contracting support or quality assurance etc., dependent on the nature of the commissioning area being supported; potentially any or all of those areas identified within paragraph 2.3 of this document.

3. What will the Project Deliver?

3.1 Project Deliverables

In summary, the project deliverables will include:-

- Redesign of HBC Adult Social Care Teams (as outlined in paragraph 2.4.1);
- Development of a single ICH;
- Identified Executive, Practice and Clinical leads for each commissioning area;
- Identified Commissioning/Management support for each commissioning area;
- Agreed network management approach across HBC Adult Social Care and NHS Halton CCG;
- Agreed Integrated Commissioning Plan for Halton Adult Health & Social Care;
- Review and revision of associated Governance Arrangements across HBC Adult Social Care and NHS Halton CCG; and
- Revision of Joint Working Agreement and associated pooled budget arrangements.

3.2 Outcomes

A number of positive outcomes/outputs will be achieved across the Health and Adult Social Care system as a result of this project including:-

- A joint market position statement - There is the potential to manage the market more effectively, utilising more robust procurement processes in order to manage/contain the general increase in costs;
- Ensure value for money contract prices, to ensure quality provision and that adults are appropriately safeguarded;
- An integrated commissioning plan for Halton Adult Services;
- Delivering high quality care closer to home;
- Reduce the need for unnecessary hospital admission and readmission;
- Ensure the appropriate use of crisis intervention and short term support to promote independence;
- Promote the use of a range of technologies to support independence and the management of risk;
- Ensure the proportion of placements in long term residential care are maintained at an appropriate level;
- Realise placements in Borough with Out of Borough placements being the exception;
- Improve the quality of care in the community and residential placements;
- Identify other opportunities for external partnership/integrated working arrangements; and
- Identify further opportunities to pool additional funding.

3.3 Other Related Work

Children's services will continue to progress with joint commissioning objectives through the Children's Trust.

In addition HBC and NHS Halton CCG are currently reviewing its approach to Transition across Health and Social Care; this work will continue and the outcome will be aligned into the overall integrated approach to service commissioning and delivery undertaken at the appropriate time.

Although the focus of this project is on Adult Services, the Integration – Joint Steering Group will ensure that where there are opportunities for further integration/alignment with Public Health then these will be activity explored. This is supported by the inclusion of the Director of Public Health onto the Integration – Joint Steering Group.

3.4 Constraints

At present known constraints that have the potential to impact on this project are:-

- Financial constraints for both NHS Halton CCG and HBC; and
- Changing landscape of the national agenda in respect of Health and Social Care

As such, the Integration – Joint Steering Group will ensure that the impact of these areas on the project is regularly assessed and appropriate action taken.

3.5 Assumptions

As the Health and Social Care economy/landscape can change quite rapidly from a local, regional and national perspective it is accepted that the project scope will have to be kept under review to ensure its appropriateness remains.

It is accepted that the quality and safeguarding of both Health and Social Care services that are commissioned run throughout the areas of work that fall within the scope of this project and we will use the existing governance arrangements in place to ensure that this is maintained.

3.6 Known Risks

An initial risk analysis has been completed on the Project and is outlined below. Any risks associated with the Project will be managed via the Project Board.

Identified Risk	**Overall Risk Score**	**Mitigating Actions**
Improvements in the overall pathways and quality of care services will not be realised.	8	Our integrated commissioning process will ensure full engagement and leadership from both clinical and practitioner leads. Performance will be managed within existing governance arrangements
The introduction of the Care Act 2014 and other policy directives will have implications in the cost of care provision, partnership working, policies and procedures and skilled and informed workforce.	8	Ensure formal links across this work stream and the Care Act Strategic Group, including regional work streams across North West ADASS.
Financial fragility because of the	10	Work on-going to forecast financial situation and

ongoing efficiencies across both HBC and the NHS Halton CCG could result in objectives not being achieved.		continue to identify efficiencies across both organisations.
The required cultural change in the workforce across HBC and NHS Halton CCG does not take place due to unwillingness or inability to work across organisations could result in staff feeling isolated, anxious and worried which may result in a reduction in job performance.	6	Building trust through effective communication, shared values, equal opportunities and effective leadership is crucial to the successful development of integrated teams.
Shifting of resources to fund new joint interventions and schemes may de-stabilise the current service providers, particularly in the acute sector.	8	Our current plans are based on the strategies we have in place covering all service areas and linking in to the priorities of the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment. Providers are on Boards and contribute to decision-making.
Operational pressures may restrict the ability of our workforce to deliver the required changes.	6	Organisational development is an important factor in the successful delivery of health and adult social care outlined in our plans. On-going evaluation of teams and skill mix will ensure the infrastructure and capacity to deliver.
If we do not manage Communication carefully there is a risk that staff, public and stakeholders do not know what is happening, why and when. Relationships may suffer and have a negative effect on the implementation.	6	• Joint Local Authority and NHS HCCG management team meetings to take place on a bi-monthly basis communicating the vision and plans for the future and involving staff at the outset. • Engagement plan set to include all relevant providers and acute trusts • Communication and media tools will be identified to ensure the public are fully aware and involved in all aspects of integration.
Failure with Information Governance, including informed consent to share information across HBC and the NHS Halton CCG would undermine potential IT solutions.	6	• Regularly monitor this project to ensure it is on track and report progress to the BCB.
Regional developments which may impact on Halton's Health and Adult Social Care integration agenda for example Mental Health Services (5 Boroughs Partnership),	8	• Appropriate leadership at necessary Boards/Groups. • Ensuring Halton's Health and Social Care system is appropriately aligned to take advantage of opportunities which may

devolution etc.		present themselves as part of any regional developments.

4. Project Organisation

4.1 Project Sponsor

The Project Sponsors are: David Parr, Chief Executive – HBC and Simon Banks, Chief Officer – NHS Halton CCG

4.2 Senior Responsible Officer

The Senior Responsible Officer is: Sue Wallace Bonner, Director of Adult Social Services - HBC

4.3 Project Manager

The Project Manager is: Louise Wilson, Development Manager, Urgent & Integrated Care -HBC

4.4 Governance Arrangements

A Project Board has been established to take forward this Project; called the 'Integration – Joint Steering Group' this Project Board is chaired by Sue Wallace Bonner, Director of Adult Social Services, HBC.

Membership of the Board is as follows:-

- Paul McWade, Operational Director, HBC
- Dave Sweeney, Director of Transformation, HBC & NHS Halton CCG
- Jan Snoddon, Chief Nurse, NHS Halton CCG
- Leigh Thompson, Director of Service Delivery, NHS Halton CCG
- Eileen O'Meara, Director of Public Health, HBC

Support to the Board will be provided by Louise Wilson, Development Manager, Urgent & Integrated Care, HBC.

The Project Board will met on a monthly basis and report progress through to Chief Officers Management Team – HBC and Executive Management Team – NHS Halton CCG on an ongoing basis.

NOTE: Reports on progress will also be presented to the Better Care Board at appropriate times, for onward reporting through to the Halton Health & Wellbeing Board and NHS Halton CCG Governing Body.

4.5 Approach to be Taken

Using a project management approach, the following is proposed:-

- An overarching Action/Project Plan to be developed for Project to ensure progress is effectively monitored.
- As part of development appropriate staff communication processes will be established.
- NHS Halton CCG and HBC Commissioning Intentions for 2016/17 will be aligned.
- **Phase 1**
  - Redesign of existing Adult Services teams to be managed via HBC Adult Senior Management Team

- Managed via the Integration – Joint Steering Group:-
  - Identification of Executive, Clinical and Practice Leads;
  - Scoping of Commissioning Support Unit support to NHS Halton CCG and the HBC Corporate support to the pooled budget; and
  - Review financial management support to the pool budget/joint working arrangements.

- **Phase 2**
  - Identified Executive Leads to identify their 'Commissioning Teams' and then establish Task and Finish Groups to develop network management approach for each commissioning area; Integration – Joint Steering Group to ensure consistency of approach.
  - Integration – Joint Steering Group will develop the structure for the ICH, with a single line management function.

REPORT TO: Health and Wellbeing Board

DATE: 12 October 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: Transforming Domiciliary Care

WARD(S): Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present the Board with the proposed developments in relation to Domiciliary Care delivered through Halton Borough Council.

2.0 RECOMMENDED: That the Board agree the contents of the report.

3.0 SUPPORTING INFORMATION

3.1 Current picture.

In Halton there are currently 9 providers who work in four different zones as agreed through the last tender process carried out in 2014. Some of the providers receive a block of hours and some are part of a spot purchase framework agreement. The providers support a total of 736 people and deliver in excess of 350,000 hours of care per year with an annual expenditure of more than £4.3million.

3.2 The amount of care and the overall expenditure is set to rise over the coming years at an estimated rate of between 2-3% per year and although there are some excellent examples of high level care within the sector, it is clear that we will need to make improvements to meet the needs of an ageing population in the coming years.

3.3 We have already commenced with reviewing the current domiciliary care sector in the borough. This has led to understanding the key principles that are at the heart of an outcome based domiciliary care service, these include:

- Moving away from a one size fits all approach
- Adopting a preventative model
- Keep people independent
- Improve quality of life
- Increase community participation
- Improve Health and Wellbeing

3.4 Consultation:

As part of the review we have carried out a significant amount of

engagement with people who use the service and carers. The views expressed were as follows:

- Services can be too time and tasked focused opposed to providing quality and interaction
- Restrictive role of some carers “that is not my job”
- Carers are not recognised for the role they do
- Professional barriers are put in place by services and agencies who should be working together
- Carers play a crucial part in safety – they need to be better equipped in identifying risks as well as understanding social isolation.
- Unsatisfactory assessment process – not always face-to-face, social worker may have limited contact with an individual and not always have an ongoing process in place
- Lack of continuity with care teams
- Need more access to preventative support and services
- Assessments and care plans need to identify possible solutions to help people improve their outcomes
- Increased knowledge of domiciliary care providers on the support and services available and how to access them
- More flexibility
- Emergency response

We have also had the initial meeting with providers, the voluntary sector, social work teams, GPs and CCG colleagues.

3.5 **The new model of care**

It is clear from the feedback that we have already collected that there is a need for change, too many pressures on times, limited capacity, poor recruitment, financial pressures, waiting lists. It is also clear that when we start to consider “the ideal” that people would like to see; then we have challenges on just how practical it will be to deliver. To help we have set out five broad groups that can define need:

1. Prevention and promotion – large number of the population who remain healthy and can access information to continue to support their health and wellbeing
2. Limited need / community participation – people who need some form of low-level support, but this can often be delivered through volunteer or community organisations
3. Service users with personal care needs – people who still have some independence, but have traditional personal care needs that need to be addressed
4. Service users with higher / long term care needs – people currently supported by domiciliary care providers but who have complex or specialist needs

5. Reablement – people who require an intensive short-term intervention that will help them to achieve a specific outcome.

By using these broad groups we can start to map the numbers and also the financial burden in these areas. Therefore if we consider groups 3 and 4 we know that these two groups support 376 people as a total, we have also concluded that 42% of these people fall into group 4 and have complex needs, whilst 58% of people are in group 3.

3.6 **Opportunities for new ways of working**

In 2015 The National Lottery opened up a new funding initiative aimed at Local Authorities developing changes within existing service provision to realise significant improvements in outcomes, both for an individual and financial for health and social care. The fund that was established was not a traditional grant funding pot, but was being offered through a Social Impact Bond (SIB).

The application was in three stages:
Stage 1 – Expression of Interest
Stage 2 – Application for development grant funding (up to £50,000)
Stage 3 – Full application for Social Impact Bond (up to £1,000,000)

So far we have been successful at stage 1 and stage 2 and we will submit the full application on September 22nd 2016.

3.7 **What is a Social Impact Bond?**

Social Impact Bonds are a new concept in public service delivery. National research suggests that they have many benefits, including bringing additional investment into public services, encouraging more innovative service delivery and creating a better contract management. However, they can also be complex and challenging to establish and implement.

A Social Impact Bond is essentially a type of payment by results (PbR) contract. Like other Payment by Results, a commissioner (usually one or more public sector bodies) agrees to pay for outcomes delivered by service providers, and unless those outcomes are achieved, the commissioner doesn't pay. Where a SIB differs from PbR is that the providers do not use their own money to fund their services until they get paid – instead, money is raised from so-called 'social investors' who get a return if the outcomes are achieved. Usually the providers get paid up front by a third party body who holds the contract, rather than holding the contract directly.

4.0 POLICY IMPLICATIONS

There are significant changes that will need to happen in relation to full implementation, however the design, action plans and overall implementation plan will be completed as part of the National Lottery funding

application and will be available from July 2016.

5.0 FINANCIAL/ RESOURCE IMPLICATIONS

None identified through this report

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

There are no implications for this priority.

6.2 Employment, Learning & Skills in Halton

There are no implications for this priority.

6.3 A Healthy Halton

The 736 people who are supported through Domiciliary Care are an important part of the overall Health and Social Care landscape. They account for a significant amount of the budget and capacity continues to be stretched. Any changes in this area will impact internally, but will also have an impact on the care that individuals receive. This must be managed sensitively and safely for each person.

6.4 A Safer Halton

There are no implications for this priority.

6.5 Halton's Urban Renewal

There are no implications for this priority.

7.0 RISK ANALYSIS

None identified.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no implications for this priority.

REPORT TO:	**Health and Wellbeing Board**
DATE:	**12th October 2016**
REPORTING OFFICER:	**Director of Public Health**
PORTFOLIO:	**Health and Wellbeing**
SUBJECT:	**Prospective Health and Wellbeing Needs Assessment for the Syrian Refugee Resettlement Programme**
WARDS:	**Borough-wide**

1.0 PURPOSE OF THE REPORT

1.1 To inform of the Health and Wellbeing Board of the findings and recommendations of a Prospective Health and Wellbeing Needs Assessment for the Syrian Refugee Resettlement Programme.

1.2 This report does not encompass initial accommodation for Asylum Seekers, widening Asylum Seeker Dispersal or Unaccompanied Minors as these as different processes, although Health and Wellbeing Needs may overlap.

1.3 Further information about Refugees, Asylum Seekers and a planning application for change of use of Lilycross Care Centre can be found at: -
http://www3.halton.gov.uk/Pages/councildemocracy/refugees.aspx
http://www3.halton.gov.uk/Pages/councildemocracy/pdfs/LilycrossHouseFAQs.pdf

2.0 RECOMMENDATIONS: That the Board

1. **note the report; and**

2. **Support the recommendations in Section 3.3**

3.0 SUPPORTING INFORMATION

3.1 Background

The UK Government has committed to resettling 20,000 Syrian refugees over the next five years. The Syrian refugees will be part of the Vulnerable Persons Resettlement Programme and have 5 years humanitarian protection.
Across the North West, local authorities including Halton Borough Council have committed to supporting the Syrian Refugee Resettlement Programme. Liverpool City Council is co-ordinating the resettlement programme of 510 refugees on behalf of other local authorities in Merseyside. It is expected that Halton will host 100 of these refugees. However, it is unknown what the family/individual profiles and needs are. The Local Authority will deliver housing provision, initial reception arrangements, casework and orientation support with English for Speakers of Other Languages classes, in line with Central Government's 'Statement Of Requirements'.

A multi-agency forum has been established with stakeholders in Halton to assess, plan and implement local delivery for the Syrian Resettlement Programme.

3.2 Key Issues from the Prospective Health and Wellbeing Needs Assessment

Syrian Refugees health and wellbeing needs will be influenced by four discrete phases of the refugee experience Pre-Flight, Flight, Temporary Settlement, Resettlement. It is anticipated that Syrian Refugees entering the UK through the resettlement programme will be the most vulnerable men, women and children, with complex health and wellbeing needs, based on the United Nations High Commissioner for Refugees criteria for resettlement eligibility.
Housing, Health, Education and Employment are identified as major critical factors in the resettlement. Integration and access to state and voluntary agencies upon resettlement can be aided or impeded by language, reciprocal cultural knowledge, social connections, safety and stability.

3.3 Recommendations

Consider Migration Yorkshire Guide and Checklists for Syrian Resettlement and discuss implementation design and plan within a Halton context

3.3.1 Housing

- Consider the availability and location of housing for Syrian refugee resettlement within Halton with a focus on safety and stability and access to facilities

3.3.2 Health

- Consider the availability and location of primary and dental care for Syrian refugees within Halton
- Identify ‘best practice model’ for primary care uptake, registration and assessment (tool) with Clinical Commissioning Group, NHS England and Public Health England
- Ascertain interpreting services and capacity, plus ensure translation policy is in place and communicated
- Establish training needs of health professionals in migrant health, refugee health needs, culture and working with interpreters
- Identify capacity and referral pathways for secondary, maternity, mental health and other specialist services
- Discuss potential social care needs, capacity and referral pathways

3.3.3 Education and Training

- Consider the availability, capacity and location of early years, primary and secondary education for Syrian refugees within Halton considering ‘catch-up’ support, English for Speakers of Other Languages (ESOL) and health and wellbeing school support.
- Discuss education opportunities for work experience, vocational training or professional registration for Syrian refugees within Halton
- Develop communications strategy with education stakeholders to ensure community cohesion within Halton

3.3.4 Employment

- Consider the skilled/unskilled employment opportunities within Halton with local/regional stakeholders
- Consider the skilled/unskilled work experience opportunities within Halton with local/regional stakeholders
- Identify processes for professional registration validation and work experience with local/regional/national stakeholders

3.3.5 Language, Culture and Social Connections

- Ascertain interpreting services and capacity (Housing, Health, Education and Employment) and implement translation policy
- Identify local and regional community/religious/black minority ethinic organisations to support integration and access to services
- Develop communications strategy for local host community to facilitate social connections and support cohesion
- Ensure individual integration plans are developed for Syrian Resettlement Refugees to facilitate social connections with host community, groups and services

4.0 POLICY IMPLICATIONS

The Syrian Refugee Resettlement Programme does not relate to a Council policy but is part of the UK response to a global humanitarian crisis.

5.0 FINANCIAL IMPLICATIONS

Local authorities will receive 12 months of a refugee's resettlement costs through Central Government for orientation support and education costs for the first year from arrival (providing £8,520 per person in year 1), with reducing support in years 2-5. Additional funding may be available for local authorities to support refugees beyond their first year in the UK. Clinical Commissioning Groups will receive funding for registration with primary care and dentists (£600 per person) and secondary care costs (£2,000 per person). Additional or exceptional, healthcare costs are to be considered on a case-by-case basis at a national level (Home Office, 2016). Health services commissioned by the Local Authority, for example school nursing, health visiting, sexual health services are not to receive additional funding.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

It is unknown how many Resettled Syrian Refugees will be children and young people. However, it is anticipated that Halton Borough Council services for children and young people including Early Years, Education, Health Visiting, School Nursing, etc will be utilised.

6.2 Employment, Learning and Skills in Halton

It is not known what the employment and skills background of Resettled Syrian

Refugees will be. However, it is anticipated that there will be a need for courses in English for Speakers of Other Languages (ESOL) and professional revalidation.

6.3 A Healthy Halton

Discussions with Halton CCG are already taking place through the Multi-Agency Forum. Liverpool City Region has formed a Health Group with Public Health in Local Authorities, Clinical Commissioning Groups, NHS England and Public Health England. It will be necessary to ensure close co-ordination between all health providers with clear standards of practice and referral pathways. Public Health England North West has developed a Migrant Health Primary Care Checklist and will provide training to practices in November.

6.4 A Safer Halton

Resettlement of refugees has the potential to increase community tension in the Borough. Nationally this issue has been used by a number of far right extremist groups to stir up racial hatred and community tensions. Discussions with Cheshire Police are already taking place through the Multi-Agency Forum. Housing allocations will be undertaken with the Police. It will be necessary to ensure close co-ordination between agencies and a clear communications strategy.

6.5 Halton's Urban Renewal

None

7.0 RISK ANALYSIS

Based on the low numbers of Syrian Refugees to be resettled in Halton, the risk is anticipated as low.

8.0 EQUALITY AND DIVERSITY ISSUES

The Equality Act 2010 protects everyone in the UK and imposes duties on public authorities that apply to Resettled Syrian Refugees

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None

Refugees – Syrian Resettlement Programme - Prospective Health and Wellbeing Needs Assessment

Halton Borough Council

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Figures and Tables

A) Background

Since 2011, Syria has experienced significant conflict, with large numbers of civilians killed, injured and displaced. The United Nations High Commissioner for Refugees (UNHCR) has documented almost five million Syrian refugees within camps located in Turkey, Egypt, Iraq, Jordan and Lebanon (UNHCR, 2016).

In autumn 2015, the UK Government announced the intention to resettle up to vulnerable 20,000 refugees from the Syrian region over the next five years.

The UNHCR identifies and assesses people in need of resettlement based on the specific criteria: - women and girls at risk; survivors of violence and/or torture; refugees with legal and/or physical protection needs; refugees with medical needs or disabilities; children and adolescents at risk; persons at risk due to their sexual orientation or gender identity; and refugees with family links in resettlement countries. The UK Home Office reviews the eligibility and medical and security checks are undertaken prior to acceptance. The International Organisation for Migration forward resettlement applications to Local Authorities who will be asked to accept or reject based on needs and local capacity (Home Office, 2015).

Refugees arriving in the UK under the Syrian Resettlement Programme will be granted humanitarian protection allowing leave to remain for five years with full access to employment, public funds and rights to family reunion. After five years, eligibility to apply for settlement in the UK will be assessed (Home Office, 2015). Local authorities will receive 12 months of a refugee's resettlement costs through Central Government. Central Government has indicated a further £130 million is available for local authorities to support refugees beyond their first year in the UK. Clinical Commissioning Groups can claim back allocated funding for registration with health professionals and initial primary care costs (at a cost of £600 per person) and some initial secondary care costs (at a cost of £2,000 per person). Additional or exceptional, healthcare costs are to be considered on a case-by-case basis at a national level (Home Office, 2016). Health services commissioned by the Local Authority, for example school nursing, health visiting, sexual health services are not to receive additional funding.

Across the North West, local authorities including Halton Borough Council have committed to supporting the Syrian Refugee Resettlement Programme. Liverpool City Council is co-ordinating the resettlement programme on behalf of other local authorities in Merseyside. It is expected that Halton will host 100 of these refugees. However, it is unknown what the family/individual profiles and needs are.

In April 2016, the Public Health team within Halton Borough Council proposed undertaking a Health and Wellbeing Needs Assessment (HNA) to: -

- Identify the potential needs of Refugees within the Syrian Resettlement Programme
- Identify strengths and gaps with local stakeholders
- Inform local multi-agency forum's strategic plan and development of services

Engagement and consultation was undertaken with the Regional Strategic Migration Partnership, Public Health England, Halton CCG and experienced third sector organisations within Liverpool.

B) Syrian Refugees Health and Wellbeing Needs

Refugees are not a homogenous group; therefore their health and wellbeing needs also vary considerably. The Dahlgren & Whitehead (1991) model considers the main determinants of health encompassing age, sex and constitutional factors, lifestyle, social and community networks, living and working conditions and general socio-economic, cultural and environmental conditions (Figure 1).

Figure 1: Main Determinants of Health and Wellbeing

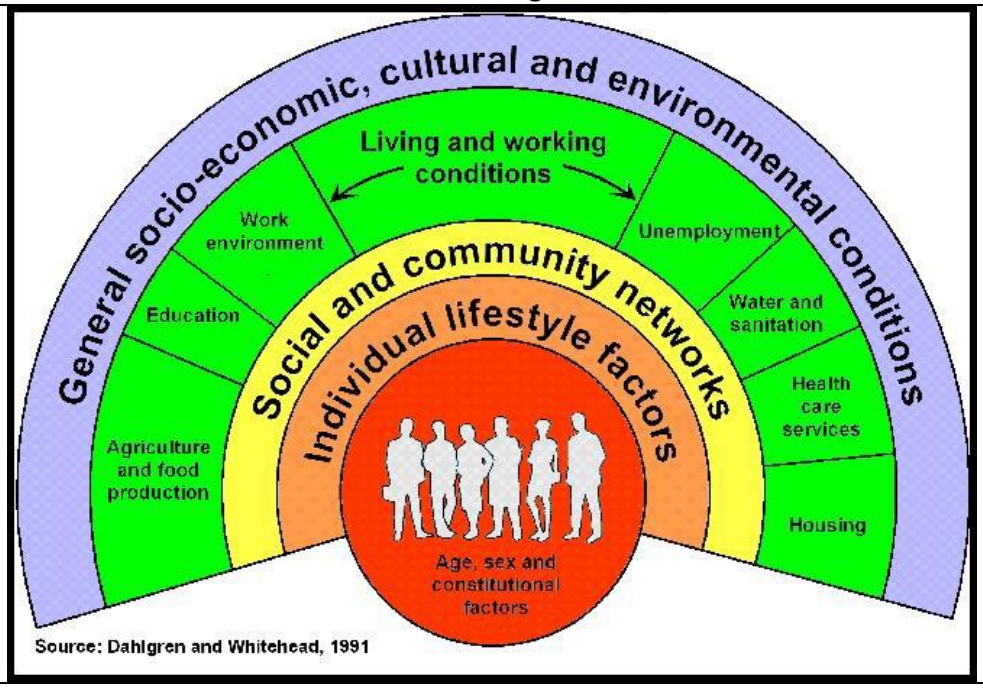

Figure 1 sourced from Dahlgren, G. & Whitehead, M. (1991) *Policies and strategies to promote social equity in health. Background document to WHO – strategy paper for Europe*. Stockholm: Institute for Futures Studies [Online]. Available from: http://whqlibdoc.who.int/euro/-1993/EUR_ICP_RPD414(2).pdf

Refugees' health and wellbeing needs are similar to that of the general population where they settle, influenced by age, gender, ethnicity, and socio-economic circumstances (HPA, 2012, Ingleby, 2009). However, some specific needs may arise depending on ethnicity or country of origin and reasons for migration.

Ager (1999) outlines four discrete phases of the refugee experience which impact on a Refugees' Health and Wellbeing Needs; **Pre-Flight, Flight, Temporary Settlement, Resettlement or Repatriation.** These phases are considered in the context of Syrian resettlement below, repatriation will not be discussed within this paper.

1. **Pre-Flight**

Prior to conflict, Syria's health indicator profile was positively improving leading causes of mortality were related to non-communicable disease and 90% of the population had access to primary health care institutions (WHO, 2009). The WHO (2015) estimates 13.5 million people affected by the Syrian conflict, 6.5 million people displaced within Syria, more than 4.3 million refugees, 1 million people injured and more than 250,000 deaths. Conflict impacts peoples' health and wellbeing through financial hardship, social disruption, oppression, physical and mental trauma. The WHO (WHO, 2016) has highlighted key health issues within Syria including: -

- Loss of health workers
- Access to public hospitals and primary health centres – maternity and long term conditions
- Production and cost of pharmaceuticals
- Lack of basic utilities including electricity, fuel, safe drinking water and sanitation;
- Increased gastrointestinal disease outbreaks
- Increase in vaccine preventable diseases
- Severe mental illness and risk of developing mental health disorders
- Traumatic injury and disability

2. Flight

Extreme factors will "push" people to leave their home, internally within Syria or crossing borders. This may involve separation from family, travelling long hazardous journeys and include experiences of physical and mental trauma. All of which will have a potential impact on refugees' health and wellbeing.

3. Temporary Settlement

Refugees from Syria are being hosted in refugee camps in Turkey, Egypt, Iraq, Jordan and Lebanon. UNHCR (2016) and other agencies have highlighted key health and wellbeing issues within refugee camps hosting Syrian refugees including: -

- Management of non-communicable disease (Hypertension, Diabetes, Asthma)
- Communicable disease outbreaks (Gastro-intestinal illness, TB, Polio, Leishmaniosis, Measles)
- Vaccination coverage
- Disability
- Nutrition
- Mental health
- Maternal Health
- Gender-based Violence
- Education and Vocational Training

These key issues are likely to influence and impact current and future health and wellbeing needs of refugees.

4. Resettlement

The Local Authority will deliver housing provision, initial reception arrangements, casework and orientation support with English for Speakers of Other Languages classes, in line with Central Government's 'Statement of Requirements' (Home Office, 2016). The Home Office (2004) previously commissioned the 'Indicators of Integration study' which considered the factors of refugee integration within the UK. Subsequently, an evidence-based conceptual framework (Figure 2) defining 10 core domains of integration was further developed by the researchers Ager and Strang (2008).

Figure 2: A Conceptual Framework Defining Core Domains of Integration (2004)

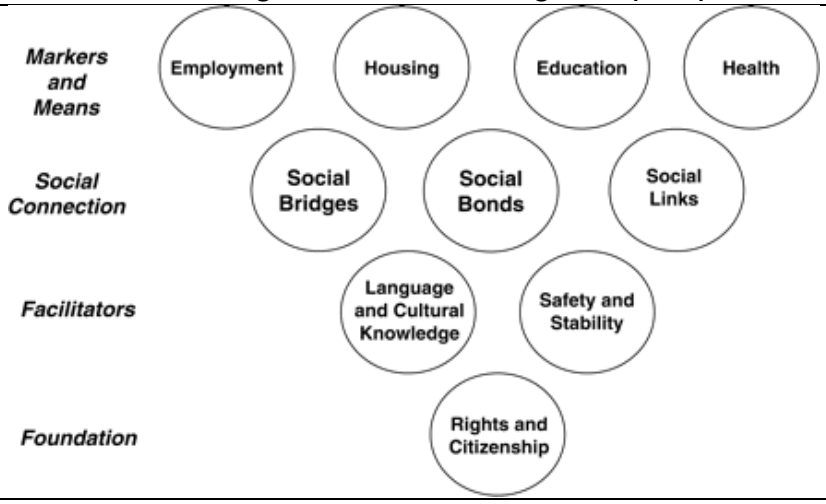

Figure sourced from Home Office (2004) Indicators of Integration final report
http://webarchive.nationalarchives.gov.uk/20110218135832/http:/rds.homeoffice.gov.uk/rds/pdfs04/dpr28.pdf

Housing, Health, Education and Employment are recognised as major critical factors in the integration (Home Office, 2004). Integration and access to state and voluntary agencies upon resettlement can be aided or impeded by language, reciprocal cultural knowledge, social connections, safety and stability.

Migration Yorkshire (2016) recently developed a comprehensive guide and checklists for Syrian Resettlement. Within Bradford, Syrian Refugees have already resettled through a holistic 'best practice model' (Horton Housing, 2015). This model has been utilised within local authority areas already resettling refugees from Syria.

Recommendation: - Review Migration Yorkshire Guide for Syrian Resettlement and discuss implementation design and plan within a Halton context

Housing

Housing impacts security and stability, opportunities for social connection, and access to healthcare, education and employment (Home Office, 2004). The ICMC Europe & UK North West Gateway Resettlement Partnership (2014) produced 'A Good Practice Guide for Housing in Refugee Resettlement'.

Recommendation: - Consider the availability and location of housing for Syrian refugee resettlement within Halton with a focus on safety and stability and access to facilities

Health

Refugees' health and wellbeing upon resettlement is essentially determined by the availability, accessibility, acceptability and quality of health and public services (Davies et al., 2010, Arai, 2005). Health and wellbeing may decline following resettlement due to acculturation, wider determinants of health and inequalities common with other Black and Minority Ethnic (BME) groups in the UK (Jayaweera, 2010, Davies et al., 2006, Kelly at al., 2005).

It is anticipated that resettled Syrian Refugees will be the most vulnerable men, women and children, with complex health and wellbeing needs, based on the UNHCR criteria for assessment. Medical assessments (Appendix A) will be undertaken by the International Organisation for Migration prior to resettlement; however un-identified needs may arise upon arrival in the UK. The International Organisation for Migration is unable to share a synthesis of resettled refugees health needs. As previously highlighted, health and wellbeing of individuals in the context of four phases of the refugee experience will need to be anticipated and assessed upon resettlement. Informal feedback from areas already resettling Syrian Refugees, indicate that mental health and dental health are prominent needs.

Recommendation: - Consider the availability and location of primary and dental care for Syrian refugees within Halton

Recommendation: - Identify 'best practice model' for primary care uptake, registration and assessment (tool) with Clinical Commissioning Group, NHS England and Public Health England

Recommendation: - Ascertain interpreting services and capacity, plus ensure translation policy is in place and communicated

Recommendation: - Establish training needs of health professionals in migrant health, refugee health needs, culture and working with interpreters

Recommendation: - Identify capacity and referral pathways for secondary, maternity, mental health and other specialist services

Recommendation: - Discuss potential social care needs, capacity and referral pathways

Education

Education creates significant opportunities for employment, for wider social connection and language learning. (Home Office, 2004).

Education system within Syria has been disrupted due to the conflict and opportunities within the refugee camps limited. Children and young people will need additional support to learn with consideration to language, culture, health and wellbeing needs (Mitchell, 2015).

Recommendation: - Consider the availability, capacity and location of early years, primary and secondary education for Syrian refugees within Halton considering 'catch-up' support, ESOL and health and wellbeing support.

Recommendation: - Discuss education opportunities for work experience, vocational training or professional registration for Syrian refugees within Halton

Recommendation: - Develop communications strategy with education stakeholders to ensure community cohesion within Halton

Employment

Resettled Syrian refugees will be eligible to work in the UK. Consideration will need to be given to individuals' skills, health and wellbeing, availability of employment, work experience and further training. Refugees with professional qualifications may need to undertake validation training and work experience in the UK. Employment is valuable in refugees (re)establishing valued social roles, developing language and broader cultural competence and establishing social connections (Home Office, 2004).

Recommendation: - Consider the skilled/unskilled employment opportunities within Halton with local/regional stakeholders

Recommendation: - Consider the skilled/unskilled work experience opportunities within Halton with local/regional stakeholders

Recommendation: - Identify processes for professional registration validation and work experience with local/regional/national stakeholders

Language, Culture and Social Connections

Historically, the Halton population has been largely white British, with only a small proportion of the population identified as being from a BME group (2.2% - 2011 census). The majority of the Halton population speak English and report Christianity as their religion.

In comparison to other local authority areas in the North West, Halton has no history of asylum seeker/refugees dispersal but has experienced small numbers of other migrant groups such as overseas students and European migrants. Resettlement of refugees has the potential to increase community tension in the Borough. Nationally, this issue has been used by a number of far right extremist groups to stir up racial hatred and community tensions.

Language is cross-cutting across all domains – Housing, Health, Education and Employment – aiding or impeding access to state and voluntary agencies and integration. Language is foreseen as a potential need for additional interpreting services, resources and education. Arabic is the predominant official language within Syria. However, there are other languages and spoken therefore identifying preferred language will be important prior to requesting interpreting services. English has historically been taught within Syrian education system. However, proficiency of English language when communicating complex information (eg. health information) should not be assumed.

Syria is a multi-faith country. It is anticipated that some resettled Syrian refugees may be Muslim. However, there is no mosque or supplier of halal food products within Halton. Mosques located near Halton are within Liverpool and Warrington, therefore access will require consideration.

Re-settled Syrian refugees integration can be supported by sharing cultural information about Halton and the UK, including customs/expectations, practical information and signposting (e.g. regarding transport, utilities, benefits etc.)

Establishing cross-cultural awareness and opportunities for social connection to support integration and cohesion between the host communities and refugee populations will be important.

Recommendation: - Ascertain interpreting services and capacity (Housing, Health, Education and Employment) and ensure translation policy communicated

Recommendation: - Identify local and regional community/religious/BME organisations to support integration and access to services

Recommendation: - Develop communications strategy for local host community to facilitate social connections and support cohesion

Recommendation: - Ensure individual integration plans are developed for Syrian Resettlement Refugees to facilitate social connections with host community, groups and services

C. Halton Local Authority Area - Syrian Resettlement Programme

In April 2015, a multi-agency forum was established with stakeholders in Halton to assess, plan and implement local delivery for the Syrian Resettlement Programme. Halton Borough Council Lead Officer and Partnership Officer attend the Liverpool City Region Co-ordination Meeting, which is chaired by Halton Borough Council Chief Executive. It will be necessary to ensure close co-ordination between all local authority areas with clear standards of practice and referral pathways.

Members of the multi-agency forum are outlined in the Box 1 below: -

Members of Multi-Agency Forum in Halton
Halton Borough Council • Chief Executive • Community Development Manager • Children and Young People • English as an Additional Language • Landlord Accreditation Officer • Lead Officer - Housing • Marketing and Communications • Partnership Officer • Public Health
British Red Cross
Cheshire Police
Department of Works and Pensions/Job Centre Plus
Halton & St Helens Voluntary & Community Action
Halton Clinical Commissioning Group
Halton Disability Partnership
Halton Housing Trust
Halton Umbrella Group
Private Landlord Representative and Letting Agents
Runcorn Churches Together
SHAP - BME Engagement
Together Liverpool

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Appendix A - International Organisation for Migration – Health Assessment Forms

	Migration Health Assessment ***WORKSHEET*** ***Form 04MH_A***	**1. Assessment Date:** **2. Program:** **3. Ref. ID No:**

4. Name :		
(Last)	***(First)***	***(Middle)***
5. Gender: F ☐ M ☐	**6. DOB:**	**7. Principal Applicant: No ☐ Yes ☐**
8. Case No.	**9. Country:**	**10. Nationality:**
11. Exam Place:	**12. Exam Country:**	**13. Doctor:**

14. Health Assessment completed on:

15. Medical Conditions Identified

☐ None	☐ Syphilis	☐ Physical impairment/disability
☐ TB, active, infectious	☐ Other sexually transmitted diseases	☐ Significant Mental health condition
☐ TB, active, non-infectious	☐ Human immunodeficiency virus	☐ Addiction(abuse) of specific substances
☐ TB, inactive		☐ Other significant condition, specify:

16. Description of significant condition / Treatment / Recommendation	**ICD Code(s)**
	Update

17. TREATMENT Administered: No ☐ Yes ☐ *(pls. provide details in Remarks above, or attach the "IOM treatment form")*

☐ **Syphilis**		☐ **Anti-malaria**		☐ **De-worming**	
Dates:	**Drugs/Dosage:**	**Dates:**	**Drugs/Dosage:**	**Dates:**	**Drugs/Dosage:**
1. 2. 3.		1. 2. 3.		1. 2. 3.	

18. VACCINES Administered: No ☐ Yes ☐

Dates:	**Vaccine:**	**Dates:**	**Vaccine:**	**Dates:**	**Vaccine:**
1.		4.		7.	
2.		5.		8.	
3.		6.		9.	

19. Travel Recommendations			**20. Pregnancy**	**No ☐ Yes ☐**
Fit to travel: Yes ☐ Conditionally ☐ No ☐			a)To travel Before:	
Special attention on pre-flight assessment: No ☐ Yes ☐			b) Not to travel before:	
Hospitalization required: Pre-depart. ☐ Post-arrival ☐				
21. Equipment / Medication			**22. Escorts**	**No ☐ Yes ☐**
☐ Ambulance	☐ Stretcher	☐ Bowel Prep.	☐ Med. Escort-POE	☐ Family escort
☐ WCHR	☐ 3 seats	☐ Diapers	☐ Med. Escort-FD	☐ Operational Escort
☐ WCHS	☐ Oxygen	☐ Urinary catheter	*Medical Escort By:*	☐ Other, specify:
☐ WCHC	☐ Interflight Th admin.	☐ Other	☐ Doctor ☐ Nurse	
23. Post-travel recommendations			**23.A Follow-up needed :**	**No ☐ Yes ☐**
Special schooling/employment needs ☐			By whom:	Within:
Consequences on daily living activities (Assistance Required) ☐			☐ by GP	☐ one week
Special housing requirements ☐			☐ by Specialist, specify:	☐ one month
Excessive demands for the health service ☐				☐ 6 months
Remarks/Details:				

Date:	**Examining physician's name address and telephone number (stamp may be used):**
Signature:	

Form 04MH_B *MEDICAL HISTORY&PHYSICAL EXAM*	**1. Assessment Date:**
	2. Program:

3. Name:	**4. Case No:**	**5. Date of Birth:**

Yes No	**1. Medical History**		
☐ ☐	Illness or injury requiring hospitalization	☐ ☐	Recurrent fever (last 6 months)
☐ ☐	Surgical interventions	☐ ☐	Coughing
☐ ☐	Heart disease or high blood pressure	☐ ☐	Loss of weight (last 6 months)
☐ ☐	Neurologic disease, incl. stroke or seizures	☐ ☐	Sexually transmitted diseases
☐ ☐	Mental illness/problems	☐ ☐	Skin problems (rash, etc…)
☐ ☐	Stomach or bowel disease (incl. recent diarrhea)	☐ ☐	Tatoos, body piercing
☐ ☐	Liver or kidney disease	☐ ☐	History of blood transfusions
☐ ☐	Diabetes or other endocrine disorder	☐ ☐	History of torture/violence
☐ ☐	Urogenital problems / conditions	☐ ☐	Displaced from home, number of months:
☐ ☐	Hematologic disease	☐ ☐	Are you taking medications, specify below
☐ ☐	Muscle, bone and joint problems	☐ ☐	Do you have any drug allergies?
☐ ☐	Problems with eyes or ears	☐ ☐	Smoking habits: Years: No/day:
☐ ☐	Cancer or tumors	☐ ☐	Alcohol habits: Years: Units/week:
☐ ☐	TB, pneumonia, or other lung disease	☐ ☐	Illicit drug use? Specify past or present, name of the drug(s), quantity, period, when stopped (if in the past), any treatment
☐ ☐	Household member with significant. inf. disease (or TB contact in general)		

2. Reproductive history *Number*			
Pregnancies:		LM Period :	
Deliveries:		Are you pregnant?	☐ No ☐ Do not know ☐Yes
Babies born alive:		Gestation (what week?):	

3. Physical Examination:			(repeat if abnormal)			
Height		*cm*	*Vital sign*	*Initial*	*Repeated*	*Units*
Weight		*Kg*	BP			*mmHg*
BMI		*Kg/m²*	Pulse			*/min*
Head circumference (< 18months)		*cm*	Resp.rate			*/min*
Visual Acuity	***Uncorrected***		***Corrected***		***Correction (if available)***	
Left/ Right	/		/		/	

	N	*Abn*	*ND*		*N*	*Abn*	*ND*		*N*	*Abn*	*ND*
General appearance	☐	☐	☐	Endocrine	☐	☐	☐	Extremities	☐	☐	☐
Visible disabilities	☐	☐	☐	Respiratory	☐	☐	☐	Skin (incl. scars)	☐	☐	☐
Mental state	☐	☐	☐	Abdominal/GIT	☐	☐	☐	Neurologic	☐	☐	☐
EENT (incl. hearing)	☐	☐	☐	Musculo-skeletal	☐	☐	☐	Lymph nodes	☐	☐	☐
Teeth	☐	☐	☐	Genito-urinary	☐	☐	☐	Breasts	☐	☐	☐
Cardiovascular	☐	☐	☐	Hernial sites	☐	☐	☐	Pregnant: Yes ☐ No ☐ Fundal height (cm):			

Remarks/Notes:

IOM • OIM

Migration Health Assessment
CXR&TB LAB WORKSHEET
Form 04MH_CXR

1. Assessment Date:	
2. Program:	
3. Ref. ID No:	

4. Name:

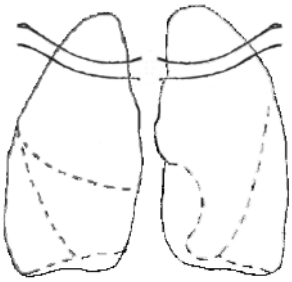
(Last) *(First)* *(Middle)*

5. Case NO:	**6. Date of Birth:**

7. Chest X-Ray	☐ **Done on** ☐ **Normal** ☐ **Abnormal F/U needed** ☐ **Abnormal no F/U**
	☐ **Not Done due to:** ☐ **Age** ☐ **Pregnancy** ☐ **Other, Specify**
8. From the Medical file:	☐ **TB signs or symptoms** ☐ **Contact with TB patient** ☐ **History of TB**

9. Chest X-ray Interpretation by the Radiologist

☐ **Can suggest Active TB** (need smears)	☐ **Can suggest INACTIVE TB** (need smears if symptomatic)	☐ **Other X-ray findings**
☐ Infiltrate or consolidation	☐ Discrete fibrotic scar or linear opacity	☐ Musculoskeletal
☐ Any cavitary lesion	☐ Discrete nodule(s) without calcification	☐ Cardiac or major vessels
☐ Nodule with poorly-defined margins *(such as tuberculoma)*	☐ Discrete fibrotic scar with volume loss or retraction	☐ Pulmonary
☐ Linear, interstitial markings *(children only)*	☐ Discrete nodule(s) with volume loss or retraction	☐ Other
☐ Pleural effusion	☐ Upper lobe retraction or volume loss	
☐ Hilar/Mediastinal adenopathy	☐ Other (such as bronchiectasis)	
☐ Other (*such as miliary findings*)		



Date:	**Radiologist's Name:**	**Radiologist's Signature:**

10. IOM Physician's Comments on CXR

11. TB Smears and Cultures

Date:	**Smears** ☐ **Done** ☐ **Not Done**						**Cultures** ☐ **Done** ☐ **Not Done**				**DST** ☐ **Done** ☐ **Not Done**
	Neg	Scanty	AFB count	1+ (1-9 /10F)	2+ (1-10 /F)	3+ (>10/F)	Neg	Pos	Cont	Non Diagn.	
	☐	☐		☐	☐	☐	☐	☐	☐	☐	
	☐	☐		☐	☐	☐	☐	☐	☐	☐	
	☐	☐		☐	☐	☐	☐	☐	☐	☐	

12. TST ☐ **Done** ☐ **Not Done**

Date taken	**Date read:**	**Result, mm:**	**History of BCG**
			No ☐ **Yes** ☐ **Unknown** ☐

Form 04MH_LAB *LAB WORKSHEET*	**1. Assessment Date:** **2. Program:**

3. **Name**	**4. Case No**	**5. Date of Birth:**

6. HIV Test ☐ **Done** ☐ **Not Done**				
Type:	**Date:**	**Test kit:**	**Test Results:**	**Test Notes:**
Screening			☐ **Neg** ☐ **Pos** ☐ **Indt.**	
Screening			☐ **Neg** ☐ **Pos** ☐ **Indt.**	
Screening			☐ **Neg** ☐ **Pos** ☐ **Indt.**	
Confirmatory			☐ **Neg** ☐ **Pos** ☐ **Indt.**	

7. Syphilis Test ☐ **Done** ☐ **Not Done**					
Type:	**Date:**	**Test kit:**	**Test Results:**	**Titer:**	**Test Notes:**
Screening			☐ **Neg** ☐ **Pos**		
Confirmatory			☐ **Neg** ☐ **Pos**		

8. Urinalysis ☐ **Done** ☐ **Not Done**						**Microscopy:**
Date: **12-Dec-2007**	**Blood**	☐ **Neg** ☐ **Pos**	**Repeat Date:** **04-Dec-2007**	**Blood**	☐ **Neg** ☐ **Pos**	
	Albumin	☐ **Neg** ☐ **Pos**		**Albumin**	☐ **Neg** ☐ **Pos**	
	Sugar	☐ **Neg** ☐ **Pos**		**Sugar**	☐ **Neg** ☐ **Pos**	

9. CBC ☐ **Done on** ☐ **Not Done**							
Name:	**Result:**	**Unit**	**Ref. range:**	**Name:**	**Result:**	**Unit**	**Ref. range:**
WBC		x 10^3/mm^3	5.0-10.0	Eosinophils, %		Percent	0-4
RBC		x 10^6/mm^3	4.1-5.3	Basophils, %		Percent	0-2
Hemoglobin		g/dL	12.0-18.0	Neutrophils, abs		x 10^3/mm^3	1.8-7.8
Hematocrit		Percent	37.0-52.0	Lymphocytes, abs		x 10^3/mm^3	0.7-4.5
Platelets		x 10^3/mm^3	140-390	Monocytes, abs		x 10^3/mm^3	0.1-1.0
Neutrophils, %		Percent	45-76	Eosinophils, abs		x 10^3/mm^3	0.0-0.4
Lymphocytes, %		Percent	17-44	Basophils, abs		x 10^3/mm^3	0.0-0.2
Monocytes, %		Percent	3-10				

10. Other tests with Numeric Results					
Date:	**Test name:**	**Result:**	**Unit:**	**Ref. Range:**	**Test Notes:**
	Select the test				
	Select the test				
	Select the test				
	Select the test				
	Select the test				
	Select the test				
	Select the test				
	Select the test				
	Select the test				
	Select the test				

11. Other tests with Neg/Positive Results				
Date:	**Test name:**	**Test kit:**	**Test Results:**	**Test Notes:**
	Hep B		☐ **Neg** ☐ **Pos**	
	Select the test		☐ **Neg** ☐ **Pos**	
	Select the test		☐ **Neg** ☐ **Pos**	
	Select the test		☐ **Neg** ☐ **Pos**	
	Select the test		☐ **Neg** ☐ **Pos**	
	Select the test		☐ **Neg** ☐ **Pos**	
	Select the test		☐ **Neg** ☐ **Pos**	
Lab Remarks:				

REPORT TO: Health and Wellbeing Board

DATE: 12 October 2016

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Halton Affordable Warmth Strategy 2016-2020

WARD(S) Borough wide

1.0 PURPOSE OF THE REPORT

1.1 This report presents the background to a new affordable warmth strategy which outlines Halton's approach to tackle fuel poverty and living in cold homes over the next 5 years. The strategy aims to enable all households in Halton to achieve the heating levels they need to maintain comfort and good health, at an affordable cost. The strategy builds upon a wide range of support that the Council and our partners already provide for households to address fuel poverty and living in cold homes.

2.0 RECOMMENDED: That the Board

1) approves the Affordable Warmth Strategy; and

2) supports the implementation of the Action Plan.

3.0 SUPPORTING INFORMATION

3.1 Fuel poverty means that households are either unable to heat their homes to an acceptable level to maintain their health and wellbeing or they are spending so much on heating their homes that they do not have enough disposable income to pay for other essential household needs.

3.2 4,992 households in Halton, (9.2% of all households) are living in Fuel Poverty. This varies from 4.2% in Birchfield to 14.1% in Appleton.

3.3 Living in cold homes can damage the health and wellbeing of all people, from toddlers to older people over 65 years. It can affect both the low income households and households of people with greater heating needs due to ill - health and disability. Fuel poverty widens inequalities as it particularly affects vulnerable groups such as the very young, elderly and income deprived.

3.4 Fuel Poverty can be caused by three main factors:

- The energy efficiency of a house which determines the amount of energy required to heat and power the home.
- Cost of domestic energy.
- Low household income

3.5 People are more likely to be affected by cold homes if they have:

- a heart disease
- a respiratory condition
- a mental health condition
- a disability
- mobility problems

3.6 Fuel Poverty can worsen existing health problems such as chest and heart disease, cause poor mental health, and increase the risk of falls and untimely death.

3.7 Fuel poverty comes at a huge cost to health services. The NHS spends about £1.4 billion per year to treat the illnesses caused and worsened by cold homes. However, investing £1 in improving affordable warmth can deliver a 42 pence saving in health costs for the NHS.

3.8 The Halton Affordable Warmth Strategy was developed in 2011. We have reviewed and updated the strategy, following a Needs assessment, in collaboration with several agencies who are already working to assist households who are vulnerable to the cold. Together we have agreed on the vision, objectives, required actions and outcomes to further reduce the harms from living in cold homes in Halton.

"Our Vision is: All households in Halton can achieve the heating levels they need to maintain comfort and good health, at an affordable cost".

To achieve this vision, this strategy will address **five main aims**

- Increase awareness, across all sectors and individuals, of the risks associated with fuel poverty and living in cold homes.
- Identify people who are living in cold homes or at risk of fuel poverty.

- Identify and monitor internal and external support that is available to people living in cold homes or at risk of fuel poverty.
- Ensure that people living in cold homes or fuel poverty are able to access available support to address the problem.
- Ensure the health and social care sector takes full account of the issue of fuel poverty when supporting clients.

This strategy is supported by a detailed action plan with realistic time scales and key partners who have agreed to ensure successful implementation of our desired objectives.

3.9 Following an assessment of local need and current provisions and gaps, a set of key recommendations and actions were identified in order to achieve each individual aim of the strategy and ultimately reduce fuel poverty and the risk of living in cold homes for people in Halton. The recommendations are covered in detail in the strategy but are summarised below:

3.9.1 **Aim 1: Increase awareness across all sectors and individuals in Halton of the risks associated with fuel poverty and living in cold homes.**

To achieve this, we will:

- Ensure that Fuel poverty remains on the agenda of key directorates and agencies in Halton
- Continue work to ensure that affordable warmth remains a part of strategic plans across the borough
- Support our frontline organisations by providing information to disseminate to their clients
- Develop campaigns to Increase awareness of fuel poverty and associated harms among people who are vulnerable to the cold, their families, carers and friends
- Work with gas engineering training centres to include fuel poverty in their training
- Continue to disseminate information about external fuel poverty campaigns resident can benefit from

Aim 2: To identify people who are living in cold homes. We will**:**

- Produce a fuel poverty checklist to facilitate identification and referral for people who may be living in cold homes
- Train our frontline professionals across all sectors to recognise people who may be living in cold homes using the fuel poverty checklist and how to refer them for help

- Make every contact count to reduce fuel poverty: We will work with partner agencies to identify people living in cold homes during home visits and assessment procedures such as the Common Assessment Framework (CAF) and the Safe and well visits by the Fire and Rescue Service.

Aim 3: Identify and monitor internal and external support that is available to people living in cold homes or at risk of fuel poverty. We will:

- produce and regularly update a directory of affordable warmth related services within Halton and beyond
- make this directory accessible to all relevant agencies
- work with the 'external funding team' to identify and secure external funding to tackle fuel poverty
- ensure that this information is disseminated to all relevant partners working with people who are vulnerable to the cold.

Aim 4: Provide support for people who are living in cold homes. We will:

- Establish a 'single point of contact' for affordable warmth in Halton
- Support a future housing stock condition survey
- Continue to explore funding opportunities to improve the housing stock and availability of services across the borough
- Ensure the availability of practical financial help such as: Benefit checks and other income maximisation support, budgeting advice and back to work support
- Facilitate the development of data sharing agreements between the range of organisations working in Halton
- Undertake more proactive work to promote better energy deals such as the 'Collective switch'.
- Produce a ‘winter check list' for agencies to share with their clients

Aim 5: Ensure the health and social care sector takes full account of the issue of fuel poverty when supporting clients

- Facilitate effective communication and partnership working between Hospital discharge teams, housing providers and organisations who can help clients who are in private rented accommodation
- Facilitate the inclusion of fuel poverty assessment into standard assessment procedures across the Health and Social care sector.
- Explore the potential for referral on schemes such as the 'social prescription scheme'.

4.0 POLICY IMPLICATIONS

4.1 The strategy addresses some key issues to reduce the risk of living in cold homes in Halton thereby improving the short and long term health and wellbeing of households in Halton. As such the recommendations will cover a broad scope of policy areas across the council, CCG and health and care partners.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There may be financial implications in the implementation of recommendations within the strategy which will be assessed and managed within the Strategic Group and through partner agencies for which the implication affects.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

For children, Fuel poverty and living in a cold home can affect normal development, including unhealthy weight gain, worsen health problems like asthma, increasing hospital admissions, reduce educational achievement leading to poorer emotional and mental well-being and reduce the ability to cope with the stress of life. For adolescents and young people, Fuel poverty can lead to poor mental health.

Improving the Health and Wellbeing of Children and Young People is a priority in Halton. Reducing fuel poverty will help to achieve this goal.

6.2 Employment, Learning & Skills in Halton

Reducing fuel poverty and living in cold homes can improve educational achievements for children and young people. This is likely to improve life chances, including employment potentials for people in Halton.

6.3 A Healthy Halton

Ensuring the health and wellbeing of the population is key priority. Protecting the health of Halton's population is a statutory responsibility for Public Health and the Council. All issues in this strategy are focused on this priority.

6.4 A Safer Halton

None.

6.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. Fuel poverty is greatly impacted by dwellings which are poor in terms of energy efficiency. Improving the energy efficiency of homes in Halton will reduce fuel poverty and living in cold homes.

7.0 RISK ANALYSIS

There are no risks associated with the development and implementation of this strategy.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 This strategy is developed in line with all equality and diversity issues in Halton.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Documents	Place of Inspection	Contact Officer
Halton Affordable Warmth Strategy 2016-2020	Runcorn Town Hall	Olukemi Adeyemi olukemi.adeyemi@halton.gov.uk
Halton Fuel Poverty Needs Assessment 2015 Summary		

Halton Affordable Warmth Strategy

2016 -2020

Improving health and well-being by reducing living in cold homes

Table of Contents

Foreword

Welcome to our Affordable Warmth Strategy for Halton. Our vision is to enable households in Halton to achieve the heating levels they need to maintain comfort and good health, at an affordable cost. Living in cold homes can damage the health and wellbeing of the pregnant woman, the growing toddler, school-aged children, the long-term ill and the elderly. It can affect both the low income households and households of people with greater heating needs due to ill -health and disability.

This strategy builds upon a wide range of support that our partners already provide for households to address fuel poverty and living in cold homes. It outlines how we will work in partnership to provide a 'single point of contact' for affordable warmth referrals in Halton to facilitate a coordinated approach. It will increase awareness of the disadvantages of living in cold homes, identify people at risk and ensure effective support is available.

The strategy highlights recent developments in affordable warmth. It describes how we will work to attract and maximise external funding opportunities and shows how we will continue to encourage households to participate in the 'collective switch' programme so that they can get best value energy tariffs. It will also assist our residents to access the financial support they are eligible for and support back to work programmes for adults who are able to work so they have less risk of being in fuel poverty.

We are pleased that the action plan outlined in the strategy has been agreed upon by all our partners from the Council, NHS Clinical Commissioning group (CCG) and our community and voluntary sector. Together we will work to improve the health and wellbeing of our people in Halton by reducing the risk of living in cold homes

Cllr Marie Wright, Halton Borough Council's portfolio holder for Health and Wellbeing

Eileen O'Meara, Halton Borough Council's Director of Public Health,

Executive Summary

About one in ten households in Halton are living in fuel poverty. This means they are either unable to heat their homes to an acceptable level to maintain their health and wellbeing or they are spending so much on heating their homes that they do not have enough disposable income to pay for other essential household needs.

Living in cold homes can lead to discomfort in the home and poor health including: increased risk of cold related illnesses, worsening of existing health conditions such as heart and lung diseases and untimely death. Living in cold homes also worsens peoples' mental health state and dietary opportunities and choices. Cold homes affect the health of all people, from toddlers to older people over 65 years.

Recommended minimum indoor temperature is "21 degrees in living areas in the daytime and a minimum 18 degrees night-time temperature for bedrooms to ensure good health and wellbeing.

Three main factors influence the risk of fuel poverty: **energy efficiency of our homes**, **household income** and **fuel cost**. The **Halton Affordable Warmth Strategy** was developed in 2011 to address these issues. We have reviewed and updated the strategy, following a **Needs assessment**, in collaboration with several agencies who are already working to assist households who are vulnerable to the cold. Together we have agreed on the vision, objectives, required actions and outcomes to further reduce the harms from living in cold homes in Halton. A full report and Visual summary of our Fuel Poverty Needs Assessment can be found at http://www4.halton.gov.uk/Pages/health/JSNA.aspx

"Our Vision is: All households in Halton can achieve the heating levels they need to maintain comfort and good health, at an affordable cost".

To achieve this vision, this strategy will address five main objectives:

1. Increase awareness, across all sectors and individuals, of the risks associated with fuel poverty and living in cold homes.
2. Identify people who are living in cold homes or at risk of fuel poverty.
3. Identify and monitor **internal and external support that** is available to people living in cold homes or at risk of fuel poverty.
4. Ensure that people living in cold homes or fuel poverty are able to access available support to address the problem.
5. Ensure the health and social care sector takes full account of the issue of fuel poverty when supporting clients.

This strategy is supported by a detailed action plan (Appendix 1) with realistic time scales and key partners who have agreed to ensure successful implementation of our desired objectives.

Introduction

About one in ten households in Halton are living in fuel poverty. This means they are either unable to heat their homes to an acceptable level to maintain their health and wellbeing or they are spending so much on heating their homes that they do not have enough disposable income to pay for other essential household needs. Fuel poverty can have significant adverse effects on health and wellbeing of people, especiallly those considered to be vulnerable.

Public Health England (PHE) [1]recommends a minimum indoor temperature of 21 degrees in living areas in the daytime and a minimum 18 degrees night-time temperature for bedrooms in order to safeguard health and wellbeing.

Three main factors influence the risk of fuel poverty: energy efficiency of our homes, household income and fuel cost.

Our Vision, Outcomes and Objectives

Although the impact of fuel poverty on health and well-being is great, it is 'preventable'.

"Our Vision is: All households in Halton can achieve the heating levels they need to maintain comfort and good health, at an affordable cost".

To achieve this vision, and increase affordable warmth in Halton, this strategy will seek to deliver two overarching outcomes:

1. Reduce the number of households living in cold homes, thereby reducing harms from living in cold homes.

2. Reduce inequalities and protect the vulnerable.

Our overriding *value* in achieving the outcomes is to "work in partnership', since no single organisation can tackle the factors that cause fuel poverty or living in cold homes alone.

In order to achieve our desired outcomes, the affordable warmth steering partners have identified the following objectives, all of which are linked to our *Outcomes*:

- Increase awareness across all sectors and individuals of the risks associated with fuel poverty and living in cold homes.
- Identify people who are living in cold homes or at risk of fuel poverty.
- Identify and monitor internal and external support that is available to people living in cold homes or at risk of fuel poverty.
- Ensure that people living in cold homes or fuel poverty are able to access available support to address the problem including:

[1] PHE, 2015, the Cold Weather Plan for England 2015. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/468160/CWP_2015.pdf

- Providing a single contact point for cold home referrals,
- Developing networks and partnerships to support those vulnerable to fuel poverty and cold homes by working with frontline services (such as primary care, housing, social services, heating engineers and meter installers) and voluntary organisations across Halton,
- Improving the energy efficiency of housing across the Borough in partnership with Social Housing Providers, Private landlords and Owner Occupiers,
- Maximising people's incomes by ensuring they receive appropriate benefits,
- Ensuring that our residents are on the best value energy tariffs at any given time,
- Providing and promoting advice on energy saving in the home,
- Encouraging greater uptake of national initiatives,
- Working to attract external funding for energy improvements to housing,
- Contributing to national and regional advocacy efforts to tackle fuel poverty.

➢ Ensure the health and social care sector takes full account of the issue of fuel poverty when supporting clients.

What is Fuel Poverty?

Using the "Low income High Costs (LIHC) definition, a household is considered to be in Fuel Poverty where they have required fuel costs that are above average (the national median level), and were they to spend that amount, they would be left with a residual income below the official poverty line. The "Low Income High Costs" indicator measures both number of households in fuel poverty and the extent of Fuel Poverty amongst these Fuel poor households (This is called the 'Fuel Poverty gap').

How many households are in Fuel Poverty?

4992 (9.2%) households in Halton are living in Fuel Poverty

In 2013:

- 4,992 households in Halton, (9.2% of all households) were living in Fuel Poverty. This varied from 4.2% in Birchfield to 14.1% in Appleton.
- 2.35 Million households in England were living in Fuel Poverty, representing 1 in 10 of all households in England with regional variations across the country.
- Households in England spent a total of £877 million more than the median required fuel costs, an average of £374 per household.

What causes Fuel Poverty?

Fuel Poverty can be caused by three main factors:

- The energy efficiency of a house which determines the amount of energy required to heat and power the home. This depends on the level of thermal insulation of the home and how good the heating system is. The energy efficiency of a dwelling is indicated by the Standard Assessment Procedure (SAP) rating. The higher the SAP rating, the more energy efficient a building is, and the lower the cost of heating the building to an acceptable indoor temperature.[2]
- Cost of domestic energy.
- Household income: Low income which can arise from factors such as unemployment, underemployment, being a Pensioner, lone parent or having low paid jobs can increase the risk of living in fuel poverty and cold homes.

The Fuel Poverty (England) Regulations 2014 set a Fuel Poverty target of minimum energy efficiency rating of Band E by 2020, Band D by 2025 and Band C by 2030.

Who is at risk of Fuel Poverty and Living in a cold home?

A wide range of people are vulnerable to the cold. This is either because of: a medical condition such as heart disease; a disability that, for instance, stops people moving around to keep warm, or makes them more likely to develop chest infections; or personal circumstances such as being unable to afford to keep warm enough. These vulnerable groups include:

- People with heart disease.
- People with respiratory conditions (in particular chronic obstructive pulmonary disease and childhood asthma).
- People with mental health conditions.
- People with disabilities.
- Older people (65 and older).
- Households with young children (from new-born to school age).
- Pregnant women.
- People on a low income.

The following groups of people are also more likely to live in cold homes:

- Households living in privately rented accommodation;
- Lone parents;
- Households with single person occupancy or having more rooms than individuals in the home;
- People living in fear of high energy bills.

[2] See Appendix 4 for " Fuel Poverty and Energy Efficiency of Dwellings"

How does Fuel Poverty affect people's health and Health Inequalities?

Fuel poverty, living in a cold home and generally, poor housing conditions can affect the health of people from all age groups. In all age groups, living in cold homes increases the frequency and severity of illnesses such as colds and flu and also leads to excess winter deaths, (EWDs)[3].

For children, Fuel poverty and living in a cold home can:

- affect normal development including unhealthy weight gain,
- worsen health problems like asthma, increasing hospital admissions,
- reduce educational achievement leading to poorer emotional and mental well-being and ability to cope with the stress of life.

For adolescents and young people,

- Fuel poverty can lead to poor mental health.

For adults, Fuel Poverty can:

- worsen existing health problems such as chest and heart disease;
- cause poor mental health;
- increase the risk of falls and untimely death.

We also know that:

- the lower a person's income is, the more likely they are to be at risk of fuel poverty;
- Children, the elderly and the vulnerable are more likely to be affected by cold housing and fuel poverty.

Children living in cold homes are twice as likely to suffer from a variety of chest problems than children living in warm homes.

More than 1 in 4 adolescents living in cold homes are at risk of multiple mental health problems compared to 1 in 20 adolescents who have always lived in warm homes.

People are more likely to die if they live in homes with low thermal efficiency and low indoor temperature.

Countries which have more energy efficient housing have lower Excess Winter Deaths*

Around 40% of Excess Winter Deaths are caused by cardiovascular diseases and around
33% of EWDs are caused by respiratory diseases

[3] Excess Winter Deaths are deaths which occur during the winter month over and above the expected number of deaths when compared with the other months in the year.

What is the Cost of Fuel Poverty?

Fuel poverty and living in cold homes comes at a huge cost to the Health Services, individuals, their families and the community as a whole. We understand that:

- The NHS (primary care and hospital) spends about £1.36 billion per year to treat the illnesses caused and worsened by cold homes.
- Reducing hazards in poor housing could deliver £600 million of savings a year for the NHS.
- Addressing fuel poverty yields a great "Return on investment". Every £1 spent on improving homes saves the NHS £70 over 10 years
- Tackling cold homes will also result in savings beyond those directly related to the NHS. Such savings come from improved mental wellbeing, increased mobility within the home, healthier lifestyles and greater social connection.

The NHS (primary care and hospital) spends about £1.36 billion per year to treat the illnesses cased and worsened by cold homes.

Return on investment

Housing interventions to keep people warm, safe and free from cold and damp are an efficient use of resources. Every £1 spent on improving homes saves the NHS £70 over 10 years.

Policy Drivers

National policy context

There is a wide range of health, environmental and social policies that support action on fuel poverty and cold homes in the United Kingdom. **Table 1** summarises those most relevant to local authorities, health and wellbeing boards, and Public Health and primary care teams. A full description of the policies can be found in Appendix 3.

Table 1: National Policies Underpinning Fuel Poverty

Policy Area	Policy
Health Policies	Health and Social Care Act 2012
	Public Health Outcomes Framework
	NHS Outcomes Framework
	Social Care Outcomes Framework
	The Cold Weather Plan for England
	Making every contact count
Policies targeting Fuel poverty	Warm Homes and Energy Conservation Act 2000 (amended with Fuel Poverty (England) Regulations 2014)
	UK Fuel poverty strategy
	NICE guideline on Excess winter deaths and illness and the health risks associated with cold homes
	The Energy Company Obligation (ECO)
Environmental policies	The Climate Change Act 2008
Policies Targeting Household Energy (Energy efficiency policy and programme aimed at those in fuel poverty)	The Energy Act 2011
Household energy bill policy	The Energy Act 2013(making provision for the reduction of number of tariffs and OFGEM regulating switching comparison sites)
Social and housing policies	Housing Health and Safety Rating System (HHSRS)
	Decent Homes Standard 2000–2010
Income measures	Winter Fuel Payment
	Cold Weather Payment
Energy tariff measures	The Warm Home Discount
Others	Priority Service Register for vulnerable people

Local policy context

The harms related to living in cold homes are well recognised by partners across Halton. We undertook a survey of on-going activities to tackle fuel poverty across Halton in 2015 and the result showed that a wide range of activities/interventions are currently on-going across the Borough to reduce the risk of people living in cold homes.[4]

[4] See the Fuel Poverty Needs Assessment for a summary of these activities -

In addition, Halton Borough Council, in partnership with registered social landlords, has funded home energy efficiency projects worth millions of pounds across the Borough since 2011. This includes the Castlefields estate regeneration programme and has been carried out with the support of funding schemes such as Warm Zone and Energy Company Obligation (ECO2).

Links to local strategies

Many local strategies are linked to, and can influence fuel poverty. The main strategies are shown in **Figure 1**.

Figure 1: Affordable Warmth and associated local strategies

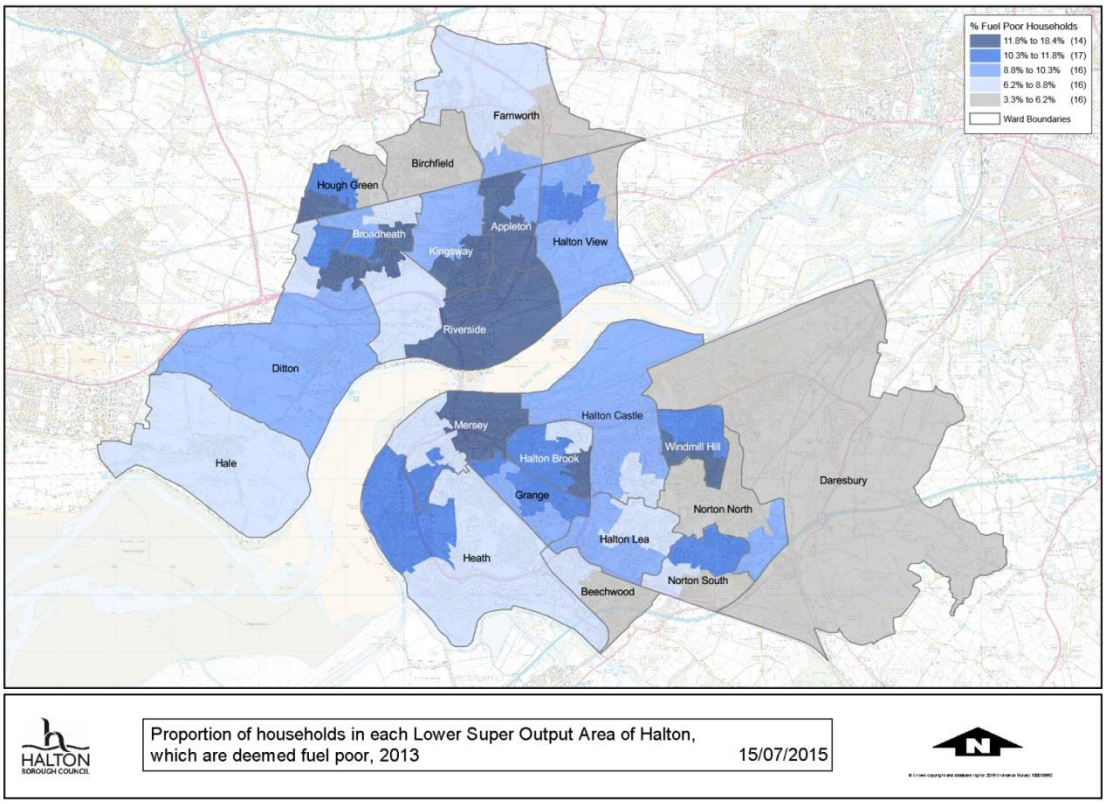
About Halton

Fuel Poverty in Halton

- In 2013, 4,992 households (9.2% of households in Halton) were estimated to be in Fuel Poverty. This varied between ward, from 4.2% in Birchfield to 14.1% in Appleton.
- This wide variation is shown in **figure 2** between Lower Super Output areas

- Fuel poverty rate in Halton is slightly lower than the England average of 10.4% households and Halton has the 4th lowest proportion of households in fuel poverty among 16 comparable local authority areas.

Figure 2: Percentage of Households in Fuel Poverty in Halton by Lower Super Output Areas in Halton (2013)



Source: Department of Energy & Climate Change

Fuel Poverty Risk Factors in Halton

The following statistics about Halton reveal the risk factors for fuel poverty in Halton

Population estimate (2012)

- Total population: 125,700
  - Ages 0-15 years: 24,900 (19.8%)
  - Ages 16-64 years: 81,200 (64.6%)
  - Ages 65+years: 19,600 (15.6%)

Deprivation, Income and poverty

- Deprivation: Halton is the 27th most deprived local authority area in England (out of 326)and 26% of Halton's population live in areas that fall in the top 10% most deprived nationally, more than the national figure (10%).

- Child poverty: about 25.6% (6,400) children in Halton live in poverty.
- Unemployment: As of January 2014, about 4.1%, (3,233) people were claiming Job Seeker's Allowance, 37th highest out of 326 Local Authorities. This rate varies across wards with Windmill Hill having the highest rate (9.3%) followed by Halton Lea (7.1%) and Halton Castle (6.4%).
- Worklessness: The percentage of working age people claiming out of work benefits in Halton is 16.2%. This compares to 13.8% for the North West and 10.9% for England. In some areas of the Borough rates are significantly above the Borough average e.g. Windmill Hill (33.5%), Halton Lea (27.4%) and Halton Castle (26.5%).

Health Status

- Long Term Condition (LTCs): In Halton, 21.4% of all people in Halton say they have a long-term health problem or disability.
- 4.3% of patients registered with a GP in Halton suffer from Coronary Heart disease, varying from 2.1% -5.1%. This is higher than 4.1% in Merseyside area, 4.0% in the North of England and 3.3% in the whole of England
- 2.5% of patients registered with a General Practice GP in Halton suffer from Chronic Obstructive Pulmonary Disease (COPD).

Housing in Halton

Several housing characteristics impact on the risk of a household living in fuel poverty. They include occupancy levels, type of tenure, the heating system and the energy efficiency of dwellings. This section gives an overview of these housing characteristics in Halton.

Occupancy level

- There was an average of 2 people per dwelling in Halton which was similar to England in 2014. This was 55,900 dwelling per 125, 000 people

Housing Tenure and Decent homes

- In 2014, 25% of dwellings in Halton were provided by the public sector including Registered Social Landlords and 75% by the private sector compared with 17.7% and 83% for England.

Data from the 2009 Halton Stock Condition Survey showed that:

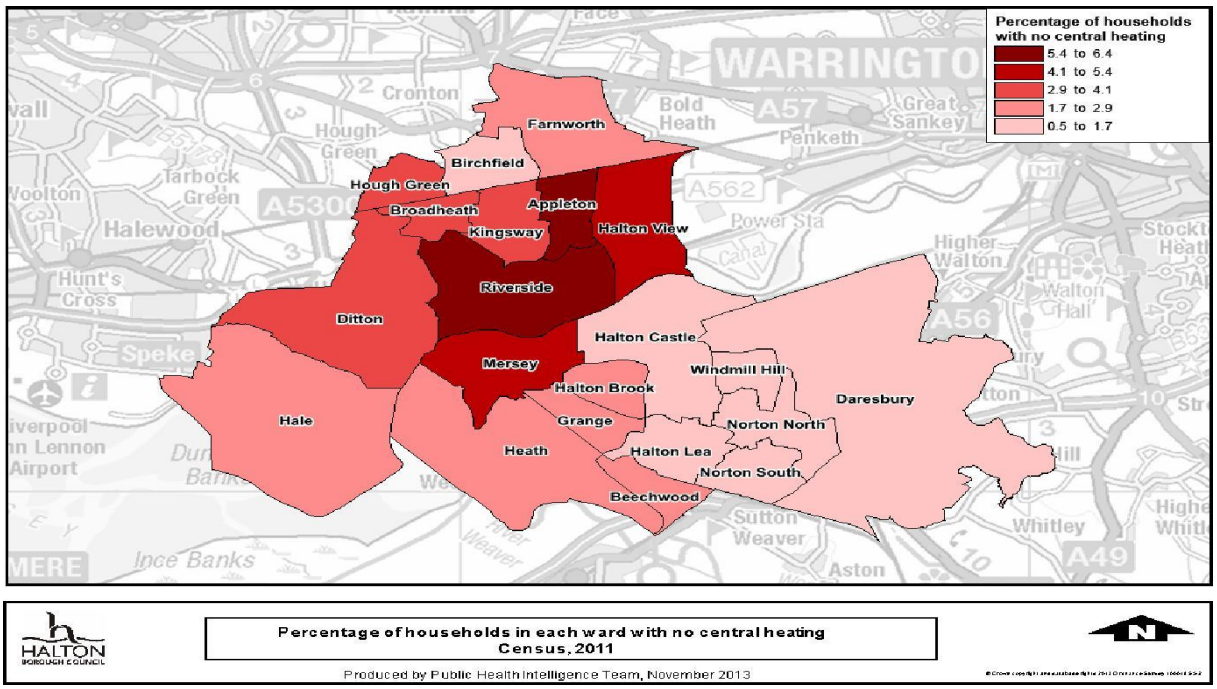
- All social housing stock in Halton met the Decent Homes Standard
- 26.2% of private sector dwellings in Halton (10,500 dwellings) failed the Decency Standard

Thermal comfort: Central Heating in homes across Halton

Figure 3 shows the percentage of households with no central heating based on the 2011 census. However, due to housing improvement programmes and energy efficiency campaigns since 2011, the vast majority of housing in Halton now has central heating

installed. However there are still some properties that do not. The highest proportion of these is located in the Riverside and Appleton wards in Widnes.

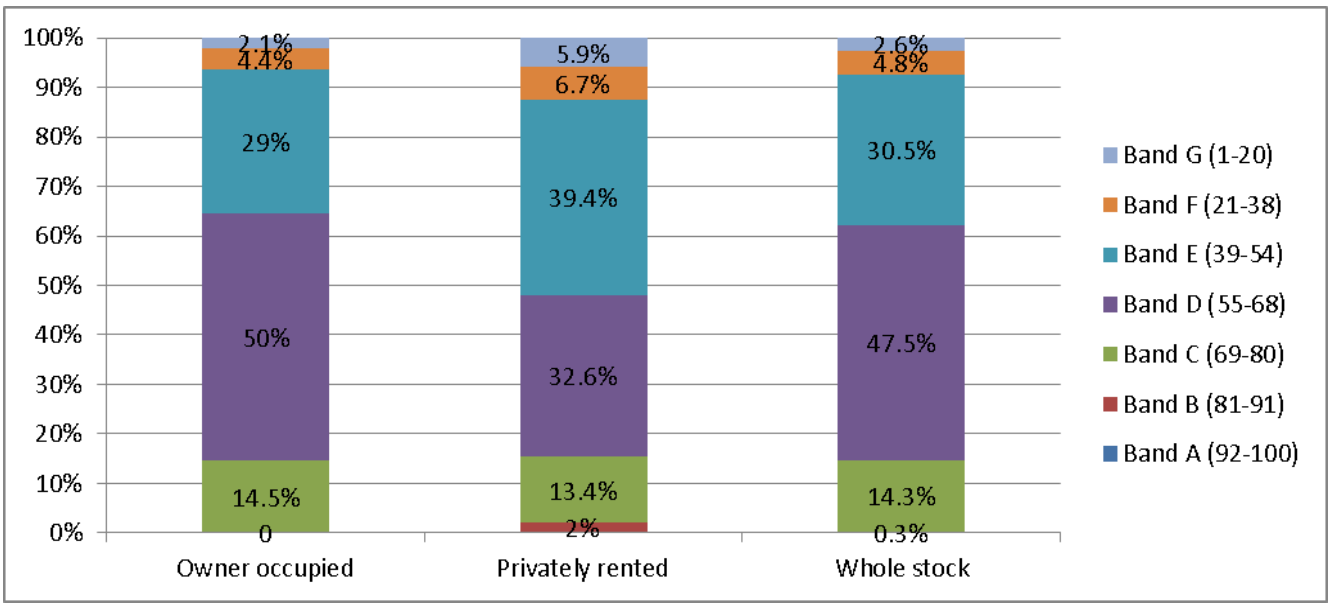
Figure 3: Central Heating in Dwellings in Halton (2011)



Energy efficiency of dwellings in Halton

Figure 4 below illustrates the distribution of energy efficiency measures (Standard Assessment Procedure, SAP/Energy Performance Certificate, and EPC, for private sector housing in the Borough.

Figure 4 – Energy Performance of Private sector Halton dwellings by EPC (SAP) rating



It is necessary to note that the energy efficiency ratings of Halton's housing stock, private or otherwise would have improved since 2009. This is because of several home improvement initiatives which have taken place across the borough since 2009.
(More details about Fuel poverty risk factors in Halton can be found in the Halton Fuel Poverty Needs Assessment 2015).

Strategy Review Process

Fuel Poverty Needs Assessment

We undertook a Fuel Poverty Needs Assessment in 2015 to understand the burden of fuel poverty and the available programmes to address fuel poverty. The full Needs Assessment report and a visual summary of the result can be found at
http://www4.halton.gov.uk/Pages/health/JSNA.aspx

Strategy consultation and engagement

In addition to formulation of a strategy review group, an audit of activities taking place across Halton to tackle Fuel Poverty was conducted in 2015 using the National Institute for Health and Care Excellence (NICE) assessment tool. The audit assessed Halton's compliance against the 2015 NICE guideline recommendations

A total of 24 responses were received across the borough. These included responses from 6 charitable organisations, Cheshire Fire and Rescue Service, four social housing providers, the respiratory team and 12 departments within Halton council. Following the audit, a workshop was held to review the key issues/gaps highlighted by the audit and action plans (**Appendix 1**) for the strategy.

The partners involved in reviewing this strategy are outlined below.

Halton Affordable Warmth Strategy Review Contributors

Agency/Department

Age UK Mid Mersey	Brookvale & Windmill Hill Children's Centres, Team around the Family
Energy Projects Plus	Halton BC - Contact Centre Halton Carers Centre
Halton Adult Safeguarding	Halton Citizens' Advisory Bureaux (CAB)
Halton Environmental Health	Halton Housing Solutions Team
Halton Health Improvement Team	Halton Inclusion 0-25
Halton Housing Trust - Asset Management	Halton Senior Services
Halton Intermediate and Urgent Care	Halton Trading Standards
Halton Sure Start to Later Life	HBC Public Health
Halton Welfare Rights Service	Plus Dane - Asset Management
NHS Halton Clinical Commissioning Group	Protection and Prevention/Cheshire Fire & Rescue
Plus Dane and SHAP	Halton Respiratory Team Service
Riverside Housing Community Engagement	Sustainable Communities-Groundwork Cheshire Lancashire and Merseyside

Taking Action to Reduce Fuel Poverty in Halton

Our action plan **(Appendix 1**) sets out how we will address fuel poverty and living in cold homes in a cross-sectorial and multi-disciplinary way, reflecting the complexity of fuel poverty. It also takes a life-course approach, **(Appendix 2),** ensuring that fuel poverty is tackled across all age groups.

We aim to:

1. Increase awareness across all sectors and individuals of the risks associated with fuel poverty and living in cold homes
2. Identify people who are living in cold homes or at risk of fuel poverty
3. Identify and monitor internal and external support that is available to people living in cold homes or at risk of fuel poverty
4. Ensure that people living in cold homes or fuel poverty are able to access available support to address the problem
5. Ensure that the health and social care sector takes full account of the issue of fuel poverty when supporting clients

This section outlines how we will achieve these aims.

Aim 1: Increase awareness across all sectors and individuals in Halton of the risks associated with fuel poverty and living in cold homes

Objectives:

- Increase awareness of Fuel Poverty at a Strategic Level across Halton
- Embed Affordable Warmth into relevant strategic areas
- Increase awareness of fuel poverty among all people in Halton
- Increase awareness of fuel poverty among frontline professionals , voluntary organisations and community groups in Halton
- Increase awareness of fuel poverty among Gas engineers
- Work with local letting agents to Increase awareness of Affordable warmth, legal / EPC rating for dwellings
- Increase awareness of regional or national campaigns such as 'Keep warm, Keep well'
- Deliver annual cold home awareness campaign for Halton

Current activities in Halton

- Reducing Fuel poverty is a priority in the Halton Health and Wellbeing Strategy, Halton Housing Strategy, and other strategies outlined in Figure 1
- Tackling fuel poverty and improving energy security is a 'work stream' in the NHS Halton CCG's Sustainable Development Management Plan (SDMP) 2016-2019

- Majority of staff at agencies who responded to our survey are aware of the risks associated with living in cold homes
- 15 out of 24 survey responders provide cold home-related information for their clients' through a wide range of avenues : face-to-face contact, telephone conversations, leaflets and booklets in accessible formats (including large print and voice recorded advice), and online resources.

Gaps in activity identified in Halton

- There is still room for more frontline staff, community groups and volunteers to be aware of fuel poverty and cold homes
- We also need to ensure that all our residents are aware of the risks associated with living in cold homes.

To increase awareness of fuel poverty, we will:

- Ensure that Fuel poverty remains on the agenda of key directorates and agencies in Halton
- Continue work to ensure that affordable warmth remains a part of strategic plans across the borough
- Support our frontline organisations by providing information to disseminate to their clients
- Develop campaigns to Increase awareness of fuel poverty and associated harms among people who are vulnerable to the cold, their families, carers and friends
- Work with gas engineering training centres to include fuel poverty in their training
- Continue to disseminate information about external fuel poverty campaigns resident can benefit from

Aim 2: To identify people who are living in cold homes

In 2013, 4992 households in Halton, (9.2% of all households) were living in Fuel Poverty. This varied from 4.2% in Birchfield to 14.1% in Appleton.

Our objectives

- To facilitate a proactive identification of people living in cold homes.
- To ensure that people living in cold homes are referred for support

Current activities

- Some of our frontline staff are trained to recognise issues relating to fuel poverty
- Some agencies review their clients' energy bills to understand energy usage and potential impact on health
- 6 out of 24 agencies responding to our survey have a 'winter checklist' to identify vulnerable people, 4 of which were housing providers.
- 8 out of the 24 agencies have system/s in place to identify young people who are living in cold homes

Gaps in activity identified in Halton

- There is a need for a more proactive approach to identifying people who may be living in cold homes in Halton or at risk of fuel poverty and for this approach to be carried out by all frontline agencies who work with people who are vulnerable to the cold.
- Assessing heating needs of clients: 21 out of 24 organisations/departments who responded to our survey carry out home visits. This was not applicable to the other 3. However only 12 out of the 21 organisations who undertake home visits assess the heating needs of people who use their services, whether during a home visit or elsewhere.
- 10 of the agencies surveyed would consider having a winter checklist for active identification.

To identify people who are living in cold homes and refer them for support, we will:

- Produce a fuel poverty checklist to facilitate identification and referral for people who may be living in cold homes
- Train our frontline professionals across all sectors to recognise people who may be living in cold homes using the fuel poverty checklist and how to refer them for help
- Make every contact count to reduce fuel poverty: We will work with partner agencies to identify people living in cold homes during home visits and assessment procedures such as the Common Assessment Framework (CAF) and the Safe and well visits by the Fire and Rescue Service.

Aim 3: Identify and monitor internal and external support that is available to people living in cold homes or at risk of fuel poverty

Our objectives

- Research and identify all current support available to residents at risk of fuel poverty or living in a cold home
- Share this information across network
- Monitor availability of support and update information to reflect changes
- Monitor for opportunities to attract external support

Current activities

Different agencies or departments within the borough source for funding to tackle fuel poverty in Halton.

Gaps in our provision

- We do not have a designated staff or department taking charge of a proactive identification of resources and support to address fuel poverty or living in cold homes.
- There is no formal communication between agencies to raise awareness of available support for people living in fuel poverty or cold homes.

To identify and monitor available fuel poverty related support, we will:

- produce and regularly update a directory of affordable warmth related services within Halton and beyond
- make this directory accessible to all relevant agencies
- work with the 'external funding team' to identify and secure external funding to tackle fuel poverty
    - ensure that this information is disseminated to all relevant partners working with people who are vulnerable to the cold.

Aim 4: Provide support for people who are living in cold homes

Objectives

- Establish a 'single point of contact' (AWSPC) or equivalent in Halton for cold home referrals. The AWSPC will receive referral from frontline practitioners, assess needs and identify appropriate support for each referral, monitor progress and obtain feedback
- Train all relevant frontline practitioners on how to refer into the SPC
- Ensure that help and support is provided for households most in need to reduce inequality
- Ensure effective data sharing between partner agencies to facilitate support for vulnerable people/households
- Provide a 'winter check list' for agencies to share with their clients
- Energy cost: Negotiate better energy deals with energy suppliers on behalf of Halton residents through schemes like Collective switch to improve access to affordable fuel
- Housing: Facilitate the Improvement of the housing stock, across all sectors, so that none falls within the High Cost category of Low Income High Cost (LIHC)
- Income: Maximise income through benefits uptake and maximisation programmes and back to work support programmes

Current activities

Our survey showed that we already have a wide range of referral options for help with fuel poverty within Halton. Some of the agencies involved are listed in appendix 5. In addition,

majority of the recommendations by the National Institute for Health and Healthcare Excellence (NICE) to reduce the risk of living in cold homes and excess winter deaths are already being carried out within Halton. These activities include:

- Advice on how to avoid the health risks of living in a cold home. This includes information about what these health risks are
- Advice on managing energy effectively in the home
- Registration on priority service registers
- Provision of services that address common barriers to tackling cold homes such as 'fixing a leaking roof', or help to clear a loft ready for insulation
- Provision of short-term emergency support in times of crisis
- Housing insulation and heating improvement programmes and grants
- Financial literacy work
- Collective switching
- Budgeting advice
- Specialist debt advice

Gaps we have identified

- The audit showed that most of the activities are not being carried out by all relevant agencies.
- Some of these services or programmes are only available to specific tenures Others depend on availability of funding as the services are non-statutory and therefore rely on commissioned or grant funded programmes
- 'Single point of contact for affordable warmth: 'A coordinated approach to tackle fuel poverty: there is a need for a recognised 'hub' for fuel poverty in Halton to maximise the efforts of various agencies currently offering help for people. Hence the need for a 'single point of contact' or its equivalence for affordable warmth.
- Housing condition survey: the latest housing condition survey was carried out in 2009. Since then, several initiatives have taken place to improve housing conditions across the borough. We will ensure that any future Housing stock condition survey provides detailed information on the energy efficiency of dwellings in Halton.

To provide support for people living in cold homes we will:

- Establish a 'single point of contact' for affordable warmth in Halton
- Support a future housing stock condition survey
- Continue to explore funding opportunities to improve the housing stock and availability of services across the borough
- Ensure the availability of practical financial help such as: Benefit checks and other income maximisation support, budgeting advice and back to work support
- Facilitate the development of data sharing agreements between the range of organisations working in Halton
- Undertake more proactive work to promote better energy deals such as the 'Collective switch'.
- Produce a 'winter check list' for agencies to share with their clients

Aim 5: Ensure the health and social care sector takes full account of the issue of fuel poverty when supporting clients

Our Objective:

- Ensure that the risk of fuel poverty and cold homes form part of any assessment of patients/clients when presenting at health services or with the social services
- Ensure patients are discharged into homes that are warm enough to support their health and wellbeing
- Train all relevant frontline practitioners on how to refer into the 'single point of contact'

Current activity in Halton

- Patients are assessed for the risk of returning to cold homes, and supported in consultation with their housing providers and family members to address any problems
- Some Frontline practitioners have referral pathways for some circumstances related to fuel poverty

Gaps in our provision

- Housing providers would welcome better communication between the hospital and themselves so they can support their residents better following their discharge from hospital
- Fuel poverty or cold home assessment is not routinely integrated into consultations across the Health and Social Care sector

To ensure the Health and Social Care sector takes full account of fuel poverty when supporting clients, we will:

- Facilitate effective communication and partnership working between Hospital discharge teams, housing providers and organisations who can help clients who are in private rented accommodation
- Facilitate the inclusion of fuel poverty assessment into standard assessment procedures across the Health and Social care sector.
- Explore the potential for referral on schemes such as the 'social prescription scheme'.

Delivering this Strategy

Expenditure on reducing cold home -related harm

There is currently no direct funding allocation to tackle fuel poverty or living in cold homes in Halton. However there are on-going programmes addressing different aspects of fuel poverty. These include the Warm and Healthy Homes programme with funding till December 2016. The Warm and Healthy Homes programmes is funded to provide measures to improve the energy efficiency of dwellings for people who are most at risk of fuel poverty.

We will work with partners to address this finding gap in the following ways:

- Integrate some of the strategy's action plans into on-going programmes at no extra cost.
- Work with the External funding team to apply for funding to implement the strategy

Appendices

Appendix 1: Halton Affordable Warmth Strategy Action Plan 2016-2020

Key Aim 1: Increase Awareness of fuel poverty and living in cold homes

Objectives	Targets/ outcomes	No	Actions	Time-scale	Lead agency
Increase awareness of fuel poverty at a Strategic Level across Halton and embed Affordable Warmth into relevant strategies	All key directorates, departments and agencies in Halton BC are aware of the harms associated with living in cold homes	1	Include fuel poverty on the agenda of key directorates and agencies, and ensure it remains on agenda	On-going Review annually	Affordable Warmth (AW) Steering group
	Affordable warmth is embedded into other related strategies such as: Housing Strategy, Respiratory strategy, Child & Family Poverty Strategy, Sustainable Communities Strategy.	2	Work with professionals in associated fields to recognise and incorporate affordable warmth into their strategic plans	On-going Review annually	Affordable Warmth (AW) Steering group
Increase awareness of fuel poverty among all people in Halton	Residents, frontline professionals, voluntary organisations and community groups in Halton across all sectors	3	Develop campaigns to Increase awareness of the harms posed by living in cold homes among Halton residents Deliver talks to groups of residents at	On-going	Affordable Warmth Lead/Single Point of Contact

	are aware of the harms posed by living in cold homes.		risk of fuel poverty Attend events to raise awareness of fuel poverty and living in cold homes Link local cold home campaigns with regional or national campaigns such as 'Keep warm, Keep well'		(AWSPC)
		4	Set up a winter warmth task and finish group Organise a 1 week annual fuel poverty awareness campaign in Halton	July 2016 September/October 2016 Repeat annually	Affordable Warmth (AW) Steering group
		5	Provide briefing sessions and reports on Fuel Poverty and living in cold homes to frontline professionals, voluntary organisations and community groups in Halton Provide cold home related resources for frontline organisations to disseminate to their clients	On-going Review annually	Affordable Warmth Lead/Single Point of Contact (AWSPC)

Key Aim 2: Identify people who are living in cold homes

Objectives	Targets/ outcomes	No	Actions	Time-scales	Lead Agency
Facilitate a proactive identification of people living in cold homes.	People living in cold homes are identified and referred for appropriate support	1	Produce a fuel poverty checklist, in consultation with partner agencies, to facilitate the identification and referral for people who are living in cold homes	June 2017	Affordable Warmth Lead/Single Point of Contact (AWSPC)
		2	Train our frontline professionals across all sectors to recognise people who are living in cold homes using the fuel poverty checklist and how to refer them for help	June 2018 -All relevant professionals trained Annual updates provided	Affordable Warmth Lead/Single Point of Contact (AWSPC)
		3	Make every contact count to reduce fuel poverty: We will work with partner agencies to identify people living in cold homes during home visits and assessment procedures such as the Common Assessment Framework (CAF) and the Safe and well visits by the Fire and Rescue Service.	June 2018	Affordable Warmth Lead/Single Point of Contact (AWSPC)
Facilitate cross - sectorial data sharing to identify at risk people for targeted support	Data about Halton residents held by various agencies are accessible to identify people who are at risk of living in cold homes	4	Create a priority list of areas in Halton where households are most at risk of living in cold homes for targeted intervention	June 2017	Affordable Warmth Lead/ Single Point of Contact (AWSPC)

Key Aim 3: Identify and monitor internal and external support that is available to people living in cold homes or at risk of fuel poverty

Objectives	Targets/ outcomes	No	Actions	Time-scales	Lead agency
Research and identify all current resources and support available to residents at risk of fuel poverty or living in a cold home	Halton has an up-to-date directory of resources and support to address fuel poverty or living in cold homes	1	Produce a directory of services to help people who are living in cold homes in Halton	June 2017 Updated regularly	Affordable Warmth Lead/Single Point of Contact (AWSPC)
		2	Produce and disseminate a bi-annual Affordable warmth bulletin as a formal communication between agencies to raise awareness of available support for people living in fuel poverty or cold homes	September 2017 Bi-annual edition	Affordable Warmth Lead/Single Point of Contact (AWSPC)
Monitor for opportunities to attract further support for people living in cold homes	Evidence of success at securing funding and other relevant support for people living in cold homes from external agencies	3	We will work with the 'external funding team' and partners to identify available funding to tackle fuel poverty	On-going Review annually	Affordable Warmth Lead/Single Point of Contact (AWSPC) Halton External funding team

Key Aim 4: Provide support for people who are at risk of fuel poverty or living in a cold home

Objectives	Targets/ outcomes	No	Actions	Time-scales	Lead agency
Establish a 'single point of contact' (AWSPC) or equivalent in Halton coordinate an 'Affordable warmth network' for cold home referrals. The AWSPC will receive referral from frontline staff, assess needs and identify appropriate support for each referral, monitor progress and obtain feedback.	Halton Affordable warmth 'single-point-of-contact' (AWSPC) established	1	Determine the Single-point-of-contact model for Halton	December 2016	Halton Affordable warmth steering group
		2	Obtain resources/funding for the Single Point of Contact	March 2017	Halton Affordable warmth steering group
		3	Establish the Halton Affordable Warmth single-point-~~0~~of-contact	March 2017	Halton Affordable warmth steering group
		4	Develop clear local pathways to enable frontline practitioners to refer people to the Single-point-of contact	June 2017	Affordable warmth single-point-of contact
		5	Provide training for frontline professionals, voluntary organisations and community groups on how to refer people to the Single Point of Contact	June 2018	Affordable warmth Lead/ single-point-of contact

Ensure that help and support is provided to those households most in need	The proportion of households in fuel poverty decreases at a greater rate in our most deprived neighbourhood compared with areas less deprived	6	Establish a prioritisation mechanism to target households most at risk of fuel poverty Identify most appropriate targeting methods e.g. by client group and /or by geographical area, house condition, house type, so that resources are directed effectively.	June 2017 Review fuel poverty data annually	Affordable warmth Lead/single-point-of contact
Ensure effective data sharing between partner agencies to facilitate support for vulnerable people/households	Data sharing between agencies in the process of making referrals is legal and effective	7	Work with partner agencies to agree on an acceptable data sharing process which respects clients' confidentiality and complies with individual organisation's data policy.	September 2017	Affordable warmth Lead/single-point-of contact
Winter Checklist: Produce a 'winter check list' for agencies to share with their clients	Organisations working with people who are vulnerable to the cold have a 'winter checklist' to share with their clients to help them prepare for, and safe during the winter	8	Produce and disseminate a winter checklist' for all relevant organisations	September 2017	Affordable warmth Lead/single point of contact
Housing					
Facilitate the Improvement of the housing stock, across all	Reduction in the number of dwellings in Halton with SAP ratings of Band D	9	Establish a mechanism to regularly update the existing Energy Performance database as improvements are made to dwellings overtime.	September 2017	Affordable warmth Lead/ Housing providers and

sectors, so none fall within the High Cost category.	and E in favour of Band C				agencies
		10	Work with the Private Landlords' Forum to engage private landlords		Affordable warmth Lead/ single-point-of contact
		11	Work with local letting agents to Increase awareness of Affordable warmth, legal SAP rating for dwellings and schemes available for home improvement		Affordable warmth Lead/single-point-of contact
		12	Enforce improvements to tackle cold hazard through the Housing Health and Safety Rating System (HHSRS)		HBC Environmental health
		13	Explore funding sources for hard to treat properties, e.g., those with solid walls		Affordable warmth Lead/single point of contact
			Make home owners aware of the AWSPC for any available support		
Ensure that changes to buildings are carried out to comply as a minimum with the legal requirements under building regulations.	All changes to buildings in Halton are carried out to comply as a minimum with the legal requirements under building regulations	14	Provide information for building inspectors to raise awareness of fuel poverty and living in cold homes	September 2017	Affordable warmth Lead/single point of contact

Income					
Maximise income through benefits uptake and maximisation programmes and back to work support programmes	Increased number of Halton residents are in receipt of financial support they are eligible for.	15	Provide benefit maximisation advice and support for people at risk of fuel poverty	On-going	Affordable warmth Lead/single point of contact
		16	Train staff who provide benefits advice, the basics of affordable warmth, health impacts and the links between benefits and energy grants	June 2018	
Affordable Fuel		17	Increase awareness of schemes to help households access better energy tariffs such as 'Collective switch'	On-going	AWSPC
To facilitate access to best value fuel for households in Halton, especially vulnerable households	All households have access to best value fuel tariffs, thus reducing their heating bills Increasing number of households in Halton participate in schemes such as the 'collective switch'.	18	Negotiate better energy deals with energy suppliers on behalf of Halton residents through schemes like Collective switch Actively promote these fuel cost saving schemes among people in Halton Assist households to access the most cost-effective energy tariffs	On-going	Affordable warmth Lead/single point of contact, Energy project plus Citizens advisory bureaux

Key Aim 5: Ensure the health and social care sector takes full account of the issue of fuel poverty when supporting clients

Objective	Target/Outcome		Action	Time-scale	Lead agency
Ensure that patients are discharged into warm homes to protect their health and well-being	All patients are assessed for risk of fuel poverty on admission to hospital and discharged into warm homes	1	Assess patients on hospital admission on whether they are likely to be vulnerable to the cold and if action is needed to make their home warm enough for them to return to Ensure that the home is warm enough to return to following a planned discharge. Ensure that any heating issues are resolved in a timely manner, so as not to delay discharge from hospital	June 2018	Affordable warmth lead/Hospital discharge services
Ensure that fuel poverty and cold homes form part of any assessment of vulnerable patients/clients when presenting to health and social care facilities.	Health and social care staff are proactive on identifying patients who may be living in cold homes	2	Facilitate the inclusion of fuel poverty assessment into standard assessment procedures across the Health and Social care sector.	June 2018	Affordable warmth lead/single point of contact

Appendix 2: Tackling Fuel Poverty and Living in Cold Homes across the Life Course

This section is intended to demonstrate how the action plan outlined in Appendix 1 can be interpreted through the life course –from pregnancy to old age.

Preconception and pregnancy				
Objective	**Targets/ outcomes**	**Actions**	**Lead Agency**	**Key Partners**
Increase awareness of the harm that living in a cold home pose to pregnant women. (prevention)	Pregnant women understand that living in a cold home is dangerous for their health, and consequently, the health of their unborn baby, Less pregnant women living in fuel poverty	Develop a local education campaign to increase the awareness of the harm that living in a cold home pose to the health of pregnant women	Affordable warmth Single Point of Contact (AWSPC)	Midwifery GPs
		Ensure that GPs and midwifes provide advice about the harm of living in a cold home to pregnant women	AWSPC	Midwifery/ GPs
		Ensure that pregnant women are aware of what help is available and how to access it		
Ensure that pregnant women at risk of fuel poverty or living in cold homes are	All pregnant women living in cold homes or at risk of fuel poverty are identified and referred to the AWSPC	Promote the fuel poverty checklist among midwives and GPs to identify pregnant women who are at risk of fuel poverty or	Midwifery GPs	AWSPC

identified and referred to the AWSPC (Early identification)		are living in a cold home		
		Ensure that all women identified as being at risk of fuel poverty or living in a cold home are referred to the AW SPC	Midwives/GPs	AWSPC
Ensure pregnant women identified as living in a cold home are supported through the single point of contact to identify available help. (Intervention)	All pregnant women referred are supported by the SPC to explore possible support	Pregnant women referred to the AWSPC are assessed to identify most appropriate source of help, referred and followed up to establish the outcome of intervention.	AWSPC	All partners
Early years (age 0-5)				
Objective	**Targets/ outcomes**	**Actions**	**Lead Agency**	**Key Partners**
Raise awareness of the harms of living in a cold home among parents of babies and toddlers (prevention)	All parents of children aged 0-5 are aware of the harm associated with living in a cold home especially for their babies and toddlers Fuel poverty awareness messages included in parenting programmes across the borough.	Develop and disseminate an information resource for new parents which includes key messages around healthy homes including appropriate indoor temperature	AWSPC	Sure start Children centres
		Identify all available local parenting programmes and	AWSPC	Sure start Children

		ensure they include messages of the harms cold homes may have upon young Children.		centres
Ensure the early identification and support of children who may be living in a cold home (Early intervention)	All families with children under 5 living in a cold home are identified and referred to the AWSPC	Ensure key clinical and non-clinical early years staff are trained on fuel poverty Ensure key clinical and non-clinical early years staff identify families of children living in a cold home by using the fuel poverty checklist Ensure families are referred to the AW SPC	AWSPC	Sure start Children centres
Ensure families with babies and toddlers identified as living in cold homes can access effective support (Intervention)	Less families with children under 5 yrs. living in a cold home	All families with children under 5 who are living in a cold home to be supported by the SPC to address the reasons for fuel poverty	AWSPC	
School age children (age 5 to 18yrs)				
Objective	**Targets/ outcomes**	**Actions**	**Lead Agency**	**Key Partners**
Increase awareness of the harm that cold homes pose to school age	All families with school age children are aware of the harms associated with living in a cold home for school aged children,	Develop a coordinated fuel poverty awareness campaign aimed at schools, young people and their parents	AWSPC	Schools Colleges education welfare

children (prevention)	especially those with disabilities and long standing health conditions All organisations working with school age children are aware of the risk associated with fuel poverty			officers, health visitors, children's social workers
Ensure the early identification and support of school age children living in a cold home (identification)	All families of school age children living in a cold home are identified and referred to the SPC. Every family with a vulnerable child./young adult to be assessed for risk of fuel poverty	Ensure frontline staff working with school age children is trained to identify children and young people living in a cold home using the fuel poverty checklist. Ensure the implementation of this training. To include staff who work with Vulnerable young people including children with special educational needs and disabilities. Ensure that families of children and young people living in a cold home are referred to the SPC	AWSPC	
Ensure that families of school age children living in cold homes are supported to address the problem	Less households with school aged children living in a cold home	All families with school-aged children who are living in a cold home to be supported by the SPC to address the reasons for fuel poverty	AWSPC	

(Intervention)				
Adults (19yrs and over)				
Objective	**Targets/ outcomes**	**Actions**	**Lead Agency**	**Key Partners**
Increase awareness of the harm that cold homes pose to people especially adults with long term health conditions and disabilities (prevention)	All adults especially those with long term health conditions and disability, and their careers, are aware of the health risks associated with living in a cold home All frontline staff working with adults, especially those with disability and long term health issues are aware of the risks associated with living in a cold home	Develop a coordinated fuel poverty awareness campaign aimed at adults, and frontline professionals working with adults	AWSPC	All partners
Ensure that adults living in fuel poverty and cold homes are identified and referred to the AWSPC	All adults identified as living in a cold home are referred to the SPC for support.	Ensure frontline staff working with vulnerable adults are trained to identify those living in a cold home using the fuel poverty checklist. Facilitate the implementation of this training. To include staff who work with Vulnerable adults, including adults with long tern health conditions and disabilities.	AWSPC	All partners working with vulnerable adults

		Ensure that adults living in a cold home / at risk of fuel poverty are referred to the SPC		
Ensure that adults in fuel poverty are able to access relevant support to address fuel poverty	Less number of adults living in fuel poverty.	AWSPC to develop and monitor access points and methods to ensure all adults can access support	AWSPC	All partners

Appendix 3: National Policies

There is a wide range of health, environmental and social policies that support action on fuel poverty and cold homes in the UK. This section summarises those most relevant to local authorities, health and wellbeing boards, and public health and primary care teams.

Health Policies

Health and Social Care Act 2012
The Health and Social Care Act 2012 requires the Secretary of State for Health to reduce health inequalities – the avoidable and unfair differences in health between people in different social circumstances, in partnership with other parts of the health system such as clinical commissioning groups (CCG).[5]

Public Health Outcomes Framework
The Public Health Outcomes Framework for England 2013–2016, identifies reducing fuel poverty as one of its key indicators to address the wider determinants of health. Reducing illness and cold-related deaths from cardiovascular and respiratory diseases are also identified as indicators against which the public health system should deliver improvements. The outcomes reflect a focus not only on how long people live (Life Expectancy), but on how well they live at all stages of life (Healthy Life Expectancy).[6],[7]

NHS Outcomes Framework and Social Care Outcomes Framework
The Public Health Outcomes Framework is also linked with the outcomes frameworks for the NHS and social care. Many indicators relating to fuel poverty and cold homes are shared across the three frameworks with the aim to facilitate a holistic approach to improving health across the entire health system.

[5] Health and Social Care Act 2012, Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (Accessed: 3 March 2016).
[6] DoH, (2013), Public Health Outcomes Framework 2013 to 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263658/2901502_PHOF_Improving_Outcomes005FPT1A_v1_1.pdf, Last accessed 22012015
[7] UKHF-HP (2014), FUEL POVERTY: HOW TO IMPROVE HEALTH AND WELLBEING THROUGH ACTION ON AFFORDABLE WARMTH, A guide to delivering action on fuel poverty for public health professionals, health and wellbeing boards, and local authorities in England, http://www.fph.org.uk/uploads/UKHF-HP_fuel%20poverty_report.pdf

The Cold Weather Plan for England
The Cold Weather Plan for England is produced annually. It aims to "prevent avoidable harm to health, by alerting people to the negative health effects of cold weather, and enabling them to prepare and respond appropriately."[8]

Making every contact count
The NHS's 'Making Every Contact Count' (MECC)[9,10] is relevant to fuel poverty and cold homes, The MECC initiative is based on the understanding that all organisations responsible for health, wellbeing, care and safety have the opportunity to impact on people's mental and physical health and wellbeing. Health practitioners can use their time with patients to find out whether they are able to keep warm in their homes, understand how this is affecting their health and wellbeing, and provide treatment, support and referral, where appropriate. It represents a proactive approach to prevention of ill health and lays a greater emphasis on addressing the wider determinants of health, such as education, housing or social environment.

Policies targeting Fuel poverty

Warm Homes and Energy Conservation Act 2000
The first Warm Homes and Energy Conservation Act was produced in 2000. It set a fuel poverty target and places duty on government to have a fuel poverty strategy to meet the target. In 2014, the Act was amended with the Fuel Poverty (England) Regulations 2014.[11] This set of regulations, which became law on 5 December 2014 set a new fuel poverty target for England. [12]

Fuel poverty strategy
The UK's fuel poverty strategy was launched in 2001 following the Warm Homes and Energy Conservation Act 2000 and set as its interim target "to eliminate fuel poverty in England among vulnerable households by 2010." the latest version was published in

[8] PHE 2015, Cold Weather Plan for England 2015, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/468160/CWP_2015.pdf
[9] NHS England, An Implementation Guide and Toolkit for Making Every Contact Count : https://www.england.nhs.uk/wp-content/uploads/2014/06/mecc-guid-booklet.pdf
[10] [10] NHS England, Making Every Contact Count: Briefing for the Voluntary and Community Sector, http://learning.wm.hee.nhs.uk/sites/default/files/voluntary_and_third_sector_briefing.pdf
[11] UKHF-HP (2014), Fuel Poverty: How to improve health and wellbeing through action on Affordable warmth, A guide to delivering action on fuel poverty for public health professionals, health and wellbeing boards, and local authorities in England, http://www.fph.org.uk/uploads/UKHF-HP_fuel%20poverty_report.pdf
[12] Gov.UK, (2015), Cutting the cost of keeping warm – a fuel poverty strategy for England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408644/cutting_the_cost_of_keeping_warm.pdf

2015, setting a target, 'to ensure that as many fuel poor homes as is reasonably practicable achieve a minimum energy efficiency rating of Band C, by 2030'.[13]

NICE guideline on Excess winter deaths and illness and the health risks associated with cold homes

This guideline was published in 2015 by the National Institute for Health and Healthcare excellence (NICE)[14]. It is aimed at commissioners, managers and health, social care and voluntary sector practitioners who deal with vulnerable people who may have health problems caused, or exacerbated, by living in a cold home. It will also be of interest to clinicians and others involved with at-risk groups, housing and energy suppliers. The guideline makes recommendations on how to reduce the risk of death and ill health associated with living in a cold home. The aim is to help:

- Reduce preventable excess winter death rates.
- Improve health and wellbeing among vulnerable groups.
- Reduce pressure on health and social care services.
- Reduce 'fuel poverty' and the risk of fuel debt or being disconnected from gas and electricity supplies
- Improve the energy efficiency of homes.
- Improving the temperature in homes, by improving energy efficiency, may also help reduce unnecessary fuel consumption.

Environmental policy

The Climate Change Act 2008

The Climate Change Act 2008 sets out UK policy to reduce carbon emissions, including its commitment to reduce CO2 by at least 80% in 2050 from a 1990 baseline. Tackling fuel poverty and cold homes contributes to the UK's legally binding carbon budgets by reducing carbon emissions from the current housing stock as well as reduced demand on the NHS, and supporting climate change adaptation planning.[15]

Policy Targeting Household Energy

[13] Gov.UK, (2015), Cutting the cost of keeping warm – a fuel poverty strategy for England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408644/cutting_the_cost_of_keeping_warm.pdf

[14] NICE 2015, Excess winter deaths and illness and the health risks associated with cold homes, https://www.nice.org.uk/guidance/ng6/chapter/About-this-guideline

[15] UKHF-HP (2014), FUEL POVERTY: HOW TO IMPROVE HEALTH AND WELLBEING THROUGH ACTION ON AFFORDABLE WARMTH, A guide to delivering action on fuel poverty for public health professionals, health and wellbeing boards, and local authorities in England, http://www.fph.org.uk/uploads/UKHF-HP_fuel%20poverty_report.pdf

Energy efficiency policy and programmes aimed at those in fuel poverty

The Energy Act 2011 includes provision for improving energy efficiency through the Green Deal and the Energy Company Obligation. The Energy Company Obligation and the Warm Home Discount Scheme provides direct energy bill support for many Low Income High Costs households and many Low Income Low Costs households. This means that the policy both contributes to our fuel poverty objectives and also helps to address broader affordability concerns. [16]

The scheme aims to achieve £30–£35 savings on household bills, on average, in 2014 and they are part of a wider package of changes to reduce the cost of household bills by £50 a year on average.

The Energy Act 2013

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266867/Energy_Bill_Summary_Policy_Brief_RA.pdf

The Energy Company Obligation (ECO)

The Energy Company Obligation (ECO) requires the largest domestic energy suppliers to fund energy efficiency improvements in the homes of certain consumers. To meet their obligation, participating energy companies promote and subsidise the cost of installing improvements to make homes warmer, healthier and more energy efficient.

Homeowners or people living in privately rented accommodation, and who are in receipt of certain benefits and/or tax-credits are eligible for help under this scheme. Support may include boiler repairs or replacements and a range of insulation improvements.

Household energy savings policy

Collective Switch Scheme

Collective switching is when a large group of people get together and use their collective buying power to negotiate a better deal from energy suppliers. The more people who are involved in a switch, the bigger the buying power and the better the deal they are likely to get. The aim of the Collective Switch programmed is to reduce energy bills. Collective switching is safe and easy, saves

[16] Gov.UK, (2015), Cutting the cost of keeping warm – a fuel poverty strategy for England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408644/cutting_the_cost_of_keeping_warm.pdf

time and saves money. In Merseyside's 6 Collective Switch sessions, local residents have saved in total over £1,000,000 at an average of £206 per year on their energy bills.[17]

Social and housing policy

Housing Health and Safety Rating System (HHSRS)

The Housing Act 2004 includes provision for the Housing, Health and Safety Rating System – a tool for local authority inspection and assessment of risks arising from hazards in residential properties – which came into effect in 2006. Excess cold is included in its list of category 1 hazards.

Decent Homes Standard 2000–2010

The Decent Homes Standard was launched by government in 2000 and updated in 2006 to reflect the Housing Act 2004. It is a standard for public housing in the United Kingdom. The NHS uses four broad criteria to assess housing conditions. A dwelling should:
A -be above the legal minimum standard for housing (measured by the presence of category 1 hazards under the Housing, Health and Safety Rating System), and
B - Be in a reasonable state of repair, and
C - Have reasonably modern facilities (such as kitchens and bathrooms) and services, and
D - Provide a reasonable degree of thermal comfort (effective insulation and efficient heating).

The definition of standard D has been revised and it now requires a dwelling to have both:

- efficient heating; and
- Effective insulation.

Despite its closure in 2010, some local authorities have continued programmes.

Income measures

Two main government benefits are provided to tackle fuel poverty and improve affordable warmth. They are the Winter Fuel Payment and Cold Weather Payment.

[17] Liverpool city region, Collective switching, http://www.lcrenergyswitch.co.uk/what-is-collective-switching/

Winter Fuel Payment
The Winter Fuel Payment, of between £100 and £300 tax-free, is an annual payment to help with heating costs. It is made to households with someone over Pension Credit age. A person under 80 years of age will normally receive £200, and £300 if they are 80 years or over.[18]

Cold Weather Payment
A Cold Weather Payment is made to people receiving certain benefits. It is paid if the temperature in a person's area is recorded as, or forecast to be, zero degrees Celsius or below for 7 consecutive days. A £25 payment is made for each seven-day period of very cold weather from 1 November until March.[19]

Energy tariff measures

The Warm Home Discount
Under this discount, Eligible customers receive a one-off payment of £140 on their winter electricity bills, usually paid between October and March. Participating energy suppliers will also offer the discount to a wider group of other low income and vulnerable customers, such as those with a disability or long-term illness, and families with young children on certain benefits,[20]

Others

Priority Services Register[21]
The Priority Services Register requires suppliers and electricity Distribution Network Operators (DNOs) but not Gas Distribution Networks (GDNs) to keep registers of vulnerable customers. Under this scheme, companies have to provide specified non-financial services to customers who are: of pensionable age, disabled, chronically sick, deaf, hearing impaired, blind or partially sighted. Suppliers must also make information about their obligations and how to join the register readily accessible on their website, and tell customers once a year about it People on this register can obtain benefits, (depending on their supplier), such as: warnings and advice if their energy supply is going to be interrupted, Free annual gas safety checks, bills and letters in alternative formats, help with reading meters and relocation of meters for easier access.

[18] Winter Fuel Payment, https://www.gov.uk/winter-fuel-payment/overview
[19] Cold Weather Payment, https://www.gov.uk/cold-weather-payment/overview
[20] Warm Home Discount Scheme, https://www.gov.uk/the-warm-home-discount-scheme/what-youll-get
[21] Ofgem, 2014, Review of the Priority Services Register https://www.ofgem.gov.uk/ofgem-publications/88552/condocpsrreview-pdf Accessed 18/08/2016

Appendix 4: Respondents to Survey

Name of department /or organisation	Type of organisation (Group)
Age UK Mid Mersey	Charity
Energy Projects Plus	Charity
Halton Carers Centre	Charity
Halton Citizens Advice Bureau (CAB)	Charity
Halton Senior Services	Charity
Sustainable Communities, Groundwork Cheshire Lancashire and Merseyside.	Charity
Protection and Prevention	Cheshire Fire and Rescue Service
Brookvale & windmill Hill Children's Centres, Team around the Family	Halton Borough Council
Commissioning	Halton Borough Council
Environmental Health	Halton Borough Council
Halton BC	Halton Borough Council
Halton BC - Contact Centre	Halton Borough Council
Health Improvement Team	Halton Borough Council
Inclusion 0-25	Halton Borough Council
Intermediate and Urgent Care	Halton Borough Council
Public Health	Halton Borough Council
Sure Start to Later Life	Halton Borough Council
Trading Standards	Halton Borough Council
Welfare Rights Service	Halton Borough Council
Respiratory Team	Hospital Trust
Halton Housing Trust - Asset Management	Housing
Plus Dane - Asset Management	Housing
Plus Dane and SHAP	Housing
Riverside, Community Engagement, Affordable Warmth	Housing

Appendix 5: Fuel Poverty and Energy Efficiency of Dwellings

Poor housing is a significant contributor to poor health and fuel poverty. The most significant contributor to fuel poverty is poorly insulated and hard-to-heat homes. There is also a link between excess winter deaths and cold homes.

The Standard Assessment Procedure (SAP) is the UK Government's methodology for calculating the energy performance of dwellings.[22,23] The SAP rating is based on the energy costs associated with space heating, water heating, ventilation and lighting, less cost savings from energy generation technologies. It is adjusted for floor area so that it is independent of dwelling size for a given building type. A SAP rating of 100 implies zero net cost of energy use for heating, hot water and lighting.

The calculation is based on the energy balance taking into account a range of factors that contribute to energy efficiency:

- Materials used for construction of the dwelling
- Thermal insulation of the building fabric
- Air leakage ventilation characteristics of the dwelling, and ventilation equipment
- Efficiency and control of the heating system(s)
- Solar gains through openings of the dwelling
- The Fuel used to provide space and water heating, ventilation and lighting
- Energy for space cooling, if applicable
- Renewable energy technologies
- The calculation is independent of factors related to the individual characteristics of the household occupying the dwelling when the rating is calculated, for example:
- Household size and composition;
- Ownership and efficiency of particular domestic electrical appliances;
- Individual heating patterns and temperatures.

The SAP rating is expressed on a scale of 1 to 100, the higher the number the lower the running costs. The higher the SAP rating of buildings, the less likelihood of the residents living in Fuel Poverty and the lower their level of Fuel Poverty.

[22] DECC 2013, The Government's Standard Assessment Procedure for Energy Rating of Dwellings http://www.bre.co.uk/filelibrary/SAP/2012/SAP-2012_9-92.pdf 20151016

[23] DECC (2012) The Energy Efficiency Strategy: https://www.gov.uk/government/uploads/system/uploads/attachment data/file/65602/6927-energy-efficiency strategy--the-energy-efficiency. pdf

Between 1996 and 2012 the average SAP rating for all homes increased from 45 (Energy Performance Certificate (EPC) band E) to 59 (bottom of EPC band D) for England. The age of a building and the standard of insulation affect the energy efficacy of the dwelling. Housing association properties have the highest SAP rating due to more recent improvements and higher standards of insulation. . The biggest improvements have come in the private and local authority sectors. This improvement equates to a reduction in modelled energy use of about 25 per cent. This improvement has been achieved through improvements in the efficiency of heating systems, insulation including double glazing and efficient lighting.

The obvious increase in the rate of improvement of all homes since 2008 can be attributed to a number of policies started around this time. These include new buildings regulations requiring all new boilers to be A-rated, the Carbon Emissions Reduction Target (CERT) and the introduction of Energy Performance Certificates.[24]

The depth and likelihood of being Fuel poor increases markedly with lower SAP scores. In 2013, 31 per cent of households living in G rated properties were in Fuel Poverty, with an average Fuel Poverty gap of £1,274. This is compared to those living in properties with SAP ratings A-C where just two per cent were Fuel poor and an average Fuel Poverty gap of £370.

The Fuel Poverty (England) Regulations 2014 set a Fuel Poverty target to ensure that as many Fuel poor homes as is reasonably practicable achieve a minimum energy efficiency rating of Band C by 2030. This included interim milestones, of as many Fuel poor homes as is reasonably practicable to achieve a minimum energy efficiency rating of Band E by 2020, and Band D by 2025.

[24] DECC 2015 , Energy Efficiency Statistical Summary 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/395007/stats_summary_2015.pdf, Accessed 20151016

Appendix 6: Existing Referral options for fuel poverty in Halton

Statutory sector

- Halton BC
- Welfare Rights Team
- Adult Social Care
- Halton Telehealth service
- The debt advice service
- Local authority team, LASP
- Local GP's
- Sure start to later life
- Financial inclusion team provide advice

Voluntary sector

- Wellbeing Enterprises
- care agencies
- Registered social landlords.
- Age UK
- energy suppliers for insulation checks and grants for free boiler, loft insulation etc.
- Citizens' advisory bureaux (CAB)
- Age UK
- VCA
- Local Solutions for fuel debt support
- Energy Saving Advice Service,
- Energy Providers,
- Energy Project PLUS

FUEL POVERTY IN HALTON

FUEL POVERTY means households are unable to heat their homes well enough to maintain their health or they are spending so much on heating that there is not enough disposable income for other essentials.

Some families have to choose whether to **heat** or **eat**

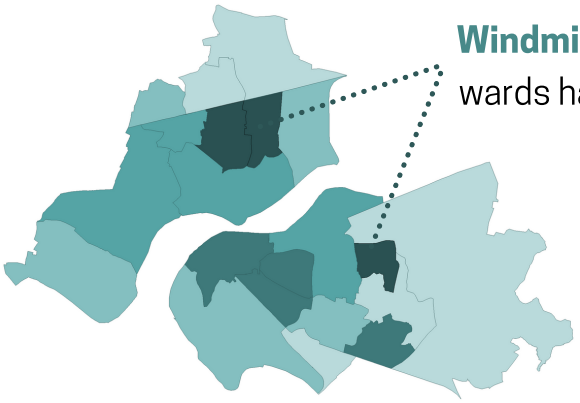
WHAT IS THE ISSUE?

Almost **1 in 10** households in Halton live in fuel poverty.

>>>> This is around **5,000** households.

This is better than the national average, but there are areas of Halton were fuel poverty is high.

>>>> Therefore there are **inequalities**



Windmill Hill, **Appleton** & **Kingsway** wards have the highest levels of fuel poverty

CAUSES OF FUEL POVERTY

- poor energy efficiency of homes
- low household income
- high fuel costs

RISK FACTORS

INCOME

Households with low income are more likely to struggle with rising fuel costs.

Unemployed people are more likely to live in fuel poverty.

Vulnerable people will be affected by cuts to benefits.

HOUSING

Households are more likely to live in fuel poverty if they:

- live in privately rented accommodation.
- do not have central heating.
- are single occupancy.
- live in homes that are not energy efficient.

HEALTH CONDITION OR DISABILITY

People are more likely to be affected by cold homes if they have:

- heart disease
- a respiratory condition
- a mental health condition
- a disability
- mobility problems

AGE

Children and the elderly are more likely to be affected by cold housing and fuel poverty.

WHAT ARE THE EFFECTS?

COST

Fuel poverty comes at a huge cost to health services. The NHS spends about £1.4 billion per year to treat the illnesses caused and worsened by cold homes.

Investing £1 in improving affordable warmth can deliver a 42 pence saving in health costs for the NHS.

INEQUALITIES

Fuel poverty widens inequalities as it particularly affects vulnerable groups such as the very young, elderly and income deprived.

HEALTH & WELLBEING

children

Living in a cold home can:

- affect development
- lead to chest problems
- worsen existing health conditions
- reduce educational achievements
- affect mental well-being

young people

Fuel poverty can lead to poor mental health.

Young people are 5 times more likely to suffer mental health problems if they live in a cold home.

adults

Living in a cold home can:

- cause poor mental health
- worsen exiting health conditions
- increase risk of falls
- increase risk of premature death
- increase excess winter deaths

WHAT CAN WE DO?

There is already a great deal of work happening by **Halton Borough Council, the voluntary sector, charities, the NHS and local Fire and Rescue Services.**

>>>> But there is more work to do

THE VISION

All households in Halton can achieve the heating levels they need to maintain comfort and good health, at an affordable cost.

OBJECTIVES

1. Increase awareness of fuel poverty amongst professionals and the public.
2. Identify people who are living in cold homes or at risk of fuel poverty.
3. Identify and monitor support available and ensure that people living in cold homes or fuel poverty are able to access support.

WE WILL ACHIEVE THESE BY

Making every contact count.

Working together to maximise efforts of various agencies.

REPORT TO: Health and Wellbeing Board

DATE: 12th October 2016

REPORTING OFFICER: Director of Public Health, Halton Borough Council and Director of Commissioning, NHS Halton CCG

PORTFOLIO: Health and Wellbeing

SUBJECT: Health and Wellbeing Strategy 2017-2022

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with a further update on the development of the new **One Halton Health and Wellbeing Strategy (2017-2022).**

2.0 RECOMMENDED: That the Board supports the development of the new strategy

3.0 SUPPORTING INFORMATION

3.1 Good progress is being made in developing a new Health and Wellbeing Strategy for Halton. The new Strategy will build upon the successes of the previous strategy and will be the overarching document for the Health and Wellbeing Board outlining the key priorities the Board will focus on has focussed on over the next five years (2017-2022).

3.2 The new strategy is being developed using a partnership approach and a multi-agency Health and Wellbeing Steering Group has been established to oversee its development. The group is co-chaired by the Director of Public Health and Director of Commissioning for NHS Halton CCG it includes membership from NHS Halton CCG, Health Watch, Halton & St Helens Council for Voluntary Services, HBC Children's Services, HBC Adult Social Care, HBC Public Health and a representative of the public, The previous strategy was well received locally and nationally – its style told a clear story about why and how we would approach our priorities - and we will build on this experience for the new Strategy. The Steering group has developed a template for the new Health and Wellbeing Strategy for Halton which is currently being completed. The new Strategy will provide:

- An updated health and wellbeing profile for Halton,
- Outline the progress made since 2013 and the challenges that remain,

- Provide an overview of priorities and how and why these were chosen,
- Outline a place based approach working with local people and using local assets,
- Outline what we will do as a system at scale to make a difference, and
- Outline how we will measure success.

3.3 The Strategy will follow the principles of:

- Focus on people and places not organisations.
- Take a life course approach
- Work in partnership: Design things together and collaborate
- Be financially sustainable
- Join budgets together
- Be fair
- Be innovative
- Strive for best quality services.

3.4 The Steering Group have used available evidence of health needs to identify issues of particular significance for the borough. Priorities identified within the new strategy will be aligned with “One Halton” areas of focus and LCR Devolution. The priorities are backed by a strong evidence base considering the local JSNA, Right Care benchmarks and performance against the range of national and local targets. They include:

- Continue to improve levels of early child development.
- The generally well, focussing on physical activity, healthy eating and alcohol reduction.
- Long term conditions, focussing on heart disease.
- Prevention and early detection of mental health problems and improved access to treatment.
- Ageing well, including falls prevention.
- Prevention and early detection of cancers and improved access to treatments.

3.5 We believe that success in delivering against the strategy can only be achieved by working in partnership with local people. Therefore, in developing the new Strategy we are consulting with a wide range of Halton residents to ensure that the principles and priorities are reflective of the experience and needs of our local communities. An engagement plan is in place and includes using the media, websites, magazines and so on. In addition it has been agreed consultation will be undertaken by the voluntary sector, Health Watch and One Halton portfolio directors using pre-existing networks and forums for engagement e.g. Halton Peoples Health Forum. The consultation will be undertaken using specifically developed Health and Wellbeing Fact Sheets

(Included within Appendix 1). The feedback received will be used to inform the new One Halton Health and Wellbeing Strategy.

3.6 The Final version of the new One Halton Health and Wellbeing Strategy will be presented to board for approval in January 2017. The final approved version will be made available online.

4.0 POLICY IMPLICATIONS

4.1 The Health and Wellbeing Strategy will inform collaborative action for the Council, NHS, Social Care, Public Health and other key partners as appropriate.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 No additional funding required. However the strategy will inform future activity and spending across the system.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton. The Health and Wellbeing Strategy will include child development as a priority.

6.2 Employment, Learning & Skills in Halton

The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents

6.3 A Healthy Halton

All issues outlined in this report focus directly on this priority.

6.4 A Safer Halton

Reducing the incidence of crime, improving Community Safety and reducing the fear of crime have an impact on health outcomes particularly on mental health.

6.5 Halton's Urban Renewal

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing.

7.0 RISK ANALYSIS

7.1 Developing the Health and Wellbeing Board Strategy does not present any

obvious risk however, there may be risks associated with the resultant recommendations. These will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 This is in line with all equality and diversity issues in Halton.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Appendix A: Health and Wellbeing Priority Fact Sheets

Health and wellbeing priorities

Children and families

What are the issues?

poverty

1 in 4 under 16s in Halton live in poverty.

The majority of families living in poverty are in employment.

Poverty has a big impact on health and achievement in education.

child development

Early development is important for what we achieve as adults.

Just over half of children locally achieve a good level of development at the end of Reception, aged 5.

This is significantly lower than the national and regional averages.

accidents

Hospital admission rates for accidents in children and young people under 25 are significantly higher than the national average.

parenting

Children who bond with their parents and have a supportive home life are more likely to grow into healthy and happy adults.

Halton's child development indicator shows we need to achieve more in terms of parenting programmes.

Health and wellbeing priorities

Children and families

What is important to you?

● Help to improve health and wellbeing in Halton ●

The Halton Health and Wellbeing Board has to set out how it will improve the health and wellbeing of people living in Halton. This will be the "Halton Health and Wellbeing Strategy".

We need and value your views on what we should focus on. We would be grateful if you could complete the following short survey to let us know what we should be doing to help children and families in Halton.

The Board will use your feedback to develop the new Halton Health and Wellbeing Strategy.

		Please tick all that are important to you
1	Enhancing school readiness programme	
2	Additions to the prevention of child accidents programme	
3	Enhancing parenting programmes	

Or is there something else? Please tell us here:

myhalton living life well

Graphics produced using Canva; all icons sourced from www.flaticon.com

Health and wellbeing priorities

Generally well

What are the issues?

infant feeding

Fewer mums in Halton breastfeed than in the rest of the North West and England.

Babies starting solid foods too early are more likely to grow into overweight toddlers.

weight

Just over 1 in 10 of 4-5 year olds in Halton are obese. This is higher than the England and the North West averages.

1 in 4 adults are obese, which is higher than other areas in Merseyside.

fruit & veg

Less than half of all adults and even fewer teenagers in Halton eat 5 or more portions of fruit and vegetables per day.

This is lower than the rest of the North West and England.

exercise

In Halton, more men achieve recommended levels of exercise than women, and more younger people than older people.

Less than half of the adults in Halton are active, which is lower than the national average.

Health and wellbeing priorities

Generally well

What is important to you?

Help to improve health and wellbeing in Halton

The Halton Health and Wellbeing Board has to set out how it will improve the health and wellbeing of people living in Halton. This will be the "Halton Health and Wellbeing Strategy".

We need and value your views on what we should focus on. We would be grateful if you could complete the following short survey to let us know what we should be doing to help the generally well in Halton.

The Board will use your feedback to develop the new Halton Health and Wellbeing Strategy.

		Please tick all that are important to you
1	A conversation with the public about their access to fresh food	
2	Enhancing the infant feeding programme	
3	Introduction of a women's exercise programme	

Or is there something else? Please tell us here:

myhalton living life well

Graphics produced using Canva; all icons sourced from www.flaticon.com

Health and wellbeing priorities

Older people

What are the issues?

loneliness

Loneliness has an effect on health.

There are an estimated 6,000 people in Halton aged 65 and over experiencing some level of loneliness.

Research shows that many people worry about becoming lonely in the future.

living alone

The older the person, the more likely they are to live alone.

People aged 85 and over are most likely to live alone, over 8 out of 10 in Halton.

The level of falls amongst older people in Halton is higher than the national average.

transport

Good transport systems are essential.

3 in 10 over 65s in Halton have no access to a private car.

Community transport is available in Halton.

However research shows that older people find it harder to travel to local facilities such as health centres.

information

Good information systems are really important.

Many older people do not have enough information on what's happening in the local area.

Health and wellbeing priorities

Older people

What is important to you?

● Help to improve health and wellbeing in Halton ●

The Halton Health and Wellbeing Board has to set out how it will improve the health and wellbeing of people living in Halton. This will be the "Halton Health and Wellbeing Strategy".

We need and value your views on what we should focus on. We would be grateful if you could complete the following short survey to let us know what we should be doing to help older people in Halton.

The Board will use your feedback to develop the new Halton Health and Wellbeing Strategy.

		Please tick all that are important to you
1	Marketing campaign on preventing loneliness	
2	Develop an older people's transport group	
3	Develop a directory of services for older people	

Or is there something else? Please tell us here:

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Graphics produced using Canva; all icons sourced from www.flaticon.com

Health and wellbeing priorities

Long term conditions

living with a disease

What are the issues?

high blood pressure

Over 19,000 people registered at GPs in Halton have been diagnosed with high blood pressure.

4 in 10 of these people never attend to be checked.

If we find and treat high blood pressure, we can prevent heart disease and stroke.

atrial fibrillation

1 in 10 emergency admissions to hospital during 2014/15 had atrial fibrillation (irregular heartbeat).

If we find and manage atrial fibrillation, we will reduce the number of people suffering strokes, which can lead to disability.

heart disease

Cardiovascular disease is the biggest cause of preventable death in England. It was responsible for 1 in 4 deaths in Halton in 2014.

If people understand their health condition, they are better able to recognise and manage if their condition changes.

prevention

The number of people who smoke has generally been falling. The proportion is higher in those in routine and manual jobs.

Halton has one of the highest levels of adult obesity in England. Levels of child obesity are also high.

Less than half of adults eat 5 portions of fruit and vegetables per day and even less young people do. Less than half of adults take enough exercise.

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Health and wellbeing priorities

Long term conditions

What is important to you?

Help to improve health and wellbeing in Halton

The Halton Health and Wellbeing Board has to set out how it will improve the health and wellbeing of people living in Halton. This will be the "Halton Health and Wellbeing Strategy".

We need and value your views on what we should focus on. We would be grateful if you could complete the following short survey to let us know what we should be doing to improve long term conditions in Halton.

The Board will use your feedback to develop the new Halton Health and Wellbeing Strategy.

		Please tick all that are important to you
1	Screening in the community for atrial fibrillation (irregular heartbeat)	
2	Enhancing early diagnosis of heart disease and self care programmes	
3	Increasing screening for hypertension (high blood pressure) in the community	

Or is there something else? Please tell us here:

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Graphics produced using Canva; all icons sourced from www.flaticon.com

Health and wellbeing priorities

Mental health

What are the issues?

common issue

At least 1 in 4 people will experience a mental health problem at some point in their life.

Mental ill health is the largest single cause of disability in Halton.

More people in Halton have been diagnosed with depression than the national average.

happiness

When asked "how happy did you feel yesterday?", just over 1 in 10 Halton residents reported a low level of happiness.

self harm

Halton had the 15th highest rate of hospital stays due to self harm of all 152 Local Authorities in England during 2014/15.

dementia

During 2015, there were over 1,000 people in Halton aged over 65 who were diagnosed with dementia.

This is predicted to almost double by 2030.

Health and wellbeing priorities

Mental health

What is important to you?

Help to improve health and wellbeing in Halton

The Halton Health and Wellbeing Board has to set out how it will improve the health and wellbeing of people living in Halton. This will be the "Halton Health and Wellbeing Strategy".

We need and value your views on what we should focus on. We would be grateful if you could complete the following short survey to let us know what we should be doing to improve mental health in Halton.

The Board will use your feedback to develop the new Halton Health and Wellbeing Strategy.

		Please tick all that are important to you
1	Review the current Child & Adolescent Mental Health Services (CAMHS)	
2	Enhancing services for adults with personality disorders	
3	Redesigning adult mental health services	

Or is there something else? Please tell us here:

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Graphics produced using Canva; all icons sourced from www.flaticon.com

Health and wellbeing priorities

Cancer

What are the issues?

biggest killer

Cancer is Halton's most common cause of death.

Of all cancer deaths, lung cancer is the biggest killer.

Halton's rates of cancer deaths under the age of 75 are amongst the highest in England.

prevention

The number of people who smoke has generally been falling. The proportion is higher in those in routine and manual jobs.

Halton has one of the highest levels of adult obesity in England. Levels of child obesity are also high.

Less than half of adults eat 5 portions of fruit and vegetables per day and even less young people do. Less than half of adults take enough exercise.

early detection

We need to help people recognise early signs and symptoms of cancer.

Halton's screening rates are low, particularly for bowel cancer,

Catching cancer early can reduce the risk of dying from the disease.

waiting times

Times to treatment need to improve.

This will help improve the chance of survival.

Health and wellbeing priorities

Cancer

What is important to you?

Help to improve health and wellbeing in Halton

The Halton Health and Wellbeing Board has to set out how it will improve the health and wellbeing of people living in Halton. This will be the "Halton Health and Wellbeing Strategy".

We need and value your views on what we should focus on. We would be grateful if you could complete the following short survey to let us know what we should be doing to improve cancer in Halton.

The Board will use your feedback to develop the new Halton Health and Wellbeing Strategy.

		Please tick all that are important to you
1	Enhancing the early detection programme	
2	Developing and actioning a tobacco control strategy	
3	Enhancing support for bowel screening to improve uptake	

Or is there something else? Please tell us here:

myhalton living life well

Graphics produced using Canva; all icons sourced from www.flaticon.com

REPORT TO: Health & Wellbeing Board

DATE: 12th October 2016

REPORTING OFFICER: Strategic Director,
Enterprise, Community & Resources

PORTFOLIO: Leader

SUBJECT: Halton Strategic Partnership Restructuring

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of the report is to update the board on work that has been going on to restructure the Halton Strategic Partnership and to inform the Board of the impact on its future agenda.

2.0 **RECOMMENDATION: That:**

i) The report be noted and the revised arrangements be supported;

ii) Members of the Board be asked to comment on future agenda management arising from the broadening of the Board's remit.

3.0 **SUPPORTING INFORMATION**

3.1 **Background**

3.1.1 In 2000 the Local Government Act put in place a formal requirement on local authorities to have a Local Strategic Partnership (LSP) for those areas that received Neighbourhood Renewal Funding.

3.1.2 The Halton Strategic Partnership (HSP) has been in existence since 2001; however there has been a Halton Partnership in various forms since the early nineties, which has encouraged and facilitated strategic dialogue across partners. Over the years the Partnership and its governance arrangements have been regularly reviewed and refreshed to ensure they are fit for purpose.

3.2 **Considerations**

3.2.1 The HSP operates at a strategic level and is tasked with delivering the Sustainable Communities Strategy (SCS), to which all stakeholders and communities are given the opportunity to

contribute towards its development.

3.2.2 Since 2010 there have been several legislative and policy changes which have impacted on the HSP and how it operates e.g. Localism Act, Deregulation Act, and Health and Social Care Act in particular.

3.2.3 These various pieces of legislation have removed statutory responsibility to have an LSP and for partners to agree an SCS. These changes sit alongside huge reductions in the resources available to partners across different sectors, meaning fewer resources are available to allow partners to engage with the wide range of partnership groups and forums which have developed over the years.

3.2.4 This changing environment provides an ideal opportunity to review the partnership governance, structures and membership of the strategic boards, ensuring resources are maximised, duplication eliminated and a rationalising of the proliferation of sub-groups that sit under the Partnership banner.

3.3 **Changes**

3.3.1 On the 2nd March 2016 the Halton Strategic Partnership held a consultation event, attended by over 70 delegates from across the partnership, to discuss a proposed restructure of the various strategic boards that sit under the partnership banner. Whilst delegates valued the previous joint working opportunities, there was an appreciation that changes were needed.

3.3.2 As there is statutory requirement to have a HWBB it was considered sensible to merge the HSP with the HWBB under the banner of the HWBB. However, it was recognised that it would be important to ensure that within the “new” expanded role of the HWBB that it still remained focussed on the wider determents of health and its formal statutory role.

3.3.3 The new structure also sees several of the other boards being dissolved or combined, with one new Board being created whose remit would include some of the areas of responsibility covered by the Liverpool City Region Combined Authority, and thus providing a partnership forum for feeding into the wider LCR agendas. Attached as an appendix to this report is a diagram that shows the proposed new partnership arrangements.

3.3.4 These changes are currently being progressed across the remaining Strategic Partnership Boards (HWBB, Children’s Trust, and Safer Halton Partnership). Work has also started on Terms of Reference and Membership for the new Economic Prosperity Board.

4.0 POLICY IMPLICATIONS

4.1 Effective partnership arrangements are essential in ensuring the best possible use of public money across the Borough. It is felt that these new streamlined arrangements will continue to ensure that happens.

5.0 FINANCIAL IMPLICATIONS

5.1 There are no direct financial implications. The revised arrangements reflect the reducing resources available to all partners.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 The delivery of all the Council's priorities is heavily dependent on working effectively with all of its partners. Reviewing these arrangements from time to time helps challenge their appropriateness, giving the ever changing circumstances faced.

7.0 RISK ANALYSIS

7.1 There are no risks associated with this paper.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no equality and diversity issues associated with this paper.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None.

Halton Strategic PARTNERSHIP

NEW BOARD STRUCTURE AND RESPONSIBILITIES

Health and Wellbeing Board

Health
NHS Planning
Five Year Forward View/Sustainability and Transformation Plan
Better Care
HWB Priorities

- Continue to improve levels of early child development
- Keeping people well, focussing on physical activity and healthy eating
- Long term conditions, focussing on cardiovascular disease
- Prevention and early detection of mental health problems and improved access to treatment
- Ageing Well
- Prevention and early detection of cancers

Wider Determinants of Health(not covered elsewhere include):-

- Living and Working Conditions (skills and employment, housing, public transport, welfare services, access to goods and facilities)
- General Social-Economic and Environmental Conditions (social, economic and environmental issues, wages, disposable income, availability of work, taxation, cost of food and services – fuel, transport, food, clothing)
- Community Cohesion/Safety and Cultural issues (community and social networks, friends and wider social circles, safe and welcoming communities to live and work in are a protective factor in terms of health)

Will Receive Quarterly Written Updates from the other 3 Boards – for information

Children's Trust	**Economic Prosperity (New Board)**	**Safer Halton**
Early Intervention (deliver services in a joined up way to make sure children and their families get the right help at the right time) Integrated Commissioning (plan and fund outcome focused services for children and families, that deliver high quality services that are value for money) Closing the Gap (focus services towards the needs of our most vulnerable children, young people and families to "close the gap" by improving health, education, social	Economic Growth Business Support Skills and Employment Environmental Issues Transport Housing and Spatial Planning Energy/Climate Change	Criminal Justice System Serious Organised Crime Community Safety Alcohol Harm Crime Anti-Social Behaviour Domestic Abuse Substance Misuse Community Cohesion Prevent/Channel

and cultural outcomes)		

ANNUAL PARTNERSHIP STRATEGIC EVENT *: Each Board to feed into annual event : What Have You Done? What Are You Doing? What Will You Do?*

Boards and Groups Currently Being Collapsed and/or Merged With Others or Already Dissolved	
Halton Strategic Partnership Board Employment, Learning and Skills Environment and Regeneration Equalities, Engagement and Cohesion Children's Trust Executive Group Halton Community Practioners Forum Closing the Gap Working Group	Halton Information and Advice Partnership Halton Housing Providers Obesity Board Tobacco Board Alcohol Board One Halton Board (now only a steering group)