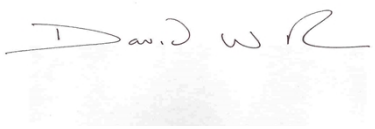
Public Document Pack

Health and Wellbeing Board

Wednesday, 10 July 2019 2.00 p.m.
The Halton Suite - Select Security Stadium, Widnes



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, 2 October 2019

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, 27 March 2019 at Halton Suite - Halton Stadium, Widnes

Present: Councillor Polhill (Chair) and T. McInerney, Woolfall and Wright and S. Bartsch, M. Charman, G. Ferguson, T. Hemming, T. Hill, N. Kershaw, R. Macdonald, L. Marler, A. McHale, D. Moore, E. O'Meara, K. Parker, D. Parr, S. Semoff, L. Thompson, M. Vasic, S. Wallace Bonner, A. Williamson and S. Yeoman.

Apologies: M. Larking, M. Pickup and R. Strachan.

Action

HWB17 MINUTES OF LAST MEETING

The Minutes of the meeting held on 3rd October 2019, having been circulated were signed as a correct record.

HWB18 EXECUTIVE PARTNERSHIP BOARD - UPDATE

The Board considered a report of the Director of Adult Social Services, which provided an update on the key issues that the Executive Partnership Board (EFP) and the associated Operational Commissioning Committee (OCC) had been focused on progressing and monitoring over the past few months. It was noted that the EFP had met on a quarterly basis and:

- Work had taken place across both the Council and Halton Clinical Commissioning Group to reduce the level of projected overspend. Financial recovery action plans were in place to achieve a balanced budget by the end of the year;
- Work had continued with all partners to help to minimise delayed transfers of care (DTOC);
- Work had been presented to the OCC on the development of an Inter-Agency Disputes Process;
- The current Joint Working Agreement (JWA) between the Council and Halton CCG expired on 31st March 2019. Work was taking place on the development of a new JWA. In the meantime the current JWA would be extended for 6 months;
- The OCC had agreed how the extra funding provided to the Council this Winter would be spent; and
- As a result of an internal audit report of Halton Integrated Community Equipment Service, five recommendations were made and a Task and Finish Group had been set up to undertake a review with

options for the future delivery of the service.

RESOLVED: That the contents of the report be noted.

HWB19 ONE HALTON - PRESENTATION

The Board received a presentation from David Parr outlining the work that had taken place to date to develop the One Halton Prevention Model and Framework.

The Board was advised that the aim of *One Halton* was to deliver a place based health, integrated, user friendly, prevention model. It would make the most of local talents and assets, services and providers and enable people to stay well and within reason manage their own health. It aimed to improve health outcomes so that people live longer, healthier and happier lives.

The presentation outlined the benefits of the One Halton Model, revised governance arrangements, the One Halton population health achievements and its future aims.

It was noted that the next stage in the development of the model and framework would be to:

- Develop a Provider Alliance Board;
- Commissioners would determine the total Halton spend on health and social care and how this would be spent under a One Halton Provider Alliance model;
- Commissioners to be clear about their joint commissioning intentions at a strategic One Halton level and “what good looks like” for Halton residents; and
- resource the capacity to deliver a One Halton Provider Alliance model and support the GP Federations to drive forward the model.

RESOLVED: That

1. the revised governance arrangements for One Halton be approved; and

2. the Board receive regular update reports on the development of One Halton.

HWB20 DEVELOPMENT DAY FOLLOW UP

The Board received an update on the follow up actions that came out of the Development Day which took place in January 2019. The development session focussed

on:-

- Describing factors in the current context that have an impact on what the Board was trying to do;
- Assessed how its performing and identified areas for improvement;
- Agreed priority areas of change that would improve performance;
- Agreed specific changes that members of the Board would make; and
- Identified actions needed to take to implement them.

During the Development Day, the Board agreed to introduce induction for new Board Members and that a Membership and contacts list should be developed for Board Members to share. In addition, as a result of feedback from the day, the following documents had been developed and were circulated to Members for approval:

- A revised terms of reference;
- Updated roles and responsibilities for Board Members; and
- A performance dashboard.

RESOLVED: That the following be approved:

1. Revised terms of reference;
2. The performance dashboard; and
3. Updated roles and responsibilities for Board Members

HWB21 REFRESHED TRANSFORMATIONAL PLAN FOR CAMHS

The Board received a presentation on the actions to date to support the Transformation of the local CAMHS offer, to identify the key drivers for the change and next steps

Following the publication of Future in Mind (February 2015) each Borough was required to submit a Plan to transform the local current CAMHS offer to deliver on the aspirations contained within the Future in Mind document. An initial Plan was submitted to NHS England and had been subject to regular refresh.

For 2018/19 the Plan had been refreshed jointly with Warrington CCG as many of the aims and objectives and redesign initiatives were shared. However, the plan did

provide each Borough with specific detail.

It was noted that the Plan had been approved by the local multi agency stakeholder group – the Emotional Health and Wellbeing for Young Peoples Partnership Group, chaired by the CCG Clinical Lead for children Denise Roberts, Deputy Chief Nurse for the Halton CCG.

RESOLVED: That

1. the presentation be noted; and

2. the Board approve the refreshed Transformational Plan for CAMHS

HWB22 HALTON SAFER ADULTS BOARD ANNUAL REPORT

The Board considered a presentation by the Independent Chair of the Halton Safeguarding Adults Board (SAB), which outlined the Annual Report 2017/18. The Board was advised on the role of the SAB, a summary analysis of the data gathered and how this information was used to inform the work priorities for 2018-19.

RESOLVED: That the report be noted.

HWB23 CARE QUALITY COMMISSION (CQC) LOCAL SYSTEM REVIEW - PROGRESS REPORT

The Board considered a copy of the CQC Local System Review Progress Monitoring Report, which was presented for information. The CQC undertook a local system review in Halton in August 2017 and the system produced an action plan in response to the CQC's findings. Following a programme of 20 local system reviews, the Department of Health and Social Care had requested the CQC to produce progress updates for these. For Halton the progress report drew on:

- Halton's self reported progress against their action plan (31/10/18);
- CQC's trend analysis of performance against the England average for six indicators; and
- Telephone interviews with four system leaders involved in the delivery and oversight of the action plan.

With regard to the progress made against the six indicators, the CQC had stated that there had been no

significant changes in A&E attendances and emergency admissions since the review. In terms of Emergency admissions from care homes these had increased a little during 2017/18. Lengths of stay remained similar to the England average, whereas Delayed Transfers of Care and Emergency readmissions both increased and were higher than the England average.

In response to CQC's progress report, the local system responded to CQC with regard to some improvements:

- Emergency Admissions in quarter 3 and 4 of 2017/18 was actually below our long-term average; and
- Emergency admissions from care homes the gap between Halton and England was now half what it was two years ago, and Halton had been below their long-term average for 4 of the last 5 quarters.

The Board noted that CQC's review of progress on the action plan concluded that there had been good progress made in all of the areas, with a few actions highlighted as on-going or requiring further development.

RESOLVED: That the report be noted.

HWB24 CHILD DEATH OVERVIEW PROCESS & GOVERNANCE ARRANGEMENTS - PAN CHESHIRE WIDE

The Board considered a report of the Director of Public Health which proposed a number of recommendations regarding the implementation of the Children and Social Work Act 2017 revised statutory guidance in relation to the Child Death Overview Panel (CDOP).

As a result of the Children and Social Work Act 2017, Local Authorities, Clinical Commissioning Groups and Police forces have had to revise their current Local Safeguarding Children Board (LSCB) arrangements. As part of these changes they have also been required to establish Child Death Overview Panels (CDOP) as a distinct set of arrangements rather than a subgroup of the LSCBs.

Under the revised guidance the new Child Death Review (CDR) partners, the Local Authority (LA) and the Clinical Commissioning Groups (CCG) had statutory responsibilities to:

- Make arrangements to review all deaths of

children normally resident in the local area and, if they considered it appropriate, for any non-resident child who has died in their area;
- Make arrangements for the analysis of information from all deaths reviewed; and
- Prepare and publish reports on what they have done and effectiveness of arrangements.

The Board was advised that the current Pan Cheshire CDOP model which represented, Halton, Warrington and Cheshire West and East was working effectively and was in line with statutory guidance in relation to reviewing deaths and identifying local lessons. Guidance required 60 cases to be reviewed each year to be viable and CDOP reviews between 55-60 cases each year making a reasonable argument to maintain this footprint. Therefore, partners proposed that as part of the revised guidance for CDOP, the Pan-Cheshire model should be maintained.

In order to ensure that the CDOP continued to operate within Statutory guidance and met the needs of the CDR partners and the model supported the most effective response to Child deaths in the area, Partners would monitor its effectiveness over the next 12 months.

RESOLVED: That

1. Each area agrees to continue with a Pan-Cheshire CDOP approach and review effectiveness in January 2020 – this includes a commitment to the current funding and business support model.

2. The governance for CDOP develops a more effective relationship between the Local Safeguarding Children's Boards (LSCB) and Health and Wellbeing Boards (H&WBB) in line with local agreements.

3. CDOP Members for each area will take responsibility for reporting into the most appropriate local forum for their area to ensure necessary activity is undertaken.

4. A workshop of CDOP members will review any required operational changes to be in line with statutory guidance such as the undertaking of thematic reviews, policy, and practice guidance amendments.

HWB25 CHAMPS PUBLIC HEALTH COLLABORATIVE STRATEGIC DELIVERY PLAN

The Board considered a report of the Director of Public Health which provided an overview on the achievements and progress of the Champs Collaborative from April 2017 to April 2018. The Board also considered a copy of the Champs Collaborative Strategic Delivery Plan 2018/20. The Plan summarised key achievements and outlined the Programme objectives for 2018-20.

RESOLVED: That the Board

1. The Champs Collaborative progress update and the Strategic Delivery Plan 2018/20 (Appendix A) be noted;

2. The implementation of the new innovative British Heart Foundation programme focusing on blood pressure and workplace health (Appendix B) be supported.

HWB26 FUTURE MEETING DATES

The following dates of future Health and Wellbeing Board Minutes were circulated to the Board. All meetings would be held at 2pm in the Halton Stadium, Widnes:

10th July 2019
2nd October 2019
15th January 2020
25th March 2020

RESOLVED: That the dates of future meetings be noted.

Meeting ended at 16.00 pm

REPORT TO: Health & Wellbeing Board

DATE: 10th July 2019

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Children, Education and Social Care

SUBJECT: Halton Family Nurse Partnership- 2018 Annual Review

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 A presentation will be given to Health and Wellbeing Board members on the Halton Family Nurse Partnership Annual Review.

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

3.0 **SUPPORTING INFORMATION**

3.1 Family Nurse Partnership (FNP) is a voluntary home visiting programme for first-time teenage mothers mums and families. It helps them:

- Have a healthy pregnancy
- Improve their child's health and development
- Reach their goals and aspirations.

FNP is underpinned by an internationally recognised evidence base which shows it can improve health, social and educational outcomes in the short, medium and long term, while also providing positive economic returns.

3.2 The programme works with families in those critical first 1001 days, to provide a secure foundation on which to build support in the early years and beyond.

It provides expert advice and support to families to enable them to provide a secure environment to lay down the foundations for emotional resilience, good physical and mental health and support their children in reaching developmental milestones.

3.3 In Halton, the FNP programme is commissioned by Halton Borough Council as part of the 0-19 programme and is delivered by Bridgewater Community Healthcare NHS Foundation Trust.

3.4 The Health and Wellbeing Board will receive a presentation on the FNP Annual Review for 2018. This will provide an overview of the programme and achievements made during this period.

4.0 POLICY IMPLICATIONS

4.1 There are no direct policy implications as a result of this report, however, the Family Nurse Partnership programme directly contributes to improving the health and wellbeing of children and families in Halton, which is a key priority for Halton Borough Council and the Halton Health and Wellbeing Board.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
The Family Nurse Partnership programme is intended to improve the life chances of children and families living in Halton through a programme of prevention and early intervention activity. Family Nurse Partnership also supports the safeguarding of children, through providing intensive support to vulnerable famimlies.

6.2 **Employment, Learning & Skills in Halton**
One of the main aims of the Family Nurse Partnership is to improve parents' economic self-sufficiency, by helping them to achieve their aspirations (such as employment or returning to education) thus contributing to this priority.

6.3 **A Healthy Halton**
The Family Nurse Partnership programme directly contributes to improving the health and wellbeing of children and families in Halton

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**
By providing information and support to children and their families the service can contribute to the wider urban renewal of Halton.

7.0 RISK ANALYSIS

7.1 N/A

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 This report and the FNP Programme itself is in line with equality and diversity policy in Halton.

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

9.1 None

REPORT TO: Health & Wellbeing Board

DATE: 10 July 2019

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Children, Education and Social Care

SUBJECT: Chief Social Worker for Adults Annual Report: 2018 to 2019 – social work leadership in changing times

WARD(S) Borough-wide

1.0 PURPOSE OF REPORT

1.1 To provide an overview of the Chief Social Worker for Adults Annual Report: 2018 to 2019, titled, "Social Work Leadership in Changing Times", Department of Health, published March 2019.

2.0 RECOMMENDATION: That the Board

1) **note Chief Social Worker's annual report; and**
2) **recognise the role of Principal Social Worker Adults and the progress to date.**

3.0 SUPPORTING INFORMATION

3.1 <u>The Role of Principal Social Worker (PSW)</u>

3.1.1 The Care Act 2014 states that local authorities should make arrangements to have a Principal Social Worker in place who is a qualified and registered social work professional practice lead who will oversee excellent social work practice. The Care Act provides additional statutory Guidance updated in May 2016 offering further clarification about the Principal Social Worker role for adults. The Guidance states that the Principal Social Worker should be visible across the organisation, from Elected Members and Senior Management, through to frontline Social workers and people who use services and their carers.

3.1.2 It is the Principal Social Workers role to take a professional leadership role across the organisation and act as a bridge for better communication and understanding between Senior Management and Social Workers.

3.1.3 The role requires the Principal Social Worker to:-

- Function at the strategic level of the Professional Capabilities

Framework

- Lead and oversee excellent social work practice
- Support and develop arrangements for excellent practice
- Lead the development of excellent Social Workers
- Support effective social work supervision and decision making
- Oversee quality assurance and improvement of social work practice
- Advice the Director of Adult Social Services (DASS) and/or wider Council in complex or controversial cases and on case or other law relating to social work practice.

3.2 Areas of Progress

3.2.1 The principal social worker in Halton attends the National Principal Social Work Forum on a quarterly basis, and chairs the Northwest region Principal Social Worker (PSW) Network Forum.
The network works closely with Directors of Adult Social Care (ADASS), North West, and are identifying ways to contribute to the ADASS Northwest branch, 2018/19 work plan. In addition the principal social worker for Halton chairs the Liverpool City Region, Strength based Assessment task group, which provides a local subset for Principal Social Workers.

3.2.2 Locally the Principal Social Worker, has established the 'Social Work Matters Forum', a quarterly event involving Social Work professionals across all services within Halton Borough Council. It is a vibrant, well attended forum for social workers. All agendas are set in collaboration with them to focus on best practice, sharing information and link local activity to national agendas and create a culture of communication and engagement. I encourage social workers to have a voice, sharing and present best practice, as well as discuss complex or controversial cases.

3.2.3 Other areas of progress include:-

1) Developing a social work progression policy, offering clear routes of progression, training, supporting successful recruitment and retention.
2) A supervision policy and procedure, including a caseload weighting process.
3) A Risk Assessment policy to support social workers managing risk.
4) A File Audits policy and chairing file audits to ensure quality and good practice.

3.3 The Role of the Chief Social Worker

3.3.1 The Chief Social Worker for Adults, Lyn Romeo, works from Government Office to:

- Provide an expert voice for social work in government, providing advice and guidance on social work and social work matters in relation to policy and legislation.
- Continue the reform of social work education, training and practice.
- Improve the wider public's perceptions and understanding of the role and value of social work in improving people's lives.

Her role was established in 2013 as part of the Social Work Reform Board's recommendations.

3.4 Chief Social Worker Annual Report

3.4.1 As Chief Social Worker, Lyn sets out in her fifth annual report progress themed around "social work leadership in changing times".

The report sets out:

- how social workers are taking a practice leadership role in delivering safe and best outcomes for people with health and care needs
- priorities over the coming year to further raise the quality and profile of adult social work across an integrated system.

3.4.2 It offers examples of social workers demonstrating leadership, professional oversight and co-operation with individuals, families and the wider health and care sector.

3.4.3 The report also looks at the way organisations, collaborate across health, community and voluntary sectors to maintain people's quality of life and independence.

3.4.4 For a fuller review and coverage of the report follow the link :-

https://www.gov.uk/government/publications/chief-social-worker-for-adults-annual-report-2018-to-2019

3.5 Halton's National Profile

3.5.1 The report contains a Ministerial foreword by Caroline Dinenage MP. Her comments are significant for Halton when she says, "As we contemplate the role of modern, progressive social work within the

broader context of social care, there has never been a better time for adult social workers to show leadership, professional oversight and cooperation with individuals and families – and the wider health and care sector."

3.5.2 Of note she states "This has been most recently demonstrated with the success of the named social worker pilot schemes, where trusted professional relationships have been built with other health and care services to better support individuals with learning disabilities and their families. These pilots epitomise the kind of leadership, Lyn espouses for the social work profession. This is not leadership in the command and control sense; this is the demonstration of respectful and focused collaboration across services, all the while keeping the person needing support at the heart of decisions about their care."

3.5.3 Halton has been instrumental in the development of the named social worker pilots with national acclaim for the work they have achieved, with many aspects of this work being rolled out to be become nationalised, leading the way as a demonstration of good social work practice. Halton's work was illustrated in a prominent article in the Guardian Newspaper.

3.6 Annual Report: Social work leadership in changing times

3.6.1 In her report Lyn highlights the following areas :-

- The culture and learning environment led by Principal Social Workers (PSWs) is the most influential lever to achieving the very best for the people with whom we work. The leadership development programme is now in its third year, supporting Principal Social Workers to lead strengths-based practice, co-designed approaches which are led by peoples lived experience, helping promote independence and quality of life. The Principal Social Worker for Halton will be completing this programme.

- Good social work is about a commitment to protecting and promoting people's human rights, striving for social justice, treating people with respect and valuing their dignity and uniqueness. Alongside this, making sure that social workers and other social care practitioners are valued, supported and have access to supervision and opportunities for continuous professional development is vital if we are to value, retain and support our social work and social care workforce.

- Social work practice is about trying to redress the obstacles that can be in the way for people to have the lives they want for themselves, to achieve inclusive lives as full citizens. Strengths based conversations, together with working with people and their carers to ensure that the right care and support options are

available, involving people and communities in designing and commissioning support, is part of what social workers should be influencing – either as practitioners working directly with individuals, through involvement in community development projects or as commissioners of services.

3.7 Chief Social Worker Priorities for 2019/20

3.7.1 Delivering better outcomes for people through improving leadership in the profession at all levels will remain at the heart of my priorities for 2019/20: Key areas are:-

1. **Embed strengths based social work practice:**
    - Publishing and promoting Strengths based practice framework and handbook.
2. **Support the quality of social work practice and leadership:**
    - Sustaining the leadership development programme for Principal Social Workers
    - Implementing capabilities and development pathway for social work with older people, learning disabilities and for people with autism
    - With the Chief Social Worker for Children and Families, improving practice for children with autism preparing for adulthood
3. **Improve knowledge and application of what works and what is the right approach to supporting people to have better lives:**
    - Promoting the Top 10 questions for social work research for development and funding with continued oversight through my Research Advisory Group
    - Working with the Social Work Teaching Partnerships to deliver improvements to: practice placement quality.
4. **Promote the value and contribution that social work and social workers bring to the health and social care system:**
    - Ensuring social work's role is reflected in the Social Care and Prevention Green Papers; review Autism Strategy and disaster/emergency response planning.

3.8 World Social Work Day

3.8.1 World Social Work Day was promoted by Lyn Romeo, Chief Social Worker as the key day in the year, March 19th 2019, that social workers worldwide stand together to celebrate the achievements of the profession and take the theme message into their communities, workplaces and to their governments to raise awareness of the social work contributions and need for further action. This year's theme focused on human relationships between people's essential relationships with each other, their environments and their futures.

3.8.2 The Social Work Matters Forum In Halton planned the day and agreed a key theme was the need to enhance Social Workers relationship with the local community and the people we support. This year we aimed to celebrate, by spending more time getting to know and build relationships in our local community. The Aims in Halton were for:-

- Social Workers to experience community activities and chat to those in the community who utilise the vital groups.
- An opportunity to make connections to local resources and see what is available in the community that can make a real difference to people we support.

3.8.3 Please see attached (Appendix 1) a presentation used at the Social Work Matters Forum reflecting on the events of the day which was well received. A plan is in place to roll out this type of approach.

3.9 Implications for Halton

3.9.1 With regards to Chief Social Worker, Lyn Romeo's report, Halton is well placed to address many areas highlighted in her report. In terms of "leadership" Halton has a high profile with the Principal Social Worker role having chairing responsibilities and presence at national and regional meetings. The work we have undertaken in Halton around the Named Social Worker project is discussed and again given high profile in the Chief Social worker report, it is held as a shining example of good leadership and has achieved national acclaim with aspects of the work from Halton now being rolled out nationally.

3.9.2 A strengths-based approach to care, support and inclusion says let's look first at what people can do with their skills and their resources and what can the people around them do in their relationships and their communities. Consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help' in considering 'what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve'. In terms of strength based practice this will require a significant culture

change in social work practice, not just for Halton, but for all councils. However the work illustrated from World Social Work Day makes a good start and we intend to build on this. But there will be more dedicated work to unfold in the coming year to develop our strengths based approaches within social work practice. There is development of a new national "Strengths based approach Practice Framework" and Practice Handbook, we are already in discussion to see how we can be involved in this work at the earlier stages in Halton.

3.9.3 We have close involvement with the Teaching Partnerships. We are currently reviewing our Assisted supported Year in Employment for Newly Qualified Workers and updating our Progression policy with workshops involving social workers. We encourage social workers to undertake practice educator training, this enables them to supervise social work students which has a positive impact on our recruitment and retention.

3.9.4 Of importance, a lot of work has gone into the establishment of the new regulator Social Work England, to replace Health and Care Professions Council (HCPC). This new body will also bang the drum for leadership, high professional standards and the constant renewal, enhancement and expansion of social workers' knowledge and skills. Halton did get involved in the recent consultation of Social Work England's proposals for new regulations.

3.9.5 The development of a new model for care management services will demonstrate working with an integrated approach with Health colleagues is a priority and promoting the role of social work in multi-disciplinary work.

4.0 POLICY IMPLICATIONS

4.1 None at present

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 None at present

6.0 OTHER IMPLICATIONS

6.1 None at present

7.0 RISK ANALYSIS

7.1 None identified.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 None at present

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

None.


World Social Work Day
2019
PUBLIC LIBRARY
SCHOOL
COMMUNITY CENTRE

Aims of the Day

This year's theme focusses on the social relationships

This year we aimed to celebrate by spending more time getting to know and building relationships in our local community

Worker to experience community activities and chat to those in the community who utilise the vital groups

An opportunity to make connections to local resources and see what is available in the community that can make a real difference to those we support

Activities Visited

The 11 O'clock Club

- At Halton Brooke Community Centre on Tuesday at 11’oclock local residents who are struggling finically for what ever reason are able to come and received a food parcel.
- Social care staff can also attend the venue and pick up a parcel on their clients behalf.

CHI Craft Group

- Community Health Initiatives based in Windmill Hill offer a variety of different free activities for local residents including;
  Craft Club, Photography Course, Sewing and Upcycling Lessons, History Club, Radio Drama Group, Cookery Classes and more.

Sew Halton

Providing 10-12 week courses where individuals can gain in new sewing skills whilst building confidence, relationships, self-esteem and self-worth.

Halton Community Radio

adio station run by volunteers, their vision is to make a difference, by providing safe, inclusive space for individuals and groups to learn, build confidence, and xpress themselves. Individuals run their own shows throughout the week; the adio station is fully inclusive and support multiple individuals some of whom ave a disability to volunteer and run their own shows.

lient Story: Client T has no verbal communication, before Community Bridge uilders became involved he had support hours but was not utilising these to get out in the community. T had a keen interest in music and was supported to gain skills in using the radio equipment to play music. Supported by his PA he now runs and presents his own mid-day show using his iPad to communicate with his listeners.

SSTLL Tea Dance

- The monthly afternoon tea social event is run for local resident's age 55+; for a very reasonable cost they are able to enjoy live entertainment and food and drinks served to the table. There are places for 100 people, and every effort is made so each event is special, with table decoration and balloon displays. Everyone is made to feel very welcome, it's a great way to make new friends, with lots of fun and laughter, singing and if people want to, they can have a dance.



Hale Shetland Rescue




Comments About the Day

‘I think the timing of the event was difficult as end of year when many team members are on a/l and deadlines are approaching for work to be completed by end of year. Having said that there is never a time when we are not extremely busy and having to prioritize our priorities. It was a very valuable and enjoyable thing to do but very hard to make time to do it.’

‘I found it hard to find time in my day to get out to the activity, but I’m glad I did as I found it very beneficial and worthwhile when I got there.’

‘The Activity I had chosen was not on, it was a little embarrassing arriving and people not knowing why I was there’

Things to Improve

‘I found the opportunity to spend an hour
f my working day to visit a local charity was really
nwhile as I believe it is vital to be connected to the
munity to which I work.’

ther day similar to this would be priceless’

have gained knowledge in a valuable local service
hich could potentially support me ensuring that the
aseline needs of the users at the centre of my care are
eing met, if in the event of a crisis’

‘I have gained knowledge about a valuable
community resource that could be of therapeuti
value to people we support.’

‘Clients that received social support hours should be
accessing meaningful opportunities in
the community like this activity’

‘I found it useful having someone from the
Community Bridge Building Team sharing their
community knowledge, showing me round a
explaining about the service’

ttending the service face to face provided me with a comprehensive insight into what the service is abou
ho can use it and the things that they can do and get involved in when there. It also provided me with a v
nage of the environment which is essential when sharing information and promoting use of services to S
sers and carers’

What Worked Well?

Social Media

ton Borough Council
larch at 14:26 ·

orld Social Work Day and Halton's Social workers are out in the promoting our services and highlighting peoples needs by he Importance of Human Relationships. #WSWD19 #widnes

2 shares

Halton Borough Council
19 March at 16:48 ·

Another example of our #SocialCare staff out and about, this time at Hale Shetland Rescue Centre #WSWD19 #RUNCORN #WIDNES

17 1 comment 1 share

Halton Borough Council
19 March at 15:25 ·

This is Kevin, Radio Station Manager @HCR923fm & a Social W visit for #WSWD19 The station, run by volunteers, provides a sa space for people to learn, build confidence, & express themselv #WSWD19 #widnes #runcorn

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Social Media

Halton Borough Council
19 March at 14:27 ·

Today social workers went to CHI craft group at Priory View, Windmill Hill – providing activities including stress management, photography, upcycling etc. Bringing the community together & opportunities & meet new friends. http://ow.ly/UlQQ50nvcGL #WSWD19 #runcorn #widnes

2

Halton Borough Council
19 March at 15:30 ·

John Patton. Practice manager of Social Care and 2nd pic Social Care workers Tracey & Chloe with Linda and Margaret from Millbrow care home. #WSWD19 #widnes #runcorn

Leanne Moss and 32 others

5 comments 6 shares

Like Comment Share

Social Media

19/03/2019 15:30	 John Patton. Practice manager of Social Care and 2nd pic Social Care			2.6K	296 54
19/03/2019 15:25	 This is Kevin, Radio Station Manager @HCR923fm & a Social Worker on a			1.9K	69 35
19/03/2019 14:27	 Today social workers went to CHI craft group at Priory View, Windmill			914	13 2
19/03/2019 14:26	 Today is World Social Work Day and Halton's Social workers are out in the			1K	11 11
19/03/2019 14:15	 Today social workers went to CHI craft group at Priory View, Windmill			867	8 2
19/03/2019 12:54	 This is Kevin, Radio Station Manager HCR923FM & a Social Worker on a			1.4K	18 15
19/03/2019 12:05	 Today is World Social Work Day and Halton's Social workers are out in the			807	1 2
19/03/2019 09:47	 Today is World Social Work Day and Halton's Social workers are out in the			918	1 0

Feedback

ow would you rate you enjoyment of today's activity?

verage Score: 8/10

Do you feel like you have gained valuable information about the activity attended that will benefit your practice and help meet the needs of those you support?

Average Score: 7/10

Is this activity something you feel the people y work with could benefit from/ help meet thei needs by attending?

100% Yes 0% Not Sure 0% No

Is this style of day something you would like to do again in the future?

67% Yes 33% Not Sure 0% No

Your Thoughts…

Thanks for Listening

REPORT TO: Health & Wellbeing Board

DATE: 10 July 2019

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Children, Education and Social Care

SUBJECT: Falls Strategy 2018-2023

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present to the Health and Wellbeing Board the Falls Strategy 2018-2023.

2.0 **RECOMMENDATION: That the Board**

1) **Note contents of the report; and**

2) **Approve the updated version of the Falls Strategy 2018-2023.**

3.0 **SUPPORTING INFORMATION**

3.1 In 2012 Halton Health and Wellbeing Board developed the first Health and Wellbeing Strategy to meet the needs of the local population. The Strategy set out the vision for Health and Wellbeing in Halton. It was the overarching document for the Health and Wellbeing Board and outlined the key priorities the Board wanted to focus on.

3.2 Informed by the Joint Strategic Needs Assessment (JSNA) and in consultation with local residents, strategic partners and other stakeholders, five key priorities were identified to help us to achieve our vision. One of the five priorities was the reduction in the number of falls in adults. The five year falls strategy was developed in 2013, this strategy is now due for review.

3.3 There is clear evidence on the importance of ensuring that falls prevention and falls care are a high priority within any Local Authority area. Halton is higher than the national average, in relation to people who fall; the human cost of this on the individuals is high and can result in falling distress, pain, injury, loss of confidence, loss of independence, loneliness and mortality. There is also an impact on family members and carers of people who fall.

3.4 This importance of falls prevention has been recognised by Halton

Borough Council and NHS Halton Clinical Commissioning Group, who have prioritised reducing the number of falls and associated hospital admissions in older people within Halton.
The cost to the NHS is estimated to be more than £2.3 billion per year.

3.5 This Falls Prevention Strategy is a further development of the current strategy, and continues to have a focus on prevention and early intervention.

3.6 The vision developed in the strategy is to:

- Provide people with early, targeted advice and intervention to prevent or reduce the risk of falls and to maintain their independence.
- Ensure effective action is taken in a timely manner to support those people who have had a fall to recover and regain their independence.
- Encourage stakeholders to work together and continuously review the evidence base of the strategy in terms of impact and effectiveness against National Institute for Health and Care Excellence (NICE) Guidance and Quality Standards.

3.7 The primary aims of this strategy are to:

- Reduce the numbers of serious injuries that result from a fall.
- Reduce the number of Emergency hospital admissions for injuries due to a fall (65+).
- Reduce the number of Emergency hospital admissions due to fracture of neck of femur (65+).
- Reduce the numbers of falls that affect older people and those at higher risk of falling.
- Commission an integrated, evidenced based, falls prevention pathway across Halton.
- Reduce the fear of falling among older people.

4.0 POLICY IMPLICATIONS

4.1 The strategy is in line with the NHS Five Year Forward View and the Care Act 2014.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The full financial costs of falls to the NHS and social care has not been calculated but we do know that hip fractures alone cost over £2.3 bn per year. Evidence shows that falls prevention services are cost effective and could make substantial savings

5.2 There is good evidence that implementing a range of interventions will reduce falls and injuries in older people. For example, for every £1 spent on physiotherapy, £1.50 is saved across the whole pathway.

5.3 No additional funding is being requested to implement this strategy

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

This strategy will focus on reducing the number of people who fall, improving their ability to live as independently as possible and maintaining health and wellbeing.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 None identified.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

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

9.1 None.

Halton Clinical Commissioning Group

Falls Strategy 2018-2023

Contents

Foreword

Falls are a common cause of injury and loss of independence in older people. As people get older, they may fall more often for a number of reasons including reduced muscle strength, problems with balance, poor vision and Dementia. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall and is estimated to cost the NHS more than £2.3 billion per year[1]. Therefore falling has an impact on quality of life, health and healthcare costs. The fear of falling has an effect on mental as well as physical health and wellbeing and can lead to activity avoidance, social isolation, loneliness and depression. However, falls are not an inevitable part of old age and whilst not completely preventable, a lot can be done to reduce the risk of falling.

People aged 65 and older have the highest risk of falling. For the purpose of this strategy older people are therefore defined as aged 65 and over and the strategy also applies to adults identified to be at a higher risk of falling. The aim of this strategy is to reduce the number of people who fall in Halton and improve outcomes for those who do.

This importance of falls prevention has been recognised by Halton Borough Council and NHS Halton Clinical Commissioning Group, who jointly with Public Health colleagues, have prioritised reducing the number of falls and associated hospital admissions in older people within Halton.

Key stakeholders make up the membership of the Falls Steering Group, and we are committed to ensuring that all older people who live in Halton have access to high quality falls prevention services, irrespective of their condition or where they live.

This high-level falls prevention strategy will be a continuation and development of the existing falls service over the past 5 years and a steering tool for the next five years.

Introduction

A fall is defined as an unintentional loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level. A fall is distinguished from a

[1] Falls in older people: assessing risk and prevention: Clinical guideline [CG161] Published date: June 2013

collapse that occurs as a result of an acute medical problem such as acute arrhythmia, a Transient Ischaemic Attack or Vertigo (NICE Quality Standard 86, 2015)

In 2012 Halton Health and Wellbeing Board developed the first Health and Wellbeing Strategy to meet the needs of the local population. The Strategy set out the vision for Health and Wellbeing in Halton. It was the overarching document for the Health and Wellbeing Board and outlined the key priorities the Board wanted to focus on.

Informed by the Joint Strategic Needs Assessment (JSNA) and in consultation with local residents, strategic partners and other stakeholders, five key priorities were identified to help us to achieve our vision. One of the five priorities was the reduction in the number of falls in adults.

As a result Halton Borough Council implemented a review of its falls services in 2012 followed by the development of a five year Falls Strategy in 2013. At the time, the rate of falls was higher than the national average with the hip fracture rate in people over 65 in Halton at 750 per 100,000, and the national average at 674 per 100,000.

The strategy focused on key objectives which included:

- To develop an integrated falls pathway for Halton
- To develop a prevention of falls pathway for Halton
- To develop a package of workforce training
- To develop an awareness raising campaign with both the public and professionals
- To improve partnership working across all agencies involved and improve governance arrangements to support falls.

To date many key actions identified in the plan have been implemented including:

- The Falls Risk Assessment Tool is now embedded into frontline practice across the Health and Social Care system and being widely used to identify those people who are at risk of falls. As a result the number of people accessing the falls service has increased three-fold from 2011/2012 baseline (223 per annum to 750+ per annum). This number includes a rise in the number of people referred post fall from hospital into the falls prevention service.

- There has been the development of the ‘Age Well exercise programme’ which offers gentle, easy exercises to improve stability, balance, coordination and strength to reduce your risk of falling. There are currently six classes per week being delivered on a rolling programme with a review every 15 weeks up to 45 weeks in total for each client. To date over 200 people have accessed the

programme with 92% of clients showing improvements in strength, balance and gait at 3rd review.

- The Age Well service also deliver a comprehensive package of training emerged from a successful ‘Living Well’ pilot in 2014/5. The pilot work focused on skilling up community staff to use screening tools to identify people aged 75 + in the community at risk of memory loss, falls or loneliness. Clinical pathways are used to identify the uptake of the screening.

- Development of an awareness raising campaign with both the public and professionals to change public and professional perception of falls services including rebranding of promotional resources in line with recommendations by ‘Later Life’ training. Over the last three years numerous community wide events have been undertaken including three borough wide events to mark Falls Prevention Awareness week.

- Integral to the progression of this work has been the establishment of a partnership group which has adopted a multiagency approach to improving falls provision in Halton. The improvement of governance and reporting arrangements across this group has supported this agenda.

Aims

The primary aims of this strategy are to:

- Reduce the numbers of serious injuries that result from a fall.
- Reduce the number of Emergency hospital admissions for injuries due to a fall (65+).
- Reduce the number of Emergency hospital admissions due to fracture of neck of femur (65+).
- Reduce the numbers of falls that affect older people and those at higher risk of falling.
- Commission an integrated, evidenced based, falls prevention pathway across Halton.
- Reduce the fear of falling among older people.

Prevention is at the forefront of any healthcare strategy for older adults In Halton, with the ultimate goal of postponing dependency for as long as possible. Within Halton we focus on improving peoples lifestyle choices before they reach the age of 65+ which relies upon a strong health promotion and improvement message during the life course, starting with early Child hood health promotion through to adolescence, young adulthood and midlife.

This strategy has a focus on prevention and early intervention, aligning with the NHS Five Year Forward View and the Care Act 2014. Older people are central to this strategy. The Strategy will ensure that those at higher risk of falls and their carers have the knowledge to be active participants in the fall prevention work; for example making them aware of the importance of having regular medication reviews, checking their home environments for potential hazards that could result in a fall, and by taking and having access to regular exercise to improve their strength and balance.

Vision

‘Working in collaboration to reduce falls and promote independence’

This vision provides the borough-wide direction for commissioning, service planning and delivery of the falls service. It will be implemented by the Halton Falls Steering Group. This Group consists of representatives from all relevant stakeholders – see Appendix 1. The Falls Steering Group will report progress to Halton Health and Wellbeing Board and The Older People’s Delivery Board regarding the effective delivery of the strategy in the coming five years.

This strategy reinforces the need to continue to strengthen partnerships to ensure a whole system approach. It is underpinned by the same key principles and approaches to improving health and wellbeing as outlined in Halton Health and Wellbeing Strategy 2015- 2020.

For example, the organisations implementing the strategy will take account of the considerable variations in general health and wellbeing between the most affluent and most deprived parts of the borough. Furthermore, it builds on the information contained in Halton’s Joint Strategic Needs Assessment and uses analysis from the Public Health Profile for Halton.

The strategy applies to all people aged 65 and over within Halton and those adults identified to be at a higher risk of falling regardless of:

- Where they reside (e.g. private home, residential care home, hospice or acute hospital)
- The person’s health or wellbeing condition.

Outcomes

The intended outcomes of this strategy are to develop a collaborative approach to falls prevention, to reduce injury rates from falls in the over 65's and adults identified to be at a high risk of falling in Halton by:

- Identifying those who are likely to fall.
- Providing support to those people likely to fall to prevent falls.
- Working effectively with people who have fallen to reduce the likelihood that they will fall again.

National

The number of people aged 65+ is projected to rise by over 40% by 2034[2] to more than 16 million. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.[3]

Risk factors for falls:

- A history of falls
- Muscle weakness
- Poor balance
- Visual impairment
- Polypharmacy
- Environmental hazards
- Arthritis
- Cognitive impairment
- Depression
- Diabetes
- High alcohol consumption
- Incontinence

Risk factors for fractures:

- Low bone mineral density
- Previous fracture
- Age
- Female sex
- History of falls
- Rheumatoid arthritis
- Smoking
- High alcohol consumption
- Low BMI
- Visual impairment
- Incontinence

[2] Office for National Statistics. National population projections for the UK, 2014-based [Internet]. 2015

[3] Falls in older people Quality standard [QS86] Published date: March 2015 Last updated: January 2017

The National Institute for Clinical Excellence (NICE) for Falls in Older People was updated in 2017. It gives recommendations for good practice based on best available evidence of clinical and cost effectiveness. The NICE guideline identifies five key priorities for implementation of a service for assessment and prevention of falls in older people, as described in the table below.

Key priorities for implementation

1) **Identifying People at Risk of Falling**
   - Older people (age 65 and over living their own home or in extended care setting) are asked about falls when they have a routine assessments and reviews with health and social care practitioners, and if they present at hospital [new 2017]
   - If there is concern that a person is at risk of falling, they can be refereed to, or advised to see, a healthcare professional or service to further assess their risk.

2) **Multifactorial risk assessment for older people at risk of falling**
   - Older people at risk of falling (people aged 65 and over who have had 2 or more falls in the past 12months, or demonstrate abnormalities of gait or balance) are referred to healthcare professionals with skills and experience in carrying out multifactorial falls risk assessment
   - Multi-factorial assessment may include the following:
     - Identification of falls history
     - Assessment of gait, balance and mobility, and muscle weakness Assessment of osteoporosis risk
     - Assessment of older person's perceived functional ability and fear relating to falling
     - Assessment of visual impairment,
     - Assessment of cognitive impairment,
     - Assessment of urinary incontinence
     - Assessment of home hazards
     - Cardiovascular examination
     - Medication review.

3) **Multi-factorial interventions**
   - Older people assessed as being at increased risk of falling have an individualised multifactorial intervention.

   - In successful multi-factorial intervention programmes the following specific components are common:

     - strength and balance training,

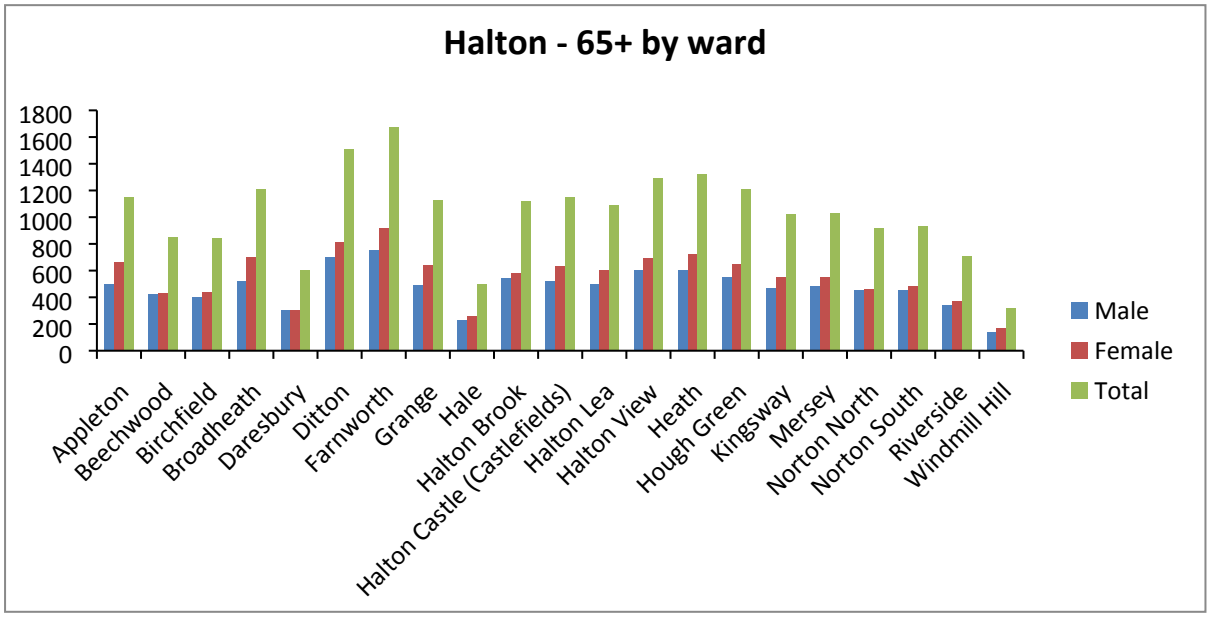
- home hazard assessment and intervention,
- vision assessment and referral,
- medication review with modification or withdrawal.

4) **Multifactorial risk assessment for older people presenting for medical attention.**
   - Older people who present for medical attention (incl variety of settings and to different healthcare practitioners and community services) because of a fall have a multifactorial falls risk assessment.

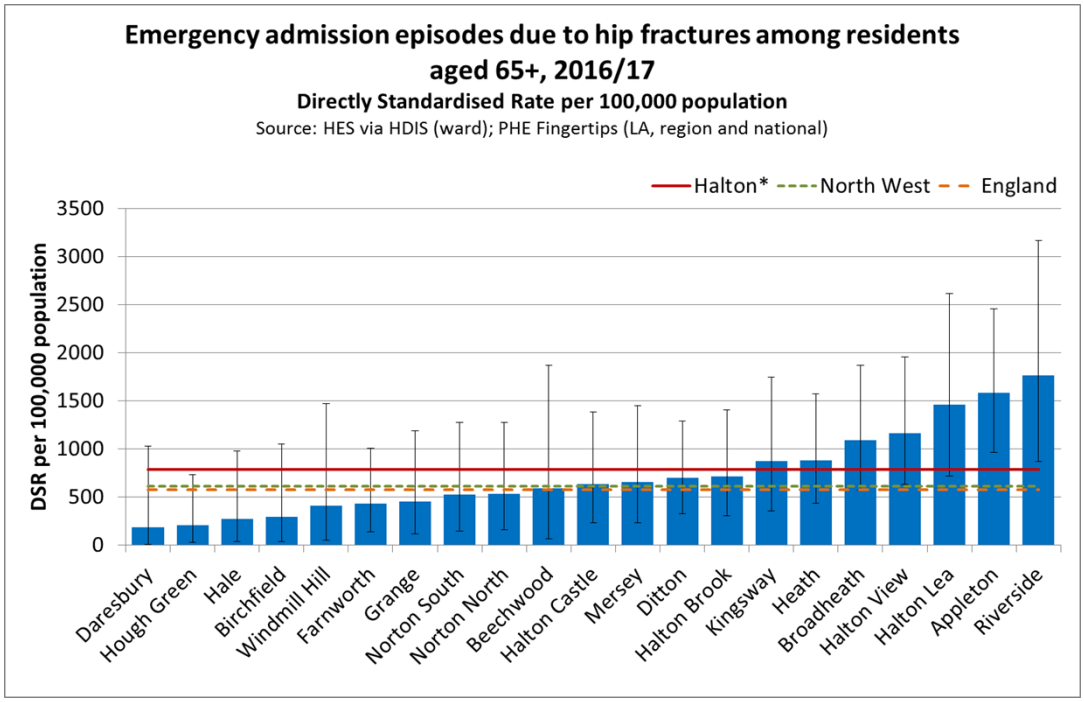
5) **Strength and balance training**
   - Older people living in the community (person who has fallen more than once in the past year have the opportunity to see an exercise programme expert) who have a known history of recurrent falls (falling twice or more within a time period of 1 year) are referred for strength and balance training

Local

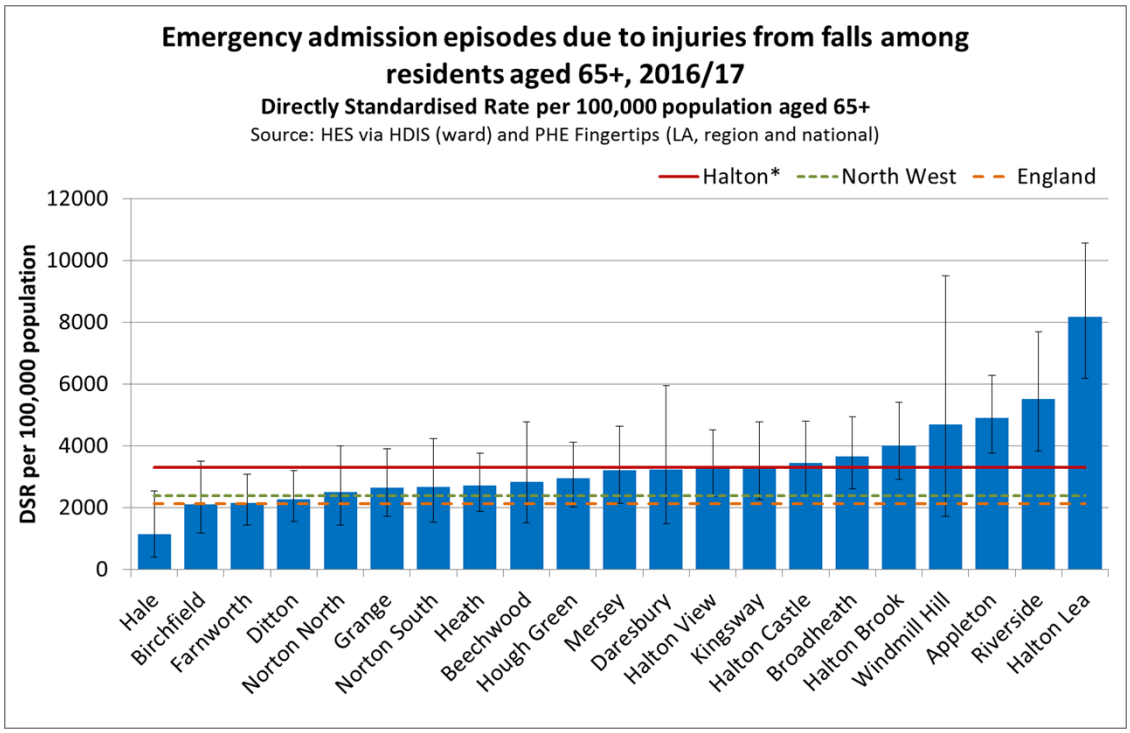
Halton has 21,570 residents aged 65+ which equates to 17.04% of the total population. The graph below illustrates the number of people aged 65+ by ward.



In Halton, we have rates of hip fractures and emergency admissions to hospital due to injuries from falls which are higher than the North West and England average. The graphs below illustrate the number of hip fractures and emergency hospital admissions due to injuries from falls by ward.



*Halton total is based on published figures, as such differs marginally from total for wards



*Halton total is based on published figures, as such differs marginally from total for wards

Costs

The human cost of falling includes distress, pain and injury, loss of confidence, loss of independence, social isolation and even death. Falling also affects the family members and the carer's of people who fall.

The annual cost of hip fractures to the UK is estimated at being around £2.3 billion per year and with an increasingly ageing population, this is set to increase.

A third of older people treated for hip fracture have not returned home 120 days after treatment and only 10% describe themselves as freely mobile and moving without aids. For some, it is the event which forces them to move into residential care.

Assets

We recognise that there are a number of key initiatives and groups across Halton that currently take place to support our older residents to remain mentally, physically and socially active and thereby reducing the risk of falling.

As part of a falls awareness campaign, the Health Improvement Team provides Age Well training to all professionals who work with Older People. The purpose of the training is to promote awareness of falls, enable staff to build confidence using screening tools and signposting to appropriate prevention services. In conjunction with falls awareness, the course is also aimed at promoting awareness of loneliness and memory loss.

The Halton Health Improvement Team run Age Well Exercise classes that offer postural stability exercises to improve stability, balance, coordination and strength to reduce the risk of falling. They are specially designed exercises to also help individuals to carry out everyday tasks more easily, increase their confidence and mobility and offer the opportunity for people to make friends. The classes run in Castlefields, Runcorn and the Frank Myler Pavilion in Widnes.

The Falls Intervention Service is a multidisciplinary service for older people who have fallen. The service aims to prevent/reduce falls and injuries in older people through multi factorial assessment and interventions.

As per Halton's Integrated Falls Pathway, individuals aged 55 and above who have experienced falls in the previous 12 months are screened using the FRAT (Falls Risk Assessment Tool). Individuals who score three and above are referred into the service. Individuals with a score of two or lower are referred to the Health

Improvement Team. The Service accepts referrals from Health, Social Care, Voluntary agencies and self-referral (backed up with Medical information). The service has referral pathways set up with North West Ambulance Service and the Fire Service.

It is a community based team; individuals are assessed in their own homes and in care settings. The Service provides Nurse, Physiotherapy, Occupational Therapy and Podiatrist interventions. All individuals accepted onto the service will receive an initial multi factorial assessment. Subsequent interventions can include balance, gait and strength exercises, bio-mechanical assessments, fear of falling interventions, functional assessments and equipment provision from Halton's Integrated Community Equipment Service. Most individuals will have some follow up interventions depending on level of need. Onwards referrals to Medical falls clinics, and other Health and Social Care Services are made depending upon need.

There are a number of Third Sector community intervention and prevention initiatives that have had a significant impact on maintaining the independence and well-being of our Halton residents. Loneliness in older people leads to low mood and sometimes depression. Various report findings have demonstrated that older people who are experiencing feelings of loneliness are less resilient and are therefore more likely to have a fall.

Age UK Mid Mersey contributes to the wider prevention agenda in tackling loneliness in Halton. Age UKMM has several participation groups in Halton which encourage a range of diverse groups of older people to get together to socialise and share ideas.

There is good evidence that implementing a range of interventions will reduce falls and injuries in older people. For example, for every £1 spent on physiotherapy, £1.50 is saved across the whole pathway.[4]

This strategy will therefore seek to build on such assets and ensure that they form a central part of a fall prevention pathway.

Areas of Action and Future Development

In order to deliver the strategic priorities for falls prevention in Halton the following broad actions will be delivered:

The Falls Prevention Steering Group

[4] Chartered Institute of Physiotherapy http://www/csp.org.uk/

The Falls Steering Group will continue to meet monthly to review and implement the new strategy. The group will focus on how to

a) Continue to develop opportunities to work collaboratively, to ensure that all available data and evidence-based practice is used to inform future falls prevention commissioning across the whole of Halton.
b) Establish agreed, clear lines of accountability for monitoring the delivery of the strategy.
c) To undertake a pathway review of current falls prevention services to ensure people know how to access the services they need and that it is easy for them to do so.
d) The review will identify any gaps in provision and better understand how people access and navigate current services. This will ensure that everyone receives the services they need in a timely manner. Particular targets are front line services such as G.P's, other front line health and social care staff including the Community Wardens where gaps already exist.
e) To continuously review the evidence base of the strategy in terms of impact and effectiveness against National Institute for Health and Care Excellence (NICE) Guidance and Quality Standards.

Workforce Training

The Health Improvement Team will continue to roll out Age Well training to all professionals to ensure they are pro-active in the use of the Falls Risk Assessment Tool in identifying people at risk of falls.

This will involve attending MDT and team meetings to encourage all professionals to;

a) Use their records to identify people at the highest risk of falling and refer them to appropriate services so that they can be offered person-centered falls prevention advice and support

b) Ensure people receive regular reviews of their medications to help limit the likelihood of a fall.

c) Ensure people with weak or fragile bones are offered treatment in line with national guidelines to help limit the likelihood of serious injury in the event of a fall.

Falls Awareness Campaign

To collectively develop a Communication Plan to improve public awareness of the importance of falls prevention to their general health and wellbeing.

How will we know if it is successful?

This strategy will be implemented through the Falls Steering Group who will agree clear lines of accountability for monitoring and delivering the Strategy. The Group will continuously review the evidence base of the strategy in terms of impact and effectiveness against National Institute for Health and Care Excellence (NICE) Guidance and Quality Standards.

An action plan will support the detailed delivery of this strategy over the 2018 to 2023 timeframe. The action plan will list all the actions required to actively improve falls prevention in Halton and ensure this improvement will continue sustainably.

For each area of focus, achievable objectives and targets will be set with appropriate timescales and clear organisational accountability. Progress against these objectives and targets will be continuously reviewed and updated by the Falls Steering Group. This process will ensure that falls prevention continues to reflect and develop in line with public and stakeholder needs and wishes and reported back to the Health and Wellbeing Board.

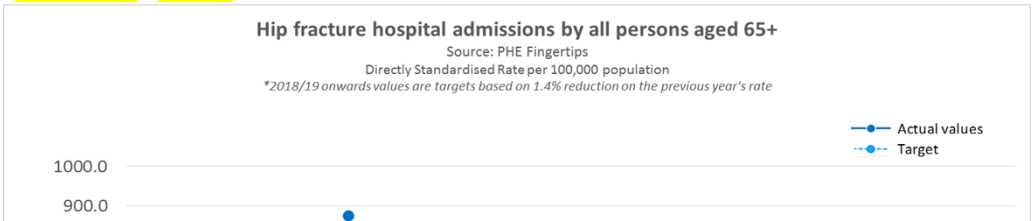
Actual Targets set by the Falls Steering Group to measure outcomes of success

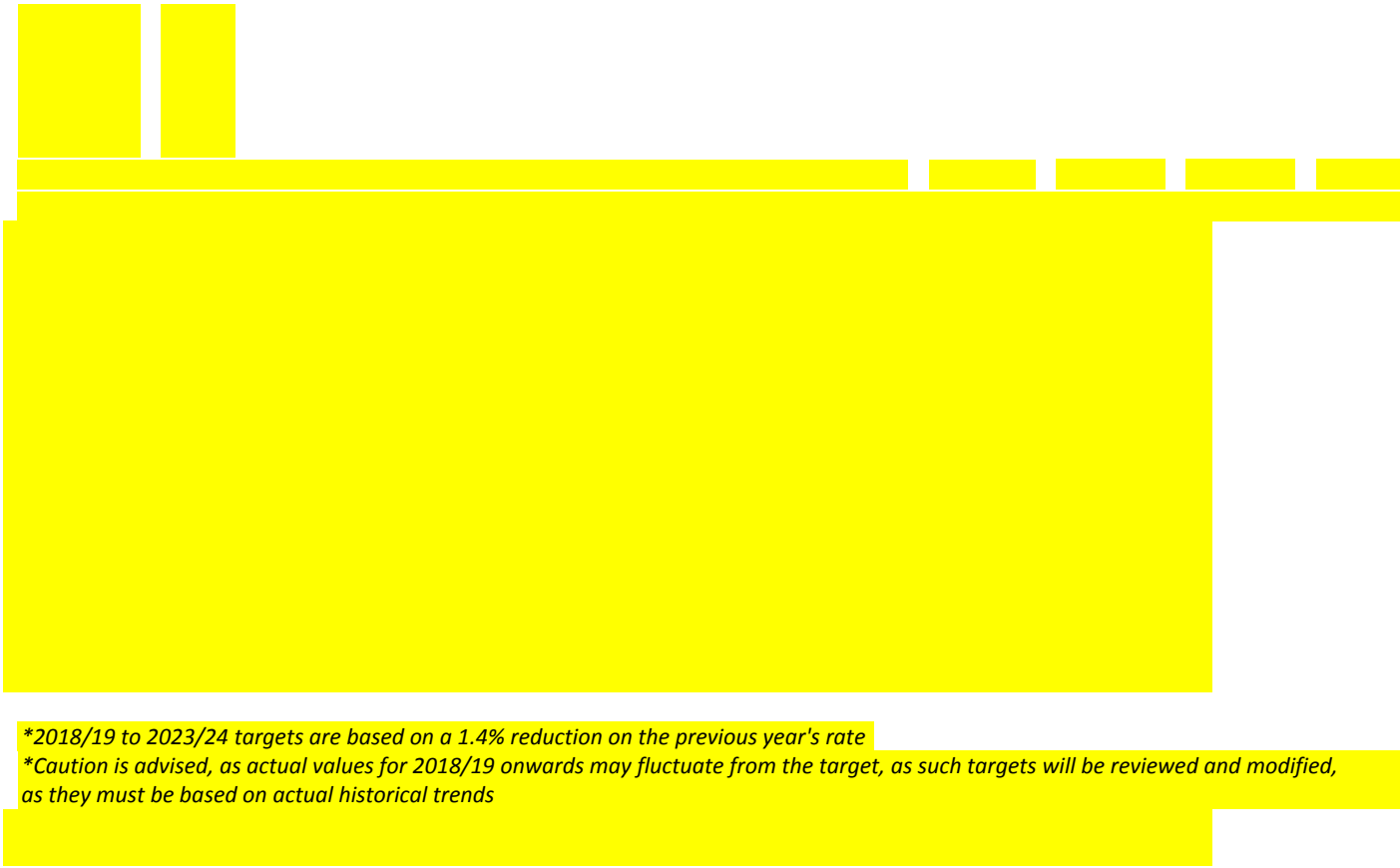
Hip fracture hospital admissions, by Halton residents aged 65+

Source: PHOF (PHE Fingertips)

Note: Target values are based on a 1.4% reduction on the previous year's value

Year	DSR	1.4% reduction*
2010/11	637.2	
2011/12	816.2	
2012/13	600.1	
2013/14	876.5	
2014/15	631.8	
2015/16	652.3	
2016/17	781.5	
2017/18	674.5	
*2018/19**	665.0	
*2019/20**	655.7	9.3
*2020/21**	646.5	9.2
*2021/22**	637.5	9.1
*2022/23**	628.5	8.9
*2023/24**	619.7	8.8





**2018/19 to 2023/24 targets are based on a 1.4% reduction on the previous year's rate*
**Caution is advised, as actual values for 2018/19 onwards may fluctuate from the target, as such targets will be reviewed and modified, as they must be based on actual historical trends*

All this work will collectively contribute to Halton's improved performance against the following national indicators contained with the Public Health Outcomes Framework.

Public Health Outcomes Framework	
2.24	Emergency hospital admissions for injuries due to falls in people aged 65 and over.
2.24	Emergency hospital admissions for injuries due to falls in people aged 65 and over – aged 80+
4.14	Emergency hospital admissions for fractured neck of femur in people aged 65 and over.
4.14	Emergency hospital admissions for fractured neck of femur in people aged 65 and over – aged 80+

Governance and Performance Management Framework

This strategy will be managed through the falls steering group that is a multi-disciplinary meeting chaired by the Local Authority. Any service development will be

reported through the Older Peoples Board and the Health and Wellbeing Board will receive quarterly performance updates.

Performance frameworks

This Evaluation Framework has been developed to support the review of falls services in Halton being carried out by the Falls Steering group. The framework aims to bring together a range of performance measures that can be applied across a number of services across Health, Social Care, voluntary and independent sector.

Appendix 1

Terms of reference and membership of the Falls Steering Group.

Aims

To exercise collective, cross organizational ownership of effective falls prevention within Halton.

Objectives

1. To draft, agree and have authorized a whole system approach to the delivery of the Falls Prevention service in Halton.
    a) To consult with the public to obtain their views upon the development of the local falls prevention service and strategic intentions towards falls prevention.
    b) Obtaining the Halton Health and Wellbeing Boards' approval for the Falls Prevention Strategy.
    c) To identify and collectively agree upon gaps/ areas of improvement in current service delivery, as matched against nationally recognized standards and evidenced based practice.
    d) Formally record the actions needed collectively and by each individual organization/ area to devise and implement an action plan that will set out to improvement the following service areas:

        - Education / awareness.
        - Exercise / balance programmes.
        - Referral and reporting.
        - Risk assessment

2. To implement the strategy over the 2018-2023 planning horizon by:

    a) Producing a collectively agreed prioritised action plan for a whole system improvement in falls prevention across Halton.

    b) Assigning individual actions to individual leads and collectively ensure that these actions are delivered in accordance with the action plan.
    c) Monitoring Halton's population level performance against key indicators that demonstrate effective falls prevention.
    d) Making necessary adjustments to the strategy and action plan, based upon population level performance over the 2017-2023 timescale.

Outcome

The intended outcomes of this strategy are to develop a collaborative approach to falls prevention, to reduce injury rates from falls in the over 65's and adults identified to be at a high risk of falling in Halton by:

- Identifying those who are likely to fall.
- Providing support to those people likely to fall to prevent falls.
- Working effectively with people who have fallen to reduce the likelihood that they will fall again.

Membership

The Falls Steering Group is chaired by Damian Nolan and has representatives from the following organisations and groups:

Name	Organisation	Role
Damian Nolan	HBC, Urgent Care	**Divisional Manager**
Lisa Taylor	HBC, Health Improvement Team	**Divisional Manager**
Zoe McEvoy	HBC, Health Improvement Team – Age Well	**Practice Manager**
Sharon McAteer	Public Health	**Development Manager**
Lucy Reid	Halton NHS CCG	**Chief Pharmacist**
Zoe Mason	Halton NHS CCG	**Care Home Pharmacist**
Rosina Price	Bridgewater Healthcare	**Falls Nurse**
Diane Platt	Halton Community Therapy Team	**Therapy Manager**
Steve Hope	Halton Community Therapy Team	**Team Manager**
Jackie Johnson	HBC - RARS & IDT	**Principal Manager**
Jacqui Tudor		
Mark Lunney	Age UK Mid Mersey	**Chief Executive Officer**
Karen Kenny	Age UK Mid Mersey	

Governance

The group is accountable directly to Halton's Health and Wellbeing Board.

Frequency of Meetings

The Group will meet on a monthly basis and the frequency of meetings will be reviewed annually.

Review

These Terms of Reference will be reviewed and revised as necessary on an annual basis.

Action Plan

Complete	In progress	Not started/at risk

Aims	The Falls Steering Group will continue to meet Bi monthly to review and implement the new strategy. The group will focus on: ➢ how to continue to develop opportunities to work collaboratively, ➢ to ensure that all available data and evidence-based practice is used to inform future falls prevention commissioning across the whole of Halton.				
Owner(s)	**Falls Steering Group**				
Task	**Action Required**	**Who**	**When**	**Progress/Next Steps**	**Status**
To strengthen and maintain Partnership working between all parties on the Steering Group	All parties to make a commitment to attend scheduled Bi Monthly Meetings.	All	Dates Specified	Dates to be circulated for the next 12 month	
	Agree a collaborative approach to data collection.	All	End of June	Data meeting to be set up to explore what Data is required to enforce the strategy.	

To identify any current gaps in the provision of the falls prevention service as a whole and devise a more streamlined pathway.	To undertake a review of all pathways into the current falls prevention services to ensure that people are able to access the services they need and that it is easy for them to do so.	Z.M/ J.J	Sept 2018	To set up an interagency meeting to review current pathways.	
The Group to continuously review the evidence base of the strategy in terms of impact and effectiveness against National Institute for Health and Care Excellence (NICE) Guidance and Quality Standards.	To implement the 5 key priorities outlined by the NICE guidelines: 1) Identifying People at Risk of Falling 2) Multifactorial risk assessment for older people at risk of falling 3) Multi-factorial interventions 4) Multifactorial risk assessment for older people presenting for medical attention. 5) Strength and balance training	All	Quarterly	The New Strategy has incorporated the new additions of the NICE guidance to Falls Prevention	

Ensure people receive regular reviews of their medications to help limit the likelihood of a fall.	Lucy Reid to make further enquiries to ensure there is a formal pathway for medication reviews by Primary Care			Lucy to review what is going on in practices	

Aims	**To continue to develop the work force across Halton to increase their awareness and understanding of the falls prevention pathways and associated services.**				
Owner(s)	**Health Improvement Team**				
Task	**Action Required**	**Who**	**When**	**Progress/Next Steps**	**Status**

To ensure that all Professionals and Front Line practitioners are pro-active in the use of the Falls Risk Assessment Tool in identifying people at risk of falls.	To continue to promote and deliver the Age Well Awareness program that includes training on the use of the Falls Risk Assessment Tool.	Age Well Team in collaboration with Alzheimers Society	Ongoing	Training dates for future Age Well training continue to be circulated to all professionals to increase uptake of the training.	
	To specifically target all front line health and social care services to increase uptake of training by attending team meetings.	Age Well team within Health improvement team	Quarterly	To review registers for the training to ensure that gaps are identified so that specific work can be done to increase uptake of training for these group who haven't yet attended or who make	
	Evaluation of service provider knowledge. by the use of an evaluation form that is incorporated as part of the training programme to review knowledge before and after training.	Maureen Gleave	After each training session	This is already something that takes place after each training session	
To increase the number of referrals to Age Well Programme service once a person has been screened below 2 using the FRAT Tool	To increase the profile of the Age Well Exercise Programme by targeting professionals . Attending MDT's, team meetings, community events and campaigning events.	Age Well team within Health improvement team	Quarterly	To undertake a quarterly data review for referral sources for all Falls Prevention Services.	

	To streamline referral processes to make it easier for professionals to refer into the appropriate services.	Z.M/J.J/JM	Ongoing	A review of Carefirst has in currently underway to explore automatic referrals to Age Well Programme. (subject to consent).	
		Z.M. Telecare Team	July 2018	To undertake a process review to streamline referral process	
To ensure that people continue to remain active after completing any falls intervention.	To devise a specific pathway that allows people to be reviewed following completion of any falls intervention.	Age Well/ Sure Start to Later Life		A referral pathway has been devised to review the activity of people after they have completed the Age Well Service.	
		Z.M /J.J	Sept 2018	A meeting to be arranged to discuss a new onward referral pathway	
	to explore reasons why people have not continued to be active to inform future development of the service	Age Well team within Health improvement team	Quarterly	To undertake a qualitative review.	
To specifically target all care home and domiciliary care providers with the view to incorporating falls prevention into contracting arrangement.	To continue to promote and deliver the Age Well Awareness program to all care staff that includes training on the use of the Falls Risk Assessment Tool.	Age Well Team in collaboration with Alzheimers Society	Ongoing	Training dates for future Age Well training have been shared with all Care Home Managers	

	To review the current referral pathways to appropriate rehab services for Care Homes/ Domiciliary Care if it is identified that a person is at risk of falls.	Care Homes Falls Prevention Service	August 2018	To arrange a meeting with care home/care provider to discuss a referral pathways	
To review good practice in care homes around falls prevention.	To review current falls recording system in care homes to ensure a consistent approach to reporting.	Quality Assurance		Ongoing work with Quality Assurance	

Aims	**To strengthen the Falls Awareness Campaign to improve public awareness of the importance of falls prevention to their general health and wellbeing.**				
Owner(s)	**Health Improvement Team**				
Task	**Action Required**	**Who**	**When**	**Progress/Next Steps**	**Status**

To improve public awareness of the importance of falls prevention to their general health and wellbeing.	To collectively devise a Falls Awareness Campaign All parties to make a commitment to contribute to the campaign	Falls Steering Group	Sept 2018	Health Improvement currently undertake a yearly campaign for Healthy and Ageing Week where all parties are invited to take part in the event	

	To increase the profile of the Age Well Exercise Programme.	Age Well/ Sure Start to Later Life	Ongoing	Age Well service to continue with Outreach visits to raise awareness in community groups, and community spaces etc.	

To target specific Wards where there is a higher rate of hip fractures and emergency admissions due injuries from falls are higher in Halton than the North West and England Average	To complete a Ward profile for each of these areas and identify any current gaps in the provision of the falls prevention service in these specific areas as a whole and devise a more streamlined pathway.	Neil McSweeney		To gather the data and bring to next falls strategy meeting to discuss key themes	

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REPORT TO: Health & Wellbeing Board

DATE: 10 July 2019

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Children, Education and Social Care

SUBJECT: Adult Social Care Funding – Improved Better Care Fund (iBCF) Allocation 2019/20

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the Health & Wellbeing Board of the iBCF allocation for Adult Social Care in 2019/20.

2.0 **RECOMMENDATION: That the Board note the contents of the report and support the allocations outlined.**

3.0 **SUPPORTING INFORMATION**

3.1 In the 2017 Spring budget, the Chancellor announced an additional £2 billion of new funding for councils in England over three years to spend on adult social care services. This additional funding was broken down as follows:-

- £1 billion to be provided in 2017-18;
- £674m in 2018-19; and
- £337m in 2019-20.

3.2 As outlined above, it is highlighted that this is the **final** year of the iBCF allocations to Councils.

3.3 As a reminder for the Board, a small number of grant conditions have been applied, to ensure that the money is spent on adult social care services and supports improved performance at the health and social care interface; specifically the funding is to be spent on schemes in three areas, as follows:-

- meeting adult social care needs;
- reducing the pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
- stabilising the social care provider market.

3.4 A number of pressures continue within our local system, as a direct result of reductions in available funding, including:

- Ability to manage increases in demand;
- Domiciliary Care capacity;
- Care Homes - sustainability/risks from closures/model of provision;
- Transfers of care from hospital - speed and availability of care; and
- Capacity and availability of Reablement packages.

3.5 Proposed Allocations

It should be noted that many of the schemes outlined below commenced in 2017/18 and work on them have continued throughout 2018/19 and will continue into 2019/20.

	Scheme	Funding 2018-19	Outcomes
1	Reablement First approach on discharge from hospital	£353k	• Improvement in a person's independence and quality of life • Reduction in the number of people delayed in hospital
2	Invest in Transforming Domiciliary Care	£170k	• Improvement in a person's independence and quality of life • Reduction in the number of people delayed in hospital
3	Improved Technology/Telecare Proactive Response i.e. Develop an innovative, preventative and proactive universal service	£132.3k	• Improvement in a person's independence and quality of life
4	Care Homes	£177k	• Development of a sector led improvement model
5	Reducing Pressure on the NHS	£71.9k	• Reduction in the number of people delayed in hospital. NB. The use of this allocation would focus on reducing the pressures on the NHS, through the provision of in reach services and early support discharge. It would support more people to be discharged from hospitals when they

			were ready by the funding of additional packages of care and placements.

4.0 **POLICY IMPLICATIONS**

4.1 None identified.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The original allocation in 2017/18 was £2,974,314, which reduced to £1,827,114 in 2018/19 and in its final year, the iBCF allocation to halton has reduced even further to £904,208.

As the Board will be aware we have been waiting for some time for Green Paper on future sustainability of the sector, the publication of which has been delayed even further.

5.2 Due to the short term nature of this additional funding, the schemes are kept under review in respect to the outcome and outcomes and financial impact achieved.

5.3 The Council is required to complete quarterly returns to the Ministry of Housing, Communities and Government in relation to the allocation of the grant.

5.4 As with 2018/19's iBCF allocation, the grant will be pooled into the Better Care Pooled Budget and once agreement has been reached at the Board, we will be in a position to confirm allocations and spend funding immediately.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**
None identified.

6.2 **Employment, Learning & Skills in Halton**

None identified.

6.3 **A Healthy Halton**

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

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 RISK ANALYSIS

7.1 The recommendations for allocation of available funding has been considered, in light of the eight high impact changes, ADASS vision for future provision[1] and our local areas of challenge, to ensure the biggest impact and future sustainability of services.

7.2 An invest to save approach continues to be undertaken to manage the risks in relation to non- recurrent funding.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

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

9.1 None under the meaning of the Act.

[1] Distinctive, Valued and Personal: Why Social Care Matters, March 2015
https://www.adass.org.uk/distinctive-valued-personal-why-social-care-matters

REPORT TO:	Health and Wellbeing Board
DATE:	10 July 2019
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Access to Healthy and Affordable Food in Halton
WARDS:	Borough Wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to outline the key findings and associated recommendations of a comprehensive study to examine access to healthy and affordable food in Halton. An action plan to address these recommendations is attached to this board report at appendix 1. The Final study report accompanies this board report for reference.

2.0 RECOMMENDATION: That

1) **The Board note the report "Access to Healthy and Affordable Food in Halton" ;**
2) **Board members support the implementation of the associated action plan; and**
3) **Board members promote the report and its findings within their own organisations and use the findings to inform future interventions to improve food access.**

3.0 SUPPORTING INFORMATION

3.1 The report follows a comprehensive study to examine food availability and the attitudes and experiences of residents. The study followed three key phases:

- Geographical mapping: Assessment of the location and quality of food outlets in relation to the local population.
- Community audit: An examination of the schemes and facilities that are available to support access to food and which could be used to support future interventions.
- Consulting the community: Assessment of the attitudes, experiences and opinions of residents in relation to food access through a survey and focus groups.

3.2 The study found that 77% of Households lived within 500m of a shop with a good availability of food. However availability of fresh fruit and vegetables in some areas was inadequate. Only 57% of households lived within 500m of a shop with a good availability of fresh fruit and vegetables.

3.3 There was no correlation between food availability and areas of deprivation or low car ownership. Some areas of deprivation had good food availability such as Windmill Hill whilst some of the areas of lowest availability are the least deprived and have the highest rates of car ownership.

3.4 Overall the study identified 3 local centre areas where retail provision could be improved to increase access to healthy food;

- West Bank, Widnes
- Bechers, Widnes
- Halton Brook, Runcorn

These areas were identified using the following criteria.

- High deprivation and low car ownership
- Low availability of fresh fruit and vegetables
- No alternative shops within walking distance

3.5 Halton's town centres of Widnes, Runcorn and Halton Lea have very good availability of food. Residents in the areas immediately surrounding the town centres benefit from this proximity. However those residents who live some distance from the town centres and don't have access to their own transport will pay a premium for their food at a local centre store or will be dependent on public transport to access the shops.

3.6 The study found a standard basket of shopping to provide a healthy balanced menu for a family of 2 adults and 2 children could be purchased for an average cost of £54 at a town centre location – whereas the average cost for the same shopping at a local centre store was £69.68 a difference of £15.68. This represents a 29% difference between town and local centre locations.

3.7 Overall 69% of universal credit recipients used a means other than their own car such as taxi, bus or walking to reach their main shop. This indicates low car ownership in the borough but also highlights how the cost of taxis or public transport limits the disposable income available to spend on food. Parents with infant children and older people also cited transport as a barrier to accessing sufficient healthy food.

3.8 70% of households live within 500m of a takeaway. The majority of takeaways are concentrated in Widnes and Runcorn Town Centres.

The study did not indicate high takeaway usage amongst residents. Only 15% of households use a takeaway once a week and only 4% of households use a takeaway greater than once a week.

3.9 Since 2012 there has been a 5 fold increase in Food Bank usage in Runcorn and Widnes. In 2017-18 a total of 5478 adults and children were provided with emergency food aid compared to 1162 in 2012. There was a noticeable spike in demand in 2013-2014 which coincided with the introduction of the benefits sanctions regime and the spare room subsidy. A further spike in 2016-2017 coincided with full implementation of Universal Credit in Halton.

3.10 Recipients of emergency food aid must be referred to the Food Banks by a referral partner who will issue a voucher for food aid. Referral partners must specify the referral reason. Analysis of referral reasons reveals that 57% of referrals are benefit related. The next largest referral reason is Low Income accounting for 16% of referrals.

3.11 In addition to the emergency food aid provided by food banks it is clear that some household require longer term support accessing sufficient food. Schemes such as the 11 o'clock club run by the Four Estates charity on Halton Brook redistribute surplus food from major caterers and retailers and at the time the report was written they had provided 1585 to 181 families in the Halton Brook area. This indicates residents across Halton would benefit from longer term support to access sufficient affordable food.

3.12 Food Poverty should be viewed as a spectrum that ranges from households that would go hungry without emergency food aid to households who have sufficient food to avoid hunger but do not have access to the foods that make up the components of a healthy balanced diet such as fresh fruit and vegetables.

3.13 The survey indicated that families on lower incomes frequently had difficulty affording enough food. Families with children were rationing their own meals as a means to ensure there was enough food for their household.

3.14 Overall the principle reason for households having insufficient food was lack of money this was cited by 68% of respondents. 21% of universal credit recipients reported they often or sometimes do not have enough money for food. Based on approximately 9,500 universal credit recipients in Halton this suggests as many as 1,900 individuals in Halton sometimes or often do not have enough money for food. 51% of universal credit recipients reported that in the last 12 months they had run out of food and did not have enough money to buy more and the same proportion reported that they had skipped a meal or reduced the size of a meal because they did not have enough food. This would equate to 4,750 individuals.

3.15 Overall 21% respondents and 32% of universal credit recipients reported that in the last 12 months they had been hungry because they did not have enough money for food. With regard to universal credit recipients this would equate to approximately 3,166 individuals.

3.16 The figures quoted in section 3.14 and 3.15 provide a useful indicator on the potential scale of food poverty in the borough but some caution is required with the figures due to the size of the survey sample not being representative of the population.

3.17 60% of universal credit recipients and 42% of respondents overall who had children in the household reported that in the last 12 months they had skipped a meal or reduced the size of their meal to ensure there was enough food for their children.

3.18 Unexpectedly, 61% of older people with children living in the household also reported reducing the size of their own meal to ensure there was sufficient food for their children. Because the number of respondents is small the results need to be treated with caution but it does suggest that some older people who still have dependent children at home are having to reduce the amount of food they eat to ensure other people in the household do not go hungry

3.19 The survey findings support the following recommendations

Recommendation 1: The Council's future development plans should consider options to improve retail provision in Bechers and West Bank in Widnes and Halton Brook in Runcorn.

Recommendation 2: The Council build on its existing work with partners such as the local housing trusts, CAB and Job Centre plus to provide advice, guidance and support to universal credit recipients to ensure they are maximising their benefit entitlement and also to help recipients avoid the circumstances that may result in a sanction.

Recommendation 3: Whilst the Trussell Trust food banks provide an essential service to those in acute food poverty - the Council and partners should investigate options to facilitate access to alternative surplus food schemes for all Halton residents who require longer term assistance with access to sufficient food. The 11 O'clock club on Halton Brook could be used as a model.

Recommendation 4: The proposed community shop should be supported by the council. The shop should be centrally located to facilitate access for all residents of the borough who require longer term assistance with access to food.

Recommendation 5: Currently 73% of eligible households take up healthy start vouchers. The council and partners should work to further improve this high level of uptake.

Recommendation 6: The Council's future transport plans could consider options to improve access to town centres for parents with infant children, older people and low income households.

Recommendation 7: The existing supplementary planning document on Hot Food Takeaways should be applied in relation to all new applications for change of use to prevent the over concentration and clustering of takeaways.

Recommendation 8: Develop a series of workshops and associated menus and recipe cards on preparing and cooking healthy food on a budget. The workshops should be available to all household in receipt of healthy start vouchers.

3.20 An action plan to address these recommendations has been produced and is set out at appendix 1 to this report. The plan also sets out observations made by departments in response to the report and reflects current and ongoing work relevant to the recommendations. It is acknowledged that some of the actions specified were initiated independently of the Food Access report.

4.0 POLICY IMPLICATIONS

4.1 In general Halton has good availability of food. In most cases an individual's access to food is limited by personal circumstances such as income, transport and mobility rather than the physical location of shops.

4.2 Many of the economic circumstances that have given rise to the current concerns are national in origin. However the recommendations from the report reflect what could be implemented locally by the council and partners to help improve access to healthy and affordable food.

4.3 The Policy implications associated with each of the recommendations will be set out in subsequent detailed reports relating to the implementation of those recommendations

5.0 FINANCIAL IMPLICATIONS

5.1 The financial implications associated with each of the recommendations will be set out in subsequent detailed reports relating to the implementation of those recommendations.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Individuals experiencing chronic food poverty are at a greater risk of malnutrition. This can lead to serious health conditions such low birth weight in infants, inadequate growth and development in children, poor

mental function and a susceptibility to disease due to impaired immune function.

6.2 **Employment, Learning and Skills in Halton**

The actions associated with recommendation 8 will improve food knowledge and awareness

6.3 **A Healthy Halton**

A diet that is high in fruit and vegetables can help prevent cancer, heart disease and diabetes. Over consumption of foods that are high in fat and sugar along with inadequate exercise can lead to obesity. Obesity is a cause of cancer, heart disease and type 2 diabetes.

6.4 **A Safer Halton**

None

6.5 **Halton's Urban Renewal**

Implementation of the actions associated with recommendation 1 will help improve retail provision in areas with poor food availability.

The actions associated with recommendation 7 will help prevent the over concentration and clustering of takeaway food premises.

7.0 RISK ANALYSIS

The risks and benefits associated with implementation of each of the recommendations will be considered in subsequent detailed reports relating to the implementation of those recommendations

8.0 EQUALITY AND DIVERSITY ISSUES

The recommendations in this report are intended to improve access to healthy and affordable for food for all residents. Specific issues in relation to the implementation of each recommendation will be considered in future detailed reports.

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

None.

Appendix 1

Food Access Report – Action Plan

	Recommendation	Proposed Action / Comments	Lead Department	Timeline
1	The Council's future development plans should consider options to improve retail provision in Bechers and Westbank in Widnes and Halton Brook in Runcorn.	Halton Local Plan (Draft May 2019) sets out plans for the improvements to the retail facilities in West Bank, Widnes including the development of a new local centre. The Access to Healthy and Affordable Food report will be considered as material information in support of future development applications in areas that the report has identified as having low availability of fresh food.	Planning Policy, Strategy and Development	Current Delivery and Allocations Plan under review – latest draft May 2019 Consideration of report as material information will be ongoing in relation to new applications
2	The council build on its existing work with partners such as the local housing trusts, CAB and Job Centre plus to provide advice, guidance and support to universal credit recipients to ensure they are maximising their benefit entitlement and also to help recipients avoid the circumstances that may result in	Feedback from Child and Family Poverty Group was that significant work is already being undertaken by the Council and partners to support low income households and reduce the impact of benefit delays and changes. • HBC Discretionary support team provide food parcels to households in urgent need of food. Tesco and	Benefits. CAB HHT DWP	Current and Ongoing

	a sanction.	Asda are used for this service. • HBC Discretionary support team provide personal budgeting advice to clients referred by DWP • 2017-18 £394 K issued in discretionary housing payments • HHT provide welfare and money advice to tenants • Halton CAB provide comprehensive advice service to UC recipients including advice on applications and on dealing with payment problems and sanctions. It is recognised that many of the factors influencing benefit delays and sanctions are due to national policy measures outside the control of the council. The Government have now introduced some measures that will reduce the “cliff edge” effect of payment delay when moving on to UC – this includes a reduction in time taken to issue first payment and provision for advance payments in the form of a loan. Although concern remains that repayment of loans risks placing claimants in debt and will require the ongoing support of the Council and partners.		

3	Whilst the Trussell Trust food banks provide an essential service to those in acute food poverty – the council and partners should investigate options to facilitate access to alternative surplus food schemes for all Halton residents who require longer term assistance with access to sufficient food. The 11 O'clock club on Halton Brook could be used as a model.	• CO-OP Food Share scheme. 2 Co-op shops in Runcorn providing surplus food Community Health Initiatives on Windmill Hill • Discussions ongoing with Co-Op to provide Grangeway Community Centre with surplus food • Community Development Department and Police have approached Recycling Lives with a view to establishing surplus food distribution scheme in Halton • Tesco Distribution Centre support Night Stop Communities North West • Fare Share make twice weekly deliveries to Halton Veterans association • Community Development team to meet with Fare Share Wirral and Merseyside to discuss extending distribution in Halton	Community Development Department Established community groups	Current and ongoing Current – in development Current – in development Current and ongoing Current and ongoing July 2019
4	Proposed community shop should be supported by the	Community shop and Onward Homes to open branch of community shop at a	Community Development	£300k capital investment

	Council. The shop should be centrally located to facilitate access for all residents of the borough who require longer term assistance with access to food.	central location at Halton lea in Runcorn. Facility will be open to all eligible Halton residents. The facility will retail food at a discount of up to 70% and will also provide community development initiatives by working with local people to develop life and work skills		secured, planning permission being progressed and aiming for the shop to be open by the end of 2019 Connections between Community Shop and Halton partners underway to develop an understanding of the model, referral arrangements & recruitment opportunities
5	Currently 75% of households take up healthy start vouchers. The council and partners should work to improve this level of uptake	Halton currently has the highest uptake of healthy start vouchers in the UK. However it is recognised that those families who become eligible after the birth of a child may not realise they are entitled to claim. HBC Public Health to work on promoting scheme amongst all early years and pre-school settings (both public and private) to ensure take up of the scheme is maximised amongst	Public Health Early Years	August / September 2019

		families who become eligible after the birth of child.		
6	The council's future transport plans could consider options to improve access to town centres for parents with infant children, older people and low income households.	The reports recommendation regarding public transport will be incorporated into the Local Transport Plan for consideration in future allocation of assisted transport budget. However the budget to date for supported bus routes (c £450k) is fully allocated. A limited door to door bus service is currently available for older people.	Transport co-ordination	Current Local Transport Plan runs 2011/12 to 2025/26 but is subject to annual review. March/April 2020
7	The existing supplementary planning document on Hot Food Takeaway should be applied in relation to all new applications for change of use to prevent the over concentration and clustering of takeaways	The existing policy relating to takeaways including over concentration and clustering is to be incorporated into Halton's Local Plan. This will raise the status of the current policy and ensure greater weight is given to the policy objectives during consideration of future development applications.	Planning Policy, Strategy and Development	Current Delivery and Allocations Plan under review – latest draft May 2019
8	Develop a series of workshops and associated menu's and recipe cards on preparing and cooking healthy food on a budget. The workshop should be available to all households in receipt of healthy start vouchers	Children's Centres operate "let get cooking classes" on a rolling programme each term includes use of left overs to prevent unnecessary food waste. The Community Shop proposed for Halton Lea will also provide a comprehensive programme of cooking, menu planning and budgeting courses for residents	Children's Centres Community Development Public Health	Current and ongoing Community shop scheduled to open end of 2019

		based around food available through the shop. Extensive educational resources available on government's Change For Life website. Future public health interventions should look to utilise these existing resources rather than invest in a unique offer to Halton.		Ongoing in response to future initiatives.

Halton Borough Council

Access to Healthy and Affordable Food in Halton

Stephen Burrows
Principal Environmental Health Officer
Public Health Department
Halton Borough Council

September 2018

Executive Summary

The purpose of this report is to examine how easy it is for Halton's residents to access healthy and affordable food. The report follows a comprehensive study to examine food availability and the attitudes and experiences of residents. The study followed three key phases:

- Geographical mapping: Assessment of the location and quality of food outlets in relation to the local population.
- Community audit: An examination of the schemes and facilities that are available to support access to food and which could be used to support future interventions.
- Consulting the community: Gain an understanding of the attitudes, experiences and opinions of residents in relation to food access through a survey and focus groups.

Overall the study found that there was good availability of food in the borough with 77% of residents living within 500m of a retail shop with good food availability. However the situation was less positive for fruit and vegetable availability. Only 57% of residents lived within 500m of a shop were an adequate quantity of fruit and vegetables could be purchased.

The study found there is no general correlation between food provision and areas of deprivation. Some of the boroughs more deprived areas had very good food availability whereas in other deprived areas there was less availability particularly of fresh fruit and vegetables.

The study found that those residents with transport and mobility issues who could not access the town centres would pay a significant premium to shop in some local centre locations.

Three areas were identified were retail food provision could be improved.

70% of households live within 500m of a takeaway. However Halton has one of the lowest takeaway densities of in the North West with most takeaways concentrated in the town centres of Runcorn and Widnes. The survey highlighted the significance of takeaway delivery and web based ordering services. 47% of respondents did not physically visit the takeaway and relied on a delivery ordered over the phone or internet.

The survey suggested that most people do not habitually use a takeaway as an alternative to food purchased from shops and prepared at home. Although young people were underrepresented in the survey the results suggested younger people used takeaways more frequently than other groups.

Food poverty can be viewed as a spectrum ranging from those in acute food need who would go hungry without emergency food aid to those who have sufficient food to avoid hunger but can't afford enough of the foods that make up a healthy balanced diet.

Although it is difficult to measure food poverty in absolute terms the use of food banks provides a good indicator of the numbers of people in the most extreme food poverty. Overall between 2013 and 2018 there has been a five-fold increase in the number of people seeking emergency food aid from Halton's food banks. Analysis of food bank data suggests the principle reason for this increase was due to changes or delays in benefits.

Overall inadequate income was the principal barrier reported to accessing sufficient healthy and affordable food.

Just 31% of universal credit recipients reported having enough of the food they wanted to eat with 68% of those respondents citing lack of money as the principle reason. The survey also revealed that a significant proportion of people skipped meals or reduced the size of their meals because they had insufficient food or to ensure there was enough food for their children.

Transport and mobility were also a barrier particularly for older and younger people. 68% of universal credit recipients were reliant on a means other than their own car to get to the shops.

The survey identified that respondents had good food knowledge and a strong desire to eat healthy food. However some families suggested extra assistance in the form workshops and demonstrations would be welcome.

The study identified the following recommendations.

Recommendation 1: The Council's future development plans should consider options to improve retail provision in Bechers and West Bank in Widnes and Halton Brook in Runcorn.

Recommendation 2: The Council build on its existing work with partners such as the local housing trusts, CAB and Job Centre plus to provide advice, guidance and support to universal credit recipients to ensure they are maximising their benefit entitlement and also to help recipients avoid the circumstances that may result in a sanction.

Recommendation 3: Whilst the Trussell Trust food banks provide an essential service to those in acute food poverty - the Council and partners such as the CCG should investigate options to facilitate access to alternative surplus food schemes for

all Halton residents who require longer term assistance with access to sufficient food. The 11 O'clock club on Halton Brook could be used as a model.

Recommendation 4: The proposed community shop should be supported by the council. The shop should be centrally located to facilitate access for all residents of the borough who require longer term assistance with access to food.

Recommendation 5: Currently 73% of eligible households take up healthy start vouchers. The council and partners should work to further improve this high level of uptake.

Recommendation 6: The Council's future transport plans could consider options to improve access to town centres for parents with infant children, older people and low income households.

Recommendation 7: The existing supplementary planning document on Hot Food Takeaways should be applied in relation to all new applications for change of use to prevent the over concentration and clustering of takeaways.

Recommendation 8: Develop a series of workshops and associated menus and recipe cards on preparing and cooking healthy food on a budget. The workshops should be available to all household in receipt of healthy start vouchers.

An action plan to address these recommendations will be produced as a separate document that will develop over time.

Introduction

The purpose of this report is to examine how easy it is for Halton's residents to access healthy and affordable food. The report follows a comprehensive study to examine food availability across the borough. Whilst the study did not seek to establish a causal link between excessive weight and other health impacts of a poor diet, the study did examine some of the factors that would influence a healthy diet such as takeaway prevalence, takeaway consumption, food knowledge and attitudes to healthy eating.

There were 3 principle reasons for initiating this study;

- **Cost of Living**

  Although the recession ended in 2009 a combination of wage stagnation, price inflation and changes to benefits have created significant pressures on the cost of living. In real terms salaries have remained the same as they were in 2004, many benefit recipients - whether in or out of work - will have seen a reduction in their income, whilst the cost of food, energy and housing have increased significantly over this period.

- **Halton's high level of obesity**

  The latest National Child Measurement Programme data shows that 22.9% of year 6 pupils in Halton are obese against an England average of 20.0% and an England low of 11.3%. Public Health England data also shows that 3 in 5 adults are either overweight or obese.

- **The need for evidence to support future public health interventions.**

  It is well established that deprivation is a significant adverse influence on public health. Areas with high levels of deprivation generally report poorer public health outcomes for their populations. Overall Halton is ranked the 27th most deprived local authority area in England. Deprivation will influence Halton's obesity levels and the ability of residents to access healthy and affordable food.

  This study sought to examine whether there are further influences either from the local environment or other circumstances that may affect the ability of residents to access healthy and affordable food.

  In addition, due to a reduction in central government funding, It is essential that spending on public health interventions is focussed on what is needed and what works. This study will help inform priorities for future public health interventions around food access and healthy eating.

Many previous studies that have examined food availability have focussed on the concept of food deserts. Food deserts are defined as areas with limited access to

healthy and nutritious food. These studies have tended have to have a narrow focus on the physical location of shops in an area and do not consider the wider individual circumstances which may influence access to food. This study sought to examine the local food environment and food availability in more detail and in the context of 5 key factors that influence the availability of food to individuals and communities.

These 5 key factors are;

Access: The physical location of shops and an individual's ability to get to those shops. Access will include issues around mobility and transport.

Affordability: The ability of an individual to purchase sufficient food or the types of food they want to eat.

Awareness: The knowledge to purchase, cook and prepare food and the concept of a healthy, balanced diet.

Acceptability: Is food available that is acceptable to an individual's personal needs? This will include special diets and medical conditions.

Appropriateness: Is the food that is available appropriate to an individual's personal requirements? This will include cultural aspects such as religious and ethical requirements.

In practice this study will predominately focus on the first 3 areas; access, affordability and awareness. There is frequently an interaction between these factors for example an individual may have enough money to purchase sufficient food providing they are able to access a range of shops to secure the best value for their money.

There were 3 key phases to the study and these will be reflected in the sections of this report.

1 Geographical food mapping

This stage of the study examined the physical location of significant food shops and other sources of food such a takeaways and their accessibility to the local population. The study also looked in detail at the quantity, quality and price of food available in each local centre area to determine how easy it was for the community to shop for the components of a healthy, affordable and balanced diet.

2 Community Audit

This stage examines what is taking place or proposed within the community to facilitate access to healthy and affordable food and included an assessment of emergency food provision through the Runcorn and Widnes food banks. This stage also examined schemes that are no longer in existence but may be used to help inform future interventions.

3 Consulting the community

This stage involved a detailed study via survey and focus groups to seek the views of Halton residents and their experiences of accessing healthy and affordable food.

Objectives

The overall objectives of the study are;

1 To identify barriers and enabling factors to food access

2 To inform council policy

3 Improve food access

The final section of the report will summarise the conclusions that can be drawn from the study and put forward recommendations in order to achieve the study objectives.

Chapter 1

1.0 Geographical mapping of food availability.

This phase of the study examined the physical location of shops and other sources of food such as takeaways. The study examined how easy it was to shop for the components of a healthy balanced diet within each local centre area and examined the cost of food in local and town centre locations.

1.1 Retail Food Shops

1.1.1 Scope of Study

The study of retail food shops will assess whether it is possible for households to purchase a standard basket of healthy food within a 500m distance of their home.

This methodology has been influenced by a number of similar studies in other areas of the UK notably Hackney, Newcastle, Sandwell and Ceredigion. A key feature of all these studies is that they reflected local circumstances. It is therefore necessary to adapt these previous studies to Halton's local circumstances. These previous studies have also approached the issue of food availability from different perspectives. The Newcastle study for example set out to examine "whether food deserts exist" and so looked at whether shops stocked not only the requirements for a healthy balanced diet but also the foods that people wanted to eat – and so included some items that may be viewed as unhealthy.

1.1.2 Method

The purpose of the Halton study was to examine whether Halton residents could purchase a healthy "basket" of shopping within 500m of their home. This would provide an indicator of the quality of food availability in the borough.

1.1.3 The Standard Basket of Shopping

The standard basket of shopping has been based very closely on a study undertaken in Hackney by the Food Policy Unit at City University London. http://openaccess.city.ac.uk/489/7/Shopping_for__Food.pdf. The Hackney approach was preferred to other studies because the Hackney study was practical and was based around shopping for the food items required for a 7 day healthy balanced menu. For the purposes of the Halton study the menu has been adapted for 2 adults and 2 children.

It is acknowledged that the menu and the basket of shopping may not be typical for every household. It is also acknowledged there are factors that may prevent a family shopping and eating in this way, e.g. affordability and adequate time for shopping and preparation. However the purpose of the menu and standard basket is to examine how easy it is for a household to shop for the components of a heathy balanced diet within their locality and thereby provide an indicator of food availability in that locality.

Figure 1 below sets out the Healthy menu for a family for a week and Figure 2 sets out the shopping basket that is required to produce this menu.

Figure 1 7 day healthy balanced menu

Breakfast

Weetabix, Cornflakes or porridge – semi skimmed milk

Eggs and Toast at weekend

Glass of Orange

Lunch

School / nursery meals for children

Sandwiches for Parents (and children at weekend)

Evening Meal

1 Cottage Pie, broccoli and carrots

2 Chicken Casserole, potatoes, carrots and cabbage

3 Bolognaise sauce and pasta

4 Cod and Parsley Sauce, Potatoes, broccoli, peas

5 Salmon with pasta salad

6 Beans on toast

7 Chicken curry and rice

Dessert

Fruit Yoghurts

Fruit

Snacks / supper

Pieces of fruit, toast, cereal with milk

Figure 2 The standard shopping basket

Item	Recommended quantity
Apples	400g
Oranges	800g
Satsuma or similar	400g
Grapes	200g
Bananas	1kg
Broccoli	1.3kg
Onion	250g
Fresh Tomatoes	1.3kg
Peas / tinned / frozen	500g
Carrot	1kg
Cabbage	1kg
Potatoes	3kg
Unsweetened Orange	3 litres
Tinned Tomatoes	1 x 400g tin
Baked Beans	2 x 415g tin
Wholemeal bread	3 x 800g
Weetabix	24 pack
Cornflakes	250g pack
Oats	500g
Pasta	500g
Rice	500g
Fresh Chicken	750g
Lean minced beef	1kg (2x 500g)
Fresh / tinned salmon	450g
Fresh cod / white fish	500g
Fresh eggs	1 Dozen
Semi skimmed	8 ltr
Fruit Yoghurt	4 x 125g x 4
Hard cheese	250g
Cooked lean meat e.g. ham / turkey	500g

1.1.4 Retail survey

The standard shopping basket was used as the basis for the survey of retailers. A survey form was produced to record the availability of each of the items from the shopping basket at each location.

There are over 250 food retailers in Halton ranging from small corner shops and newsagents to superstores. Resources did not permit a comprehensive survey of all food retailers. The list of food retailers included newsagents, off licenses and corner shops who stock some basic food items and therefore provide an important service to the community. However the primary purpose of these retailers is not to enable a family to complete a weekly shop and so there was considered little benefit including these smaller retailers in the survey. A more pragmatic, targeted approach was required.

The survey therefore focused on Halton's established Town, District and Local Centre's. The survey started with the largest shop in each location to establish if the basket can be purchased there. Further smaller shops in each location were surveyed if the largest shop did not stock the full basket to establish if the complete basket could be purchased in that location.

With respect to the town centres it was not considered necessary to survey all supermarkets – the retail provision in the town centres is known to be excellent and so only one large supermarket and one "discount" supermarket was surveyed in each town centre to enable comparison with local centre provision.

In addition a number of larger shops and local convenience stores were identified outside of the established local centres that were likely to be important to local food provision.

In total 37 town and local centre areas were surveyed. These locations are detailed in Appendix 1 to this report. In addition 14 further shops in key locations were surveyed to examine whether they made a significant contribution to food provision. Those that sold more than 50% of the standard basket or more than 50% of the fruit and vegetable items were included in the survey results.

The results of the shopping basket survey were analysed and each local centre area was categorised depending on the percentage of the standard basket and the percentage of fruit and vegetable items available.

1.1.5 Affordability

The survey recorded the cost of the individual items in the basket at each of the locations. This provided an assessment of the cost of a providing a healthy, balanced menu for the week and enabled a comparison of cost between locations and retailer type. The purpose of the survey is to inform future food policy rather than provide detailed price comparison data. Therefore the data on cost and affordability is presented in general terms and does not identify a specific retailer.

1.2 Takeaways

The Environment Health food safety team hold comprehensive data on all takeaways in the borough. This enabled the location of all takeaways to be plotted on a map and compared with population data to identify how many households lived within 500m of a takeaway.

1.3 Survey Results

The results of the shopping basket and takeaway survey have been analysed and the data plotted onto 10 maps to provide a visual representation of the survey results. This data has been compared with other population based data to examine any relationships that may further influence access to food.

1.3.1 Overall food availability

Overall 77% of Halton households live within 500m of a shop where at least 50% of the standard basket of shopping can be purchased. As an indicator, 500m is around a 10 minute walk. It is acknowledged that the distance is “as the crow flies” and does not take into account the actual route a pedestrian would take and the terrain but it is never the less considered to indicate that the majority of Halton residents enjoy good food availability close to their homes.

The results of the survey have been plotted onto a series of maps. Each location surveyed has been colour coded as follows

Green 75% to 100% of basket available.

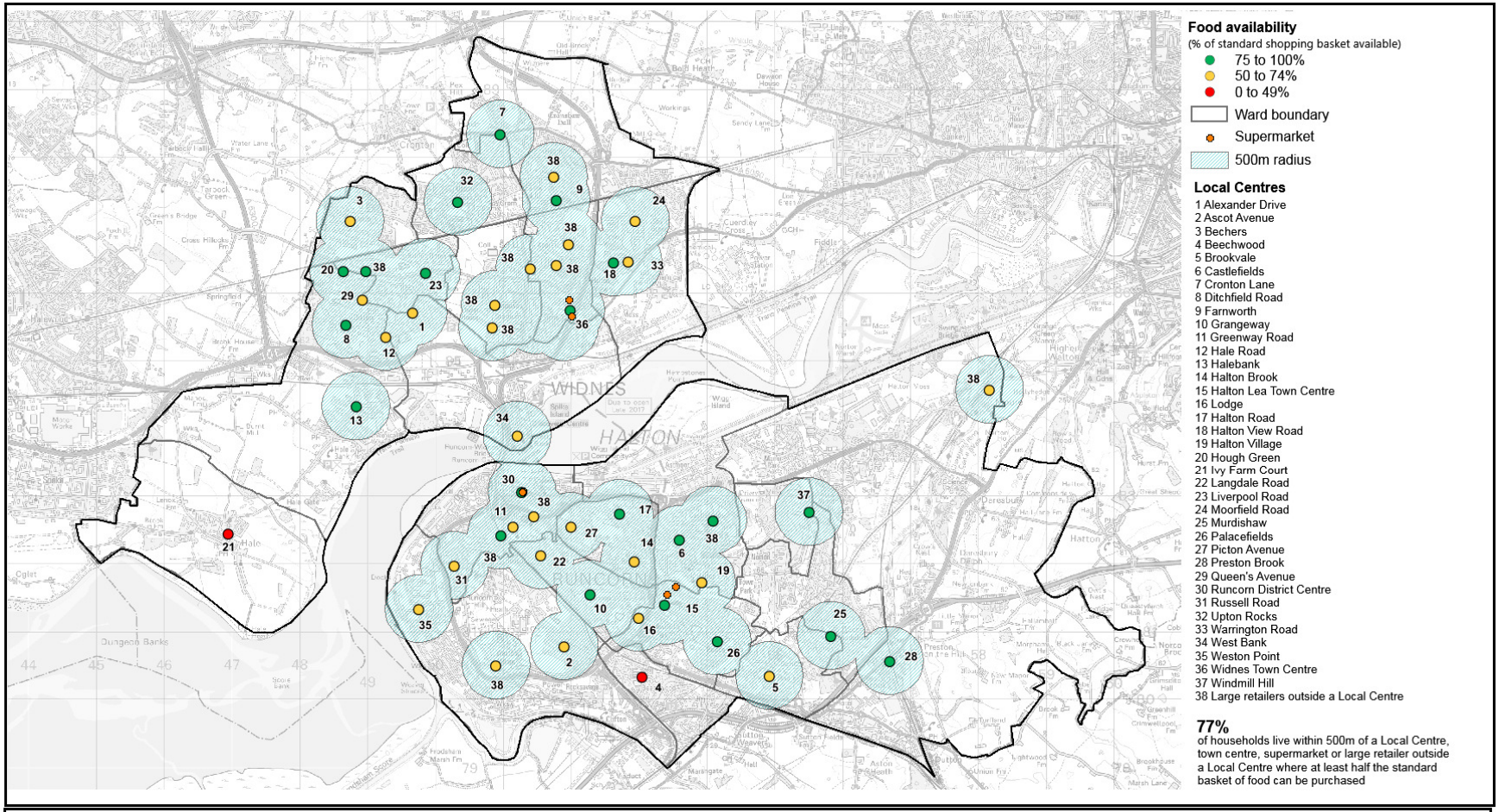
Yellow 50 to 74% of basket available.

Red Less than 50% available.

Map 1 details the survey results for each location. A numbered key accompanying Map 1 identifies each local centre area. The map also includes all supermarkets and those of the 14 shops surveyed outside a local centre that provided over 50% of the standard basket of food.

As can be seen from map 1, only 2 local centre areas Beechwood in Runcorn and Hale in Widnes provide under 50% of the standard basket. In addition there are a number of areas that are not within the 500m radius of a local centre or significant shop. In Runcorn these areas include Sandymoor, parts of Norton and Murdishaw and parts of Weston point. The new Aldi development will improve access in the Murdishaw area. In Widnes these areas include Hough Green and parts of North Widnes around Moorfield Road, the eastern section of Derby Road and Barrows Green Lane. A proposed new Aldi development in North Widnes will also improve access in these areas.

Map 1 Overall Food Availability



Food availability by Local Centre and large retailers outside Local Centres in Halton, with locations of supermarkets

Survey completed November 2015 to April 2016

Produced by Public Health Intelligence Team health.intelligence@halton.gcsx.gov.uk

1.3.2 Fruit and vegetable availability

Whilst overall the level of food availability is considered good the picture changes with regard to the availability of fresh fruit and vegetables. 57% of Halton households live within 500m of a shop where 50% or more of the fruit and vegetable items in the standard basket can be purchased. Map 2 details the survey results for each location. In total there are 13 local centre areas where less than 50% of the fruit and vegetable items can be purchased. Some of these areas are close to areas where availability is good, for example Halton Village and Halton Lodge are all close to Halton Lea and Grangeway where provision is very good. This may explain the lack of availability in these locations.

However there are locations where local provision of fresh fruit and vegetables is low and that are not close to alternative locations with good availability. In Widnes these local centres included Bechers, West Bank, Moorfield Road and Hale; areas in Runcorn included Halton Brook, Beechwood, Weston Point and Russell Road. These areas are in addition to the areas that are not within the 500m radius of a local centre or significant shop. In Runcorn these areas included Sandymoor, parts of Norton and Murdishaw and parts of Weston point. The new Aldi development will improve access in Murdishaw. In Widnes these areas include Hough Green and parts of North Widnes around Moorfield Road, the eastern section of Derby Road and Barrows Green Lane. The new Aldi development in North Widnes will improve access in this area.

1.3.3 Deprivation

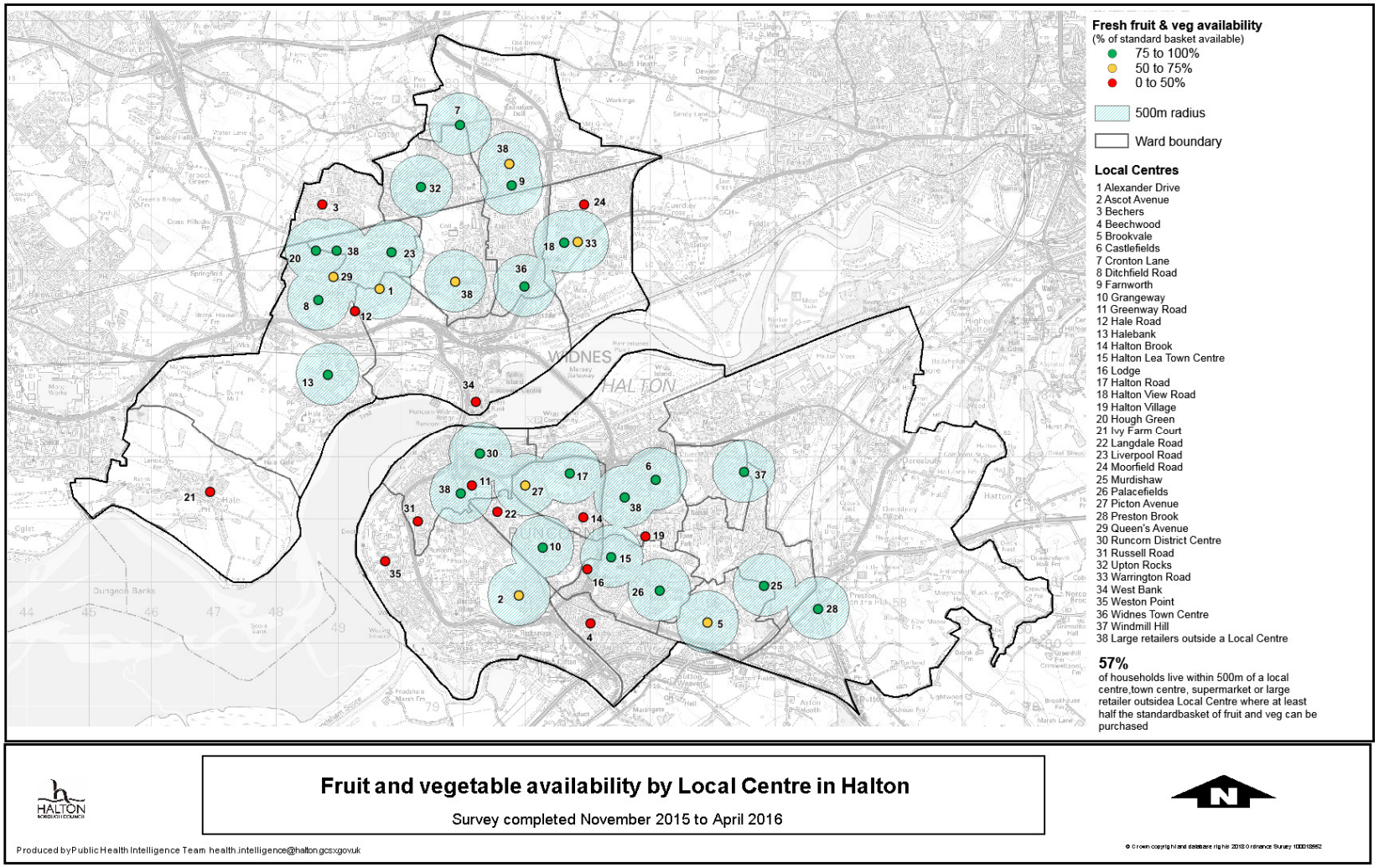
The data from the shopping basket survey has been analysed and geographically mapped at ward level to identify any correlation between areas of deprivation and food availability.

Levels of deprivation using national quintiles (fifths) were used for this analysis, to show which areas in Halton fall within the 20% most and least deprived relative to the rest of England.

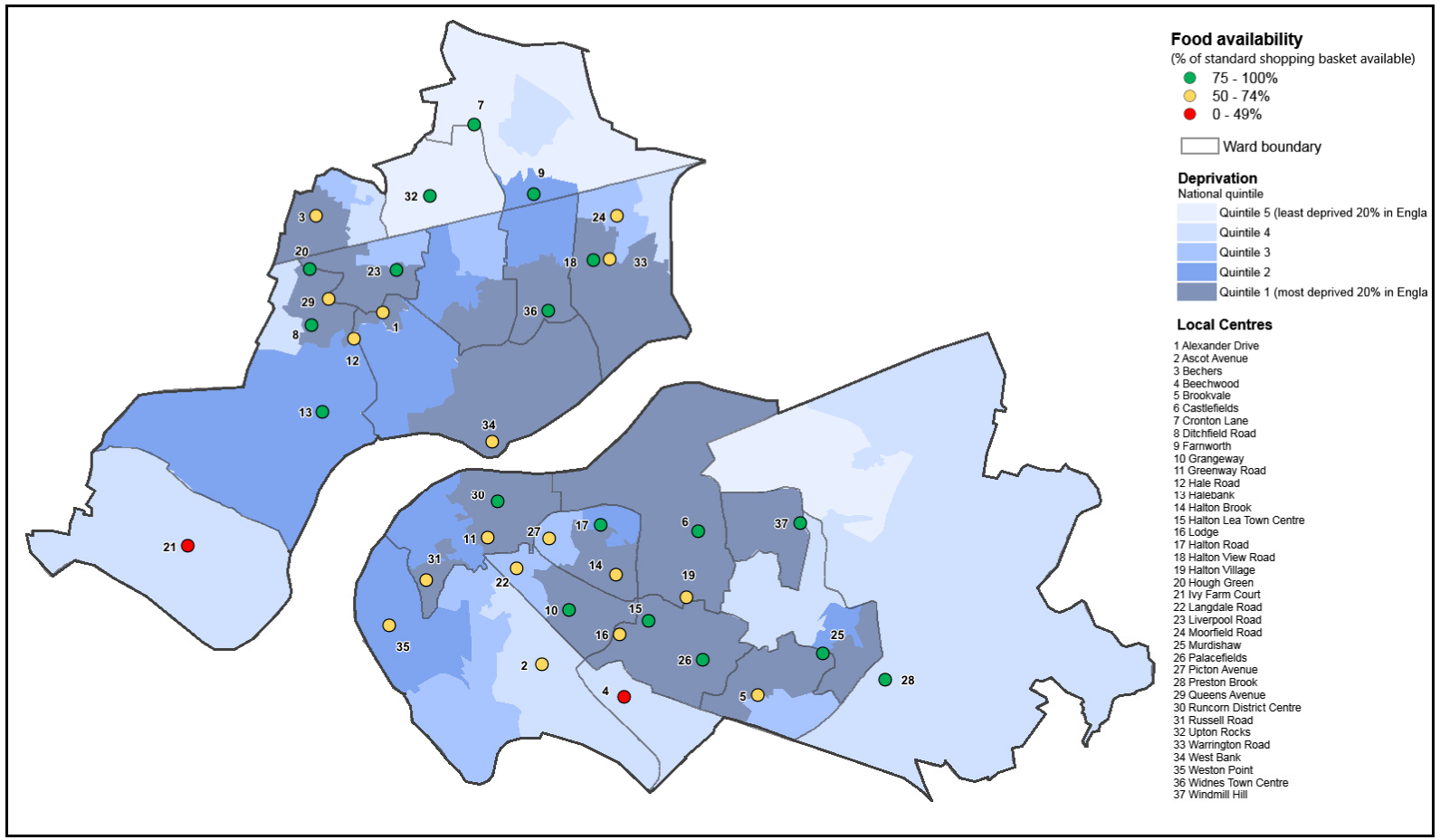
Map 3 below details the findings from this analysis.

No obvious correlation between deprivation and food availability was identified. In fact some of the more deprived areas of the borough actually have very good local availability such as Windmill Hill and Castlefields and the areas adjacent to the town centres of Runcorn and Widnes. Some of the areas of lowest availability, Beechwood and Hale, are amongst the least deprived areas in the borough.

Map 2 Fruit and veg availability



Map 3 Overall food availability and level of deprivation



HALTON BOROUGH COUNCIL

Fresh food availability by Local Centre in Halton with level of deprivation

Survey completed November 2015 to April 2016

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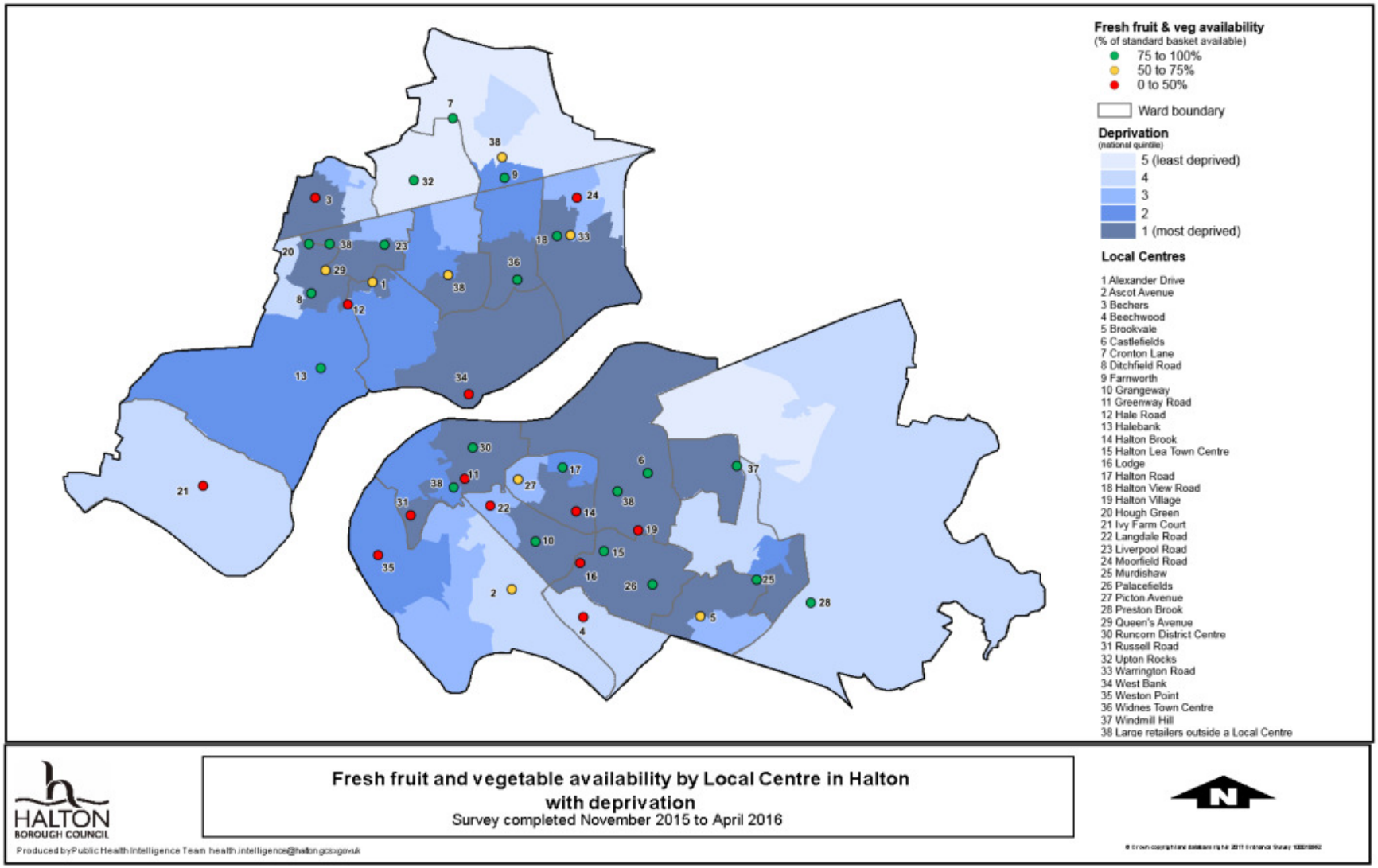
Produced by Public Health Intelligence Team. Email: health.intelligence@halton.gcsx.gov.uk

1.3.4 Fruit and veg availability and indices of deprivation

The position with regard to local fruit and veg availability is more complex. Generally there is no overall correlation between the level of deprivation and fruit and veg availability. It is a mixed picture. Some of the more deprived areas such as Windmill Hill and Castlefields have very good availability of fruit and veg with over 75% of the fruit and veg items available in these locations. Some of the more deprived wards are adjacent to the town centres of Runcorn, Widnes and Halton Lea and so residents in those areas have good access to fruit and vegetables. However it also possible to say that some of our deprived areas do have low availability of fresh fruit and vegetables – some of these areas are close to areas where availability is good e.g. Halton Lodge, however some areas with poor availability are more isolated in terms of distance from other areas where availability is good. These areas include Halton Brook, Bechers/Hough Green, West Bank, Weston Point, Russell Road.

Map 4 below illustrates this analysis.

Map 4 **Fruit and vegetable availability and areas of deprivation**



1.3.5 Car ownership and public transport

The results of the survey were analysed to examine food availability in the context of car ownership and public transport. The results are illustrated on maps 5 and 6 below.

No obvious correlation between low car ownership and availability was observed. The results indicated a mixed picture across the borough and the results were comparable with the results for deprivation. Car ownership is a factor in assessing the level of deprivation and so it might be expected that results are similar. Availability is good in some areas of low car ownership – whereas some of the areas where availability is poor are areas of highest car ownership.

However there are some areas of low car ownership such as Bechers/Hough Green and West Bank where the local provision of fruit and vegetables is poor. The mapping of bus routes suggests that public transport is available to all local centre areas including those where availability is poor, although no assessment was made of the quality or frequency of the bus service.

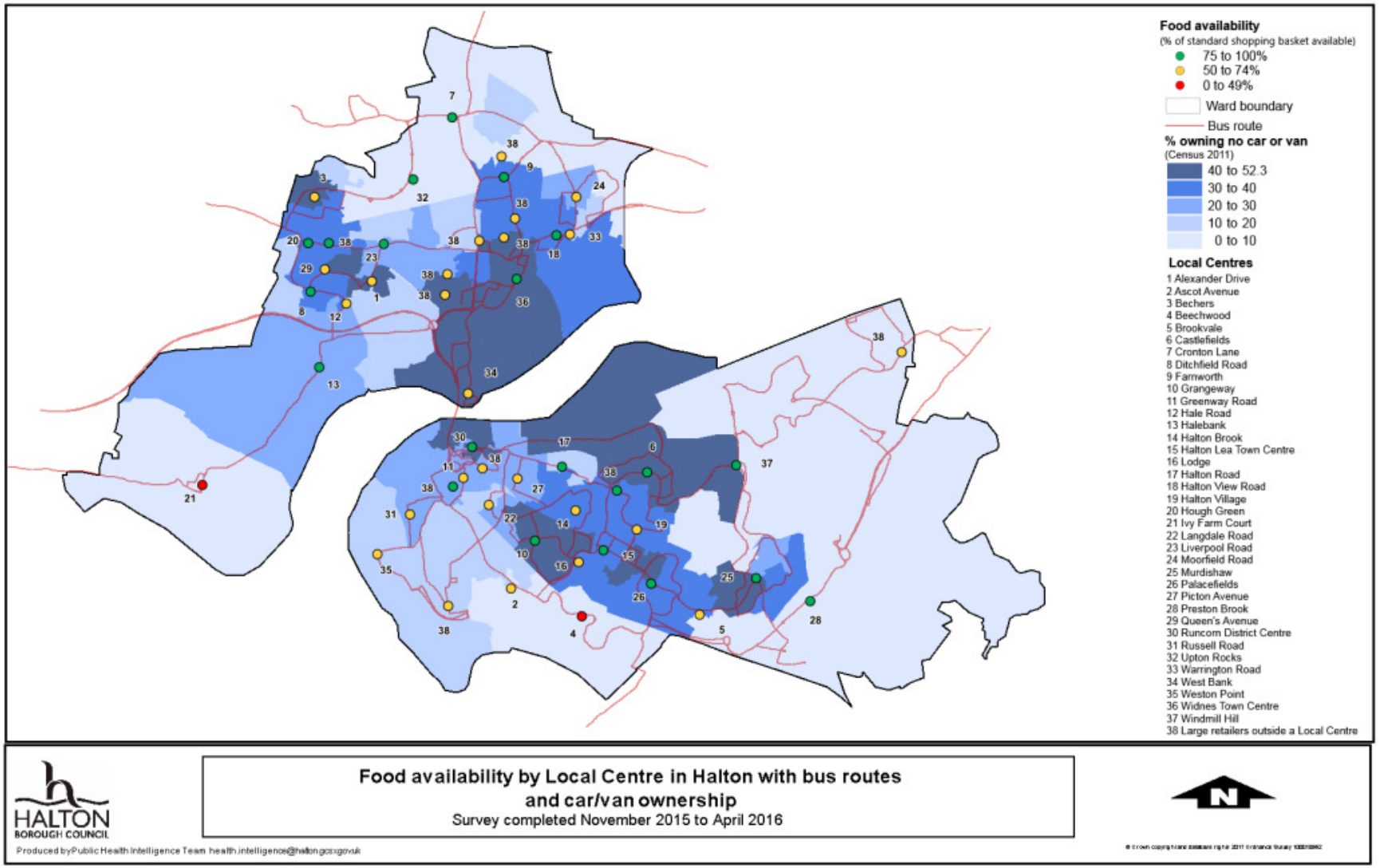
Many wards in Halton benefit from their proximity to the town centres of Widnes, Runcorn and Halton Lea where many of the major supermarkets are located providing excellent retail provision in those areas. This contracts with other towns where there has been a trend during the 90's and early 00's for larger retailers to be located "out of town".

1.3.6 Food availability and older people

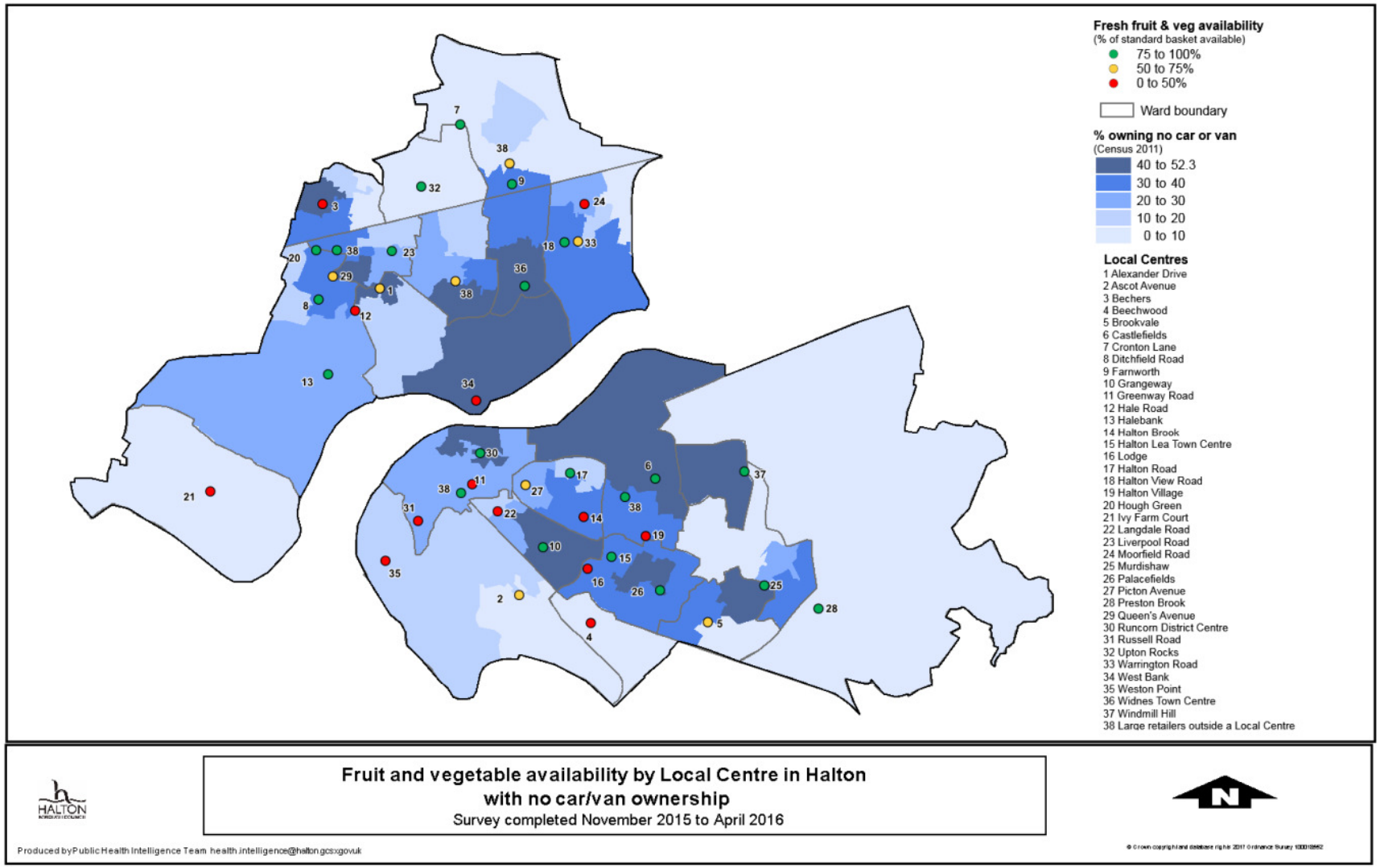
The results of the survey were analysed in the context of the number of older people living in an area. In general no correlation between age and local food availability was found with the exception of Hale which has one of the highest percentage of residents over 70 and the poorest availability of food locally. However Hale does have high levels of car ownership. This suggests that older people living in Hale without access to transport or an alternative source of purchasing food may have their access to food limited. Maps 7 and 8 illustrate this analysis.

The experiences of older people were examined in more detail in the survey and focus groups and the results of these studies provide a more meaningful insight into the issues affecting food access for older people than the geographical mapping.

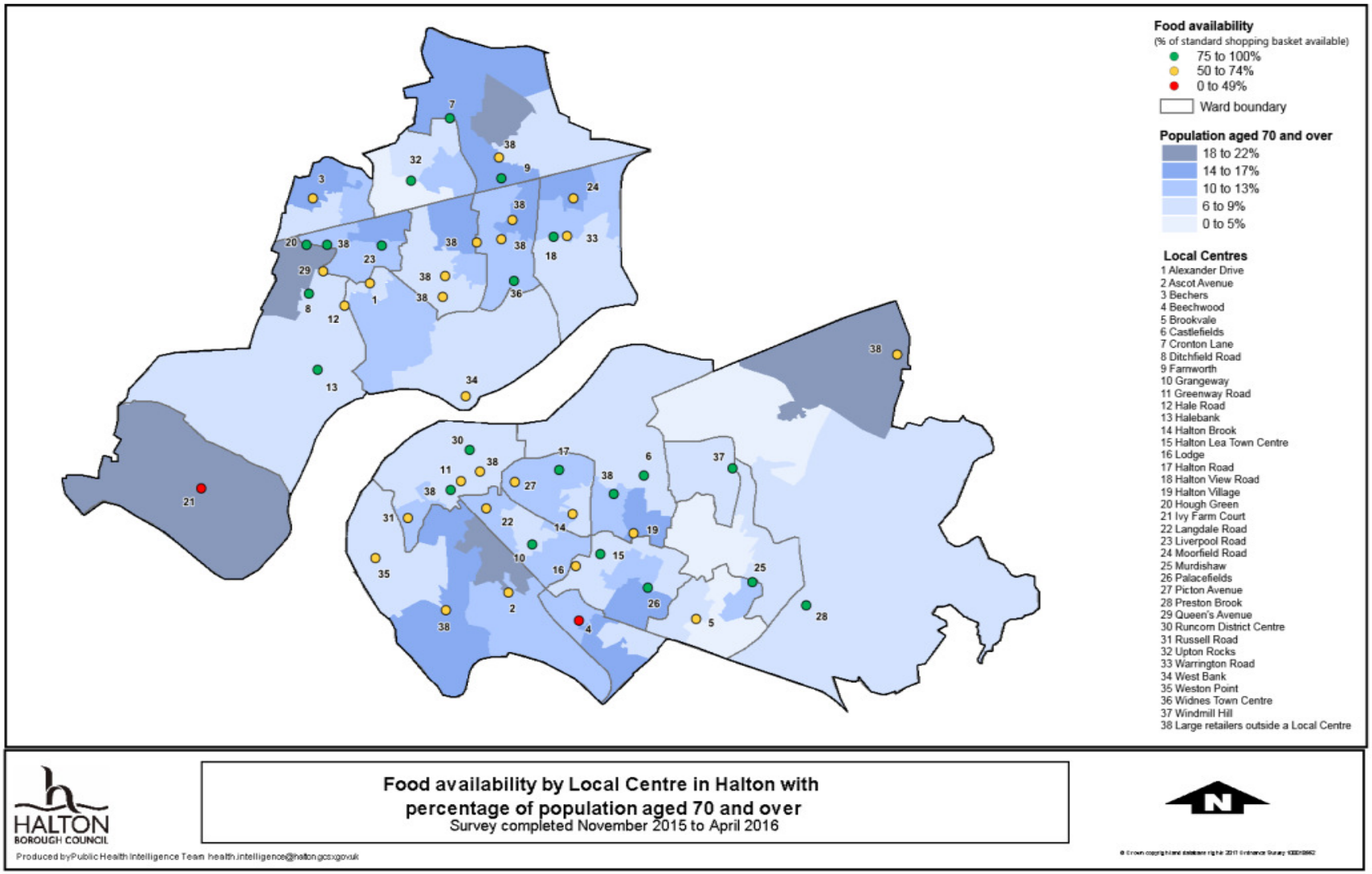
Map 5 Overall food availability and car ownership



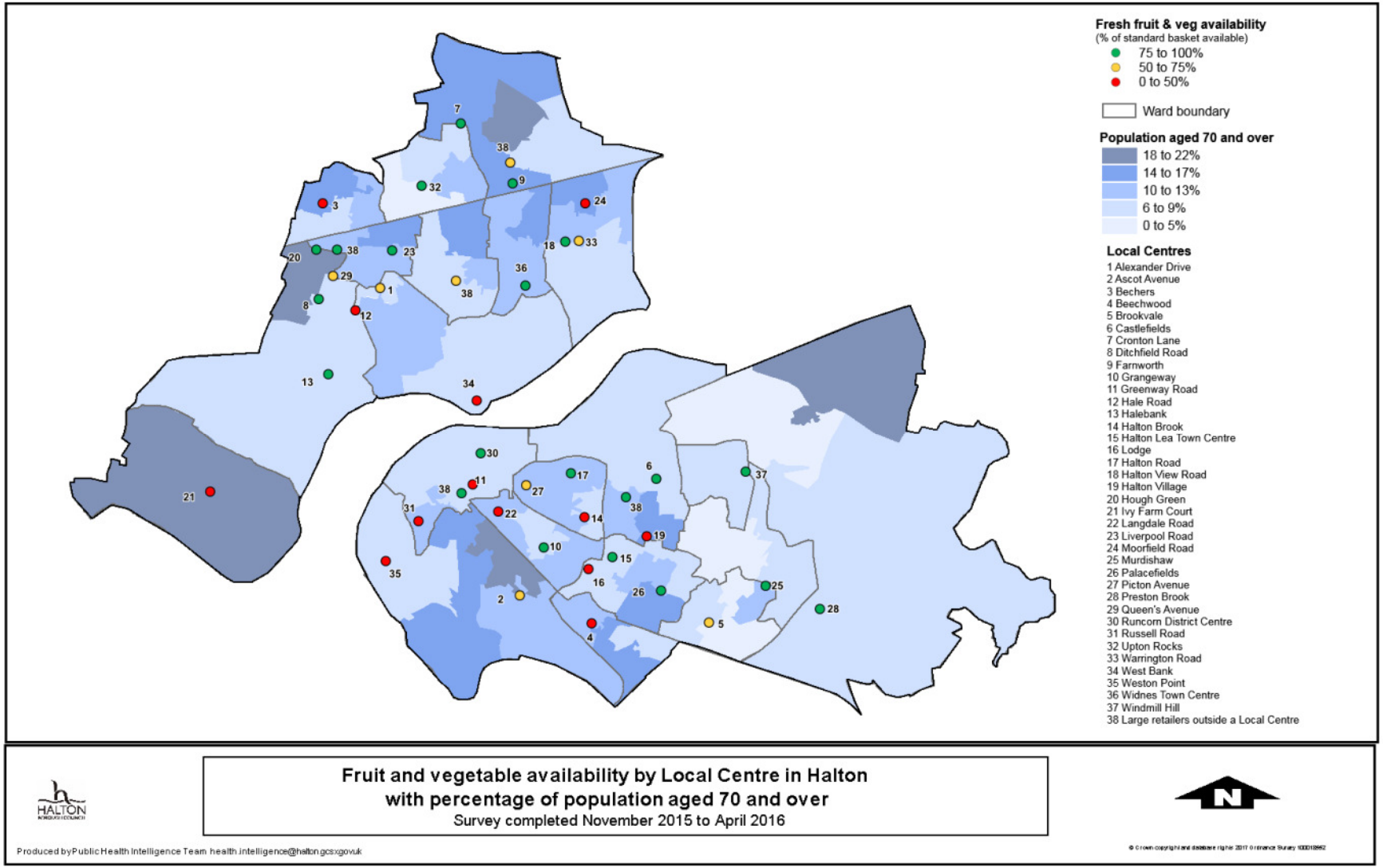
Map 6 Fruit and vegetable availability and car ownership



Map 7 Overall food availability and older people



Map 8 Fruit and vegetable availability and older people



1.3.7 Takeaways

70% of Halton households live within 500m of a takeaway – this suggests the majority of Halton residents have easy access to a takeaway within their immediate location. However the fact that 77% of households also live within 500m of a shop offering a good standard of food provision indicates that alternatives to the takeaway are available in most locations.

There is a perception that Halton has a high number of takeaways and that more should be done to control numbers – however when compared to other areas, data published by Public Health England shows that Halton has one of the lowest takeaway densities in the North West at 91.9 per 100,000 population. (https://www.gov.uk/government/publications/fast-food-outlets-density-by-local-authority-in-england). This is compared with an England average of 96.5 per 100,000 and a North West Average of 117.9 per 100,000. In this latest assessment of takeaway density Public Health England have expanded their definition of a takeaway food premises to include some restaurants that also serve takeaway food. This definition is different to the definition used to map takeaway density for this study. For the purposes of this study the Food Standards Agency definition of a "takeaway" was used and includes typical takeaway premises such as fish & chips, kebab, pizza, Indian and Chinese.

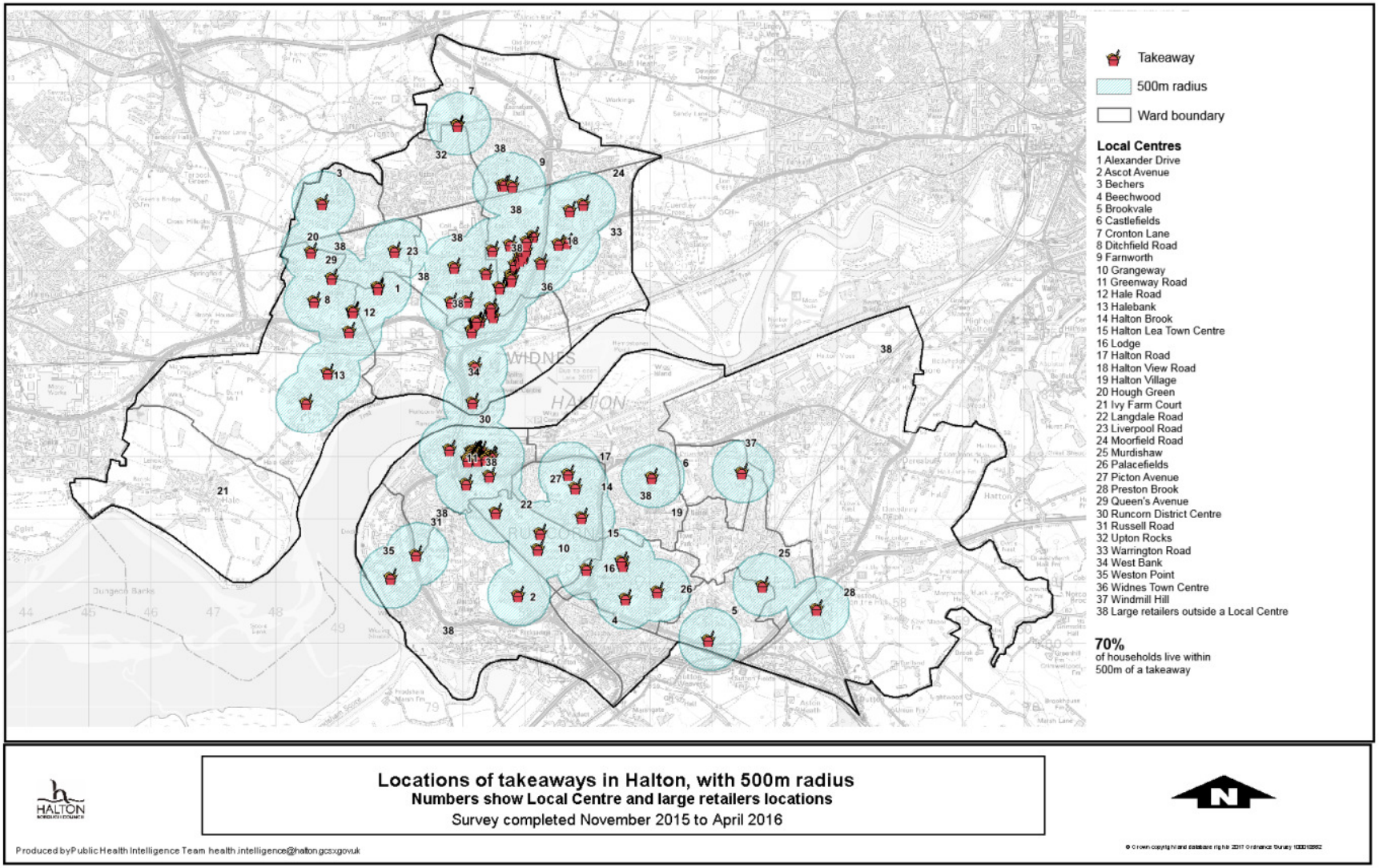
It is clear from the maps that the majority of takeaways are concentrated within established town centres of Runcorn and Widnes and elsewhere they are evenly distributed. There are 19 takeaways in Runcorn town centre and 20 in Widnes Town Centre. In general it is not possible to make a correlation between the number of takeaways and levels of deprivation. However because some of the more deprived areas of the borough are close to the town centres of Widnes and Runcorn and the high density of takeaways in those areas, it is possible to say that some of Halton's more deprived wards do have a high density of takeaways and this may influence consumption in those areas.

Unfortunately responses to the more detailed survey from the wards closest to the town centres were insufficient to examine the impact this proximity had on takeaway consumption in these wards.

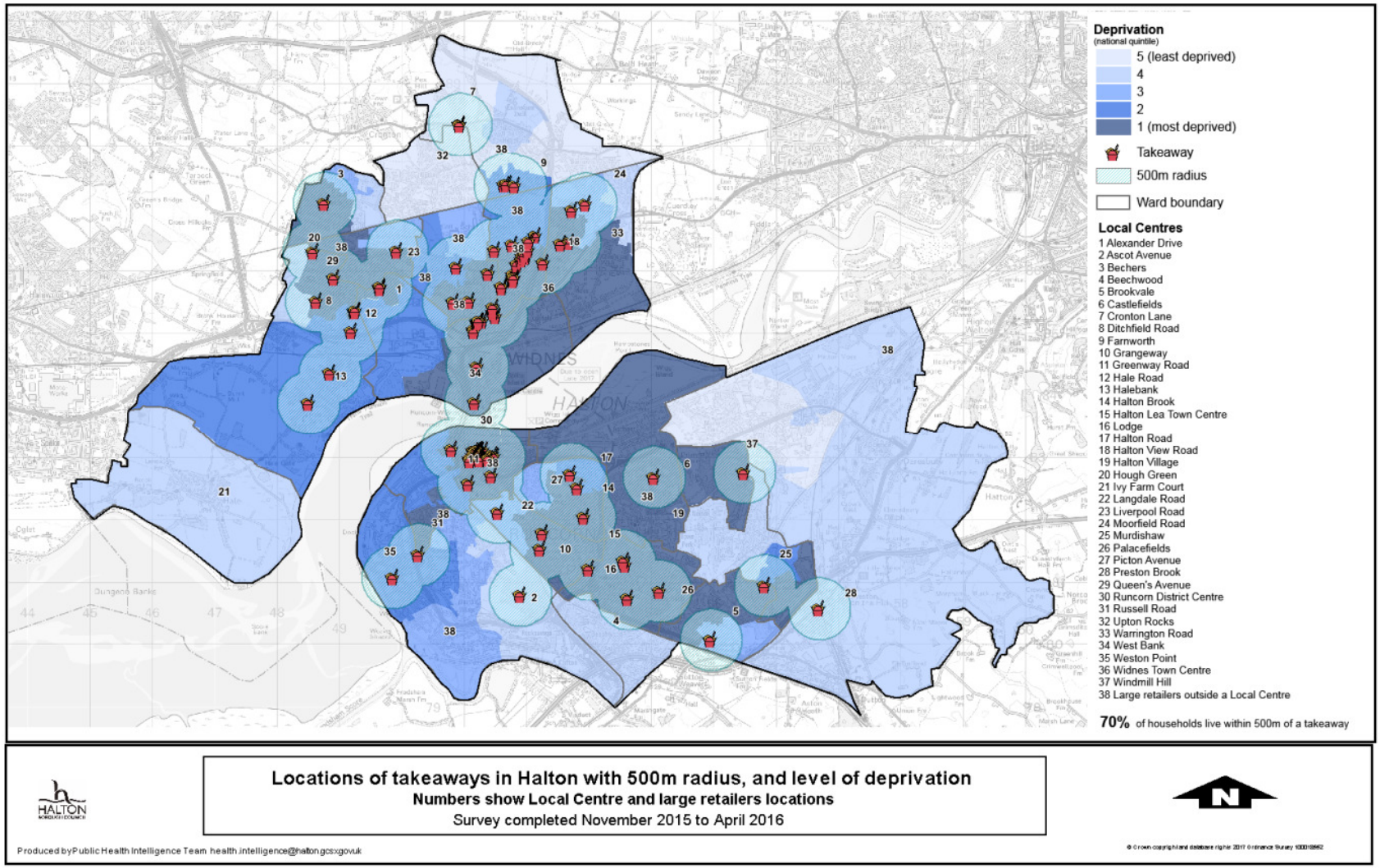
However an examination of the overall data from the surveys suggests that the location of takeaways may not have the influence on consumption as might be expected. Only 21% of respondents walked to the takeaway whilst 27% used their car – the most significant figure is that 47% of respondents did not actually visit the takeaway at all and placed their order by internet or phone.

Maps 9 and 10 below illustrate the analysis of takeaway locations.

Map 9 Takeaway locations in Halton



Map 10 Takeaway locations and deprivation



1.3.8 Price comparison between locations

As well as assessing availability of the shopping basket items, the survey also examined the price of individual items and the total cost of the basket at each location.

100% of the basket was available in both designated Town Centres (Widnes and Halton Lea) and Runcorn Old Town. 100% of the basket was also available at four local centre sites. These locations enable a price comparison between local and town centres.

A significant difference was observed between the cost of the shopping basket at Town Centres compared with local centre locations.

The average cost of the complete shopping basket at local centre stores was £69.68. Whereas the average cost at Town Centre Stores (Widnes and Halton Lea) was £54.00: a difference of £15.68. This represents a 29% difference between town and local centre locations.

The cost of the basket in Runcorn Old Town was £63.36. This was 9% cheaper than local centres but 11% more expensive than the designated town centre locations.

It is welcome that many local centres provide good food availability and are a strong asset to the community. However it is clear that residents who are unable to easily access a town centre will pay significantly more for their basket of shopping if they shop at their nearest store. This indicates that mobility and access to transport are key factors in an individual's ability to access affordable food.

This is further illustrated by the significant discrepancy between the cost of individual items at various locations. The survey methodology required the shopper to select the cheapest option available for each product at each location including multi buy offers where available. The table below shows the highest and lowest price observed during the survey for 10 of the key food items. In general the higher price was observed at a local centre location and will include premium branded products if they were the only option available. The lower price was generally available at a town centre supermarket and may include items that are own brand or part of a budget range. Therefore the individual products may not be directly comparable but provide an indication on the breadth of price and choice available.

Table 1 Price Comparison highest and lowest priced items

Product	Shopping basket quantity	Total cost of shopping basket quantity (lowest price observed during survey)	Total cost of shopping basket quantity (Highest price observed during survey)
Apples	400g (approx. 5 apples)	79p	£3.00
Bananas	1kg (approx. 7 bananas)	68p	£2.58
Potatoes	3kg	£1.38	£3.98
Milk	8 litres	£3.47	£7.28
Wholemeal Bread	3 x 800g	£1.32	£5.37
Rice	500g	40p	£3.10
Tinned Tomatoes	1 x 400g tin	31p	£1.00
Lean minced beef	1kg	£5.50	£11.19
Weetabix (or similar)	1 x 24pk	69p	£3.38
Cornflakes	250g	25p	£2.59
Total		£14.79	£43.47

The difference between the total price of the highest price items observed during the survey and the lowest price items available was £28.68. The highest price is almost three times more than the lowest price shopping basket.

It is acknowledged that some caution is needed with the figures. Whilst the products compared are similar, they are not identical although the pack / unit size was comparable. Also the individual items were sourced from a number of different premises in a range of locations and so the figures do not represent an actual shopping trip. It should also be noted that many local centre locations also stocked own brand, budget lines and multi-buy offers. However the analysis does provide further evidence of the significant range in prices between locations and illustrates how those individuals who are less mobile will have their choice limited with a significant impact on the affordability of some of the key food items that form part of a healthy balanced diet.

Chapter 2

Community Audit

2.1 Food Poverty and health

Various definitions of food poverty have been proposed but in essence food poverty can be considered to mean that an individual or household cannot afford or does not have access to sufficient nutritious food to make up a healthy diet.

Food poverty should not be viewed in absolute terms, but as a spectrum ranging from individuals and households in acute food need who would go hungry without immediate support, to households that have enough money to avoid hunger but can't afford or don't have access to the food that makes up a healthy balanced diet.

The components of a healthy balanced diet are well established. See Figure 3 below.

Figure 3 – The eatwell plate

In particular fruit and vegetables are important as a source of fibre and provide a range of vitamins, minerals and antioxidants that are essential to good health. It is fresh fruit and vegetables that are frequently absent from household diets due to the cost and limited access in some localities.

A diet that is high in fruit and vegetables can help prevent cancer, heart disease and diabetes. There has been much public health focus on rising levels of obesity. Obesity can be viewed as a disease associated with over consumption of foods that are high in fat and sugar along with inadequate exercise. Obesity can be a cause of cancer, heart disease and type 2 diabetes.

Individuals experiencing chronic food poverty are at a greater risk of malnutrition. This can lead to serious health conditions such low birth weight in infants, inadequate growth and development in children, poor mental function and a susceptibility to disease due to impaired immune function.

Because the definition of food poverty is so broad it is difficult to quantify how many people may be in food poverty. It is however possible to identify those who are most at risk. It is known that the poorest 10% of households spend 23% of their income on food compared to the wealthiest 10% who spend just 4%. It is also known that there have been considerable pressures on the cost of living with food prices rising by 20% over the last 5 years.
https://www.ifs.org.uk/uploads/publications/bns/BN213.pdf.

A study by the Institute of Fiscal Studies in 2013 demonstrated that households with young children reduced expenditure on food whilst at the same time the calorie density of food increased as households switched to foods with more calories per kilogram. https://www.ifs.org.uk/bns/bn143.pdf.

Further pressures on the cost of living have been created by significant changes to both in and out of work benefits and changes in terms and conditions of employment. With the intention of reducing the amount of public money spent on welfare the government has since 2010 introduced a number of changes that have seen a reduction in the amount of benefit received by low income households. Notable changes have been the introduction of universal credit, the spare room subsidy and the imposition of sanctions. Households that are in work have also seen a loss or reduction in working tax credits. To compensate for this loss of income for working households the government increased the minimum wage – a move supported by many – to ensure that the burden for paying a fair living wage was borne by employers. However this does not assist the income security of the increasing number of low paid workers who are employed on zero hours contracts and do not know with any certainty what their salary will be from one week to the next.

Food Banks help to alleviate the most extreme form of food poverty i.e. hunger and acute shortage of food - and there has been a significant increase in their use in recent years. However they are not intended to address longer terms food insecurity. Many commentators have observed that the very presence of food banks in a wealthy country such as the UK represents a failure of the welfare state. This concern is

reflected in the fact that a 2017 UNICEF report ranked the UK as 34th for food security out of 41 higher income countries.
https://www.unicef.bg/assets/NewsPics/2017/PDFs/Innocenty_Report_card_14.pdf

However it has long been recognised that there are many households that may not be hungry to a point where they need emergency food aid but are in a position where they either cannot afford, or do not have convenient access to, fresh fruit and vegetables. The geographical food mapping in chapter 1 confirmed that in some locations availability is inadequate and without access to transport, access will be limited. Where availability is good locally the cost is likely to be higher and this may make fruit and vegetables unaffordable for those on lower incomes and without access to transport.

This higher cost paid for goods and services by people on lower incomes due to the lack of choice available to them is often referred to as a "poverty premium". A number of initiatives in Halton have attempted to address access to fruit and vegetables and these will be examined later in this chapter.

2.2 Healthy Start Programme

The healthy start programme is a national scheme to provide vouchers to purchase fruit, vegetables, milk and infant formula. In addition vitamins are provided through a variety of outlets including children's centres, midwives and health visitors. The scheme is available to women who are at least 10 weeks pregnant and families with a child under 4 who are in receipt of certain benefits and a total monthly income under £408. Approximately 73% of eligible households in Halton have registered for healthy start vouchers and vitamins.

It is recommended that the council and partners implement measures to maximise take up of healthy start vouchers in the borough.

2.3 Food Banks

There are two food banks in Halton; one in Runcorn and one in Widnes. Each operates from a central hub with a network of distribution centres in the areas of most need. They are both operated by the Trussell Trust a charitable organisation who operate a network of 400 food banks across the UK.

Trussell Trust food banks provide emergency food aid to individuals in acute food need and who would go hungry without this help. When food banks first came to the public's attention some commentators suggested the rise in usage was due to supply of free food fuelling demand. However this is not the case. The food banks are not open to the general public. Recipients of emergency food aid must be referred by a partner organisation who issues a food voucher. This voucher can be exchanged at a food bank for a 3 day supply of food. Trussell trust food banks are run by volunteers and

food is donated by members of the public. Major food retailers and manufactures also contribute.

It is clear that those who use food banks are those in the most acute food need. The Runcorn and Widnes food banks provide an essential local service to support households at the extreme end of the food poverty spectrum. Therefore whilst an examination of food bank statistics provides a useful indicator of those in acute need it does not provide a full picture of those living in food poverty. If food bank usage represents the “tip of the iceberg” in terms of food poverty the increase in food bank usage suggests that food poverty has grown substantially in recent years.

Food bank statistics in Halton reveal the potential scale of the food poverty problem and indicate how the situation has worsened over recent years.

The charts and data tables below show the number of recipients of food aid from Runcorn and Widnes food bank and the overall figures for Halton.

2.3.1 Runcorn: Numbers of adults and children assisted with emergency food provision by year

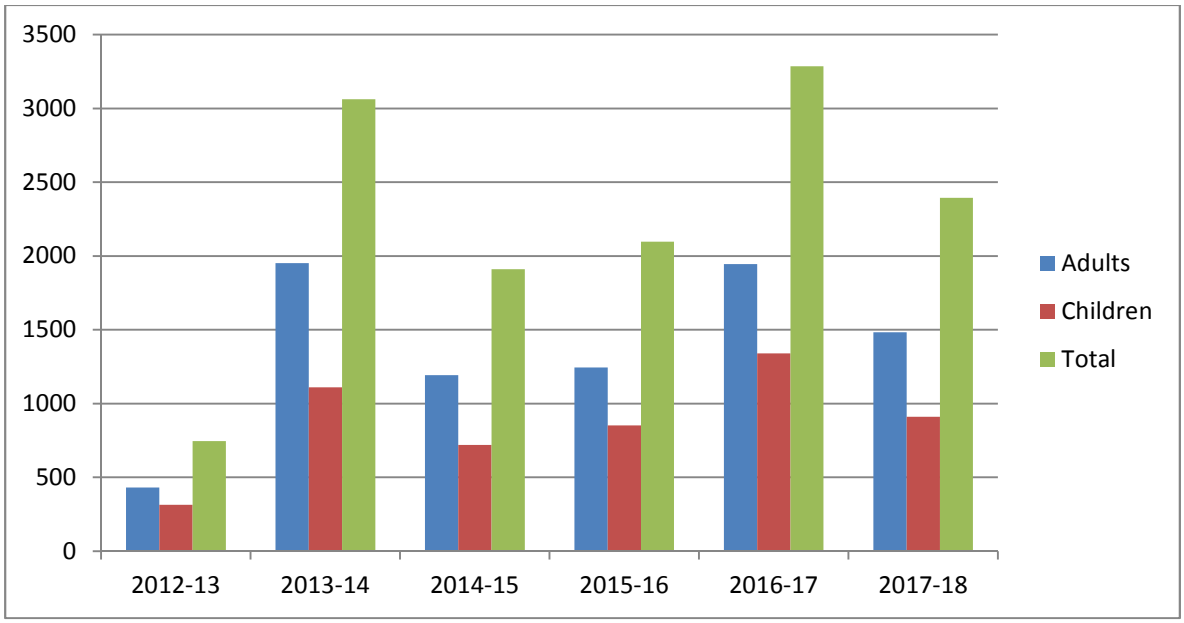


Table 2 Numbers of adults and children assisted with emergency food provision by year: Runcorn

Year	Adults	Children	Total
2012-13	431	314	745
2013-14	1951	1111	3062
2014-15	1192	719	1911
2015-16	1244	853	2097
2016-17	1945	1341	3286
2017-18	1484	911	2395

2.3.2 Widnes: Numbers of adults and children assisted with emergency food provision by years

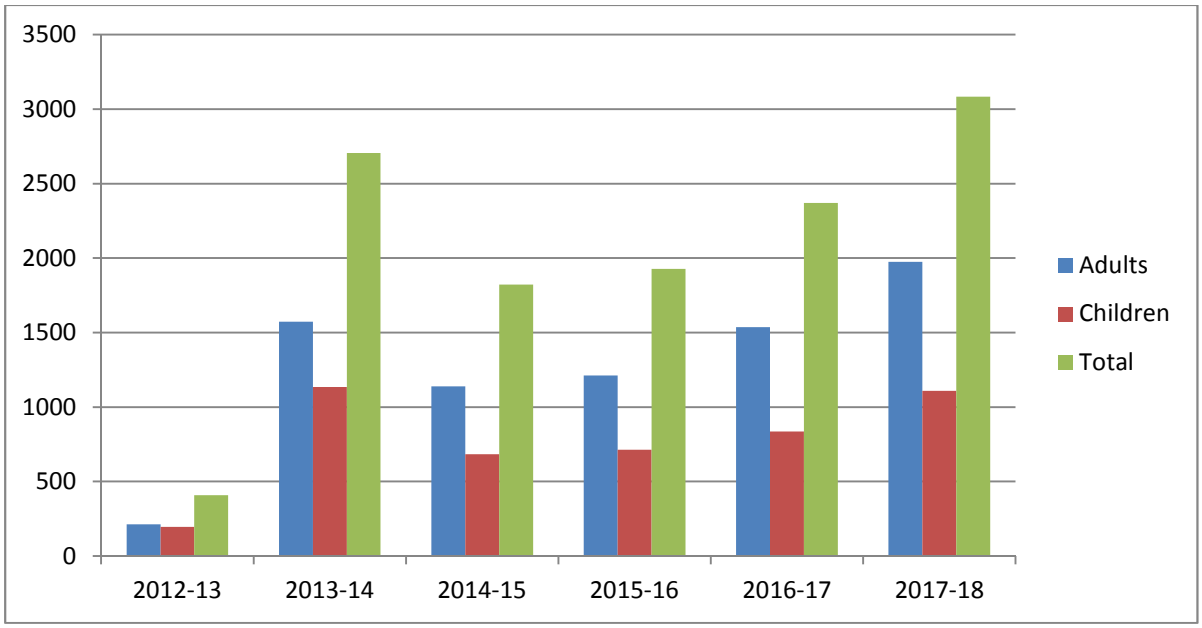


Table 3 Widnes: Numbers of adults and children assisted with emergency food provision by years

Year	Adults	Children	Total
2012-13	213	195	408
2013-14	1572	1135	2706
2014-15	1139	683	1822
2015-16	1212	713	1928
2016-17	1536	835	2371
2017-18	1975	1108	3083

2.3.3 Halton Total: Numbers of adults and children assisted with emergency food provision by years

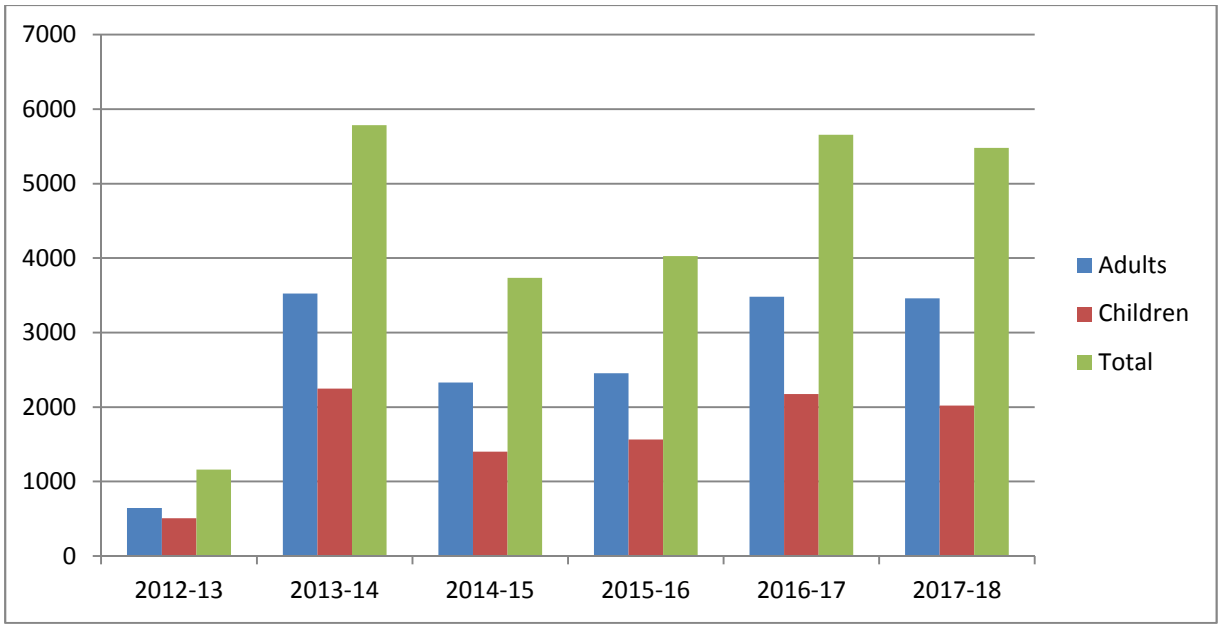


Table 4 Numbers of adults and children assisted with emergency food provision by years

Year	Adults	Children	Total
2012-13	644	509	1162
2013-14	3523	2246	5786
2014-15	2331	1402	3733
2015-16	2456	1566	4025
2016-17	3481	2176	5657
2017-18	3459	2019	5478

2.3.4 Analysis of food bank usage data

The tables above show a fluctuation over the years but in general there is an upward trend with sharp increases in 2013-14 and 2016-17. The increase in 2013-14 coincides with the introduction of the benefits sanctions regime in October 2012 and the introduction of the spare room subsidy - or bedroom tax as it was more commonly known - in April 2013. The Government's own data reported that nationally over the year from Nov 2012 to Nov 2013 580,000 benefit sanctions were issued. These sanctions had a significant acute impact on the income of recipients. The Governments own figures show that social housing tenants who remained in their home but were deemed to have a spare bedroom could expect to lose between 14% and 25% of their housing benefit payments.

The larger peak in 2016-17 coincides with the full roll out of universal credit in the Borough. In Runcorn the number of people assisted dropped slightly in 2017-18 but in Widnes the upward trend continued.

2.3.5 Analysis of Food Bank referral data

To access emergency food aid recipients must be issued with a voucher from one of the referral agencies. The Trussell Trust require the agency issuing a voucher to record the primary reason for the crisis resulting in the referral.

A summary of the "reasons for referral" data for Runcorn and Widnes is given in Table 5

Table 5 Halton: most common reasons for referral - % of all referrals

Reason	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Benefit delay	29	35	29	34	28	30
Benefit change	20	25	22	20	33	27
Low income	10	10	13	14	14	16
Debt	13	8	7	6	7	8

The data confirms that benefit changes or delay are by far the most common reasons for food bank referrals. Overall 57% of referrals in 2017-18 were benefit related. At the peak of referrals in 2016-17 - 61% were benefit related appearing to confirm the impact of the introduction of universal credit on the number of food bank referrals.

A number of organisations issue vouchers and make referrals to the food banks. These agencies include health service providers, Citizens Advice, community groups, job centres, housing associations, GP practices, welfare support organisations, churches, children's centres, social services, schools and colleges. In total over 100 agencies are registered with Trussell trust to issue vouchers and provides a comprehensive network of support across the borough. However in practice the majority of vouchers are issued by a smaller number of key referral agencies.

Tables 5 and 6 below shows the top 5 referral agencies in Runcorn and Widnes and the percentage of vouchers issued

Table 6: Runcorn: Top 5 voucher referral agencies 2017-18

Agency	**No of vouchers issued**	**% of total vouchers issued**
Job Centre Plus	225	16
CAB Halton	197	14
YMCA Halton	178	12
Children in need Runcorn	60	4
Halton People into Jobs	59	4

Table 7: Widnes: Top 5 voucher referral agencies 2017-18

Agency	**No of vouchers issued**	**% of total vouchers issued**
CAB Halton	574	16
Job Centre Plus	510	15
Children in Need Widnes	243	7
Change Grow Live	176	5
Brennan Lodge	104	3

The fact job centre plus are one of the most significant referral agencies in both Runcorn and Widnes appears to confirm that benefit related issues are a significant factor in the increase in food bank usage observed in Halton.

2.4 11 O'clock Club – Halton Brook

Four Estates is a local charity based in Runcorn providing support and services to local people via independent community centres located in Halton Brook and Palacefields. Running a community cafe from one of the centres, they found there was a small surplus of food and so they began The 11 O'clock Club as a means of redistributing this food to residents across Halton. As well as participating in the Fare Share programme the scheme has received food donations from Nando's, Tesco, Greggs, Aldi, local businesses and residents. Unlike the food banks there is no voucher referral scheme but the organisers do try to ensure that supply is based on need to ensure the system is not abused. Because there is no voucher required for referral the organisers have found that a considerable number of people have been referred by the Trussel Trust food banks because they have reached the maximum voucher entitlement (3 in 6 months) for the food banks. In total the organisers estimate they have provided 1585 food parcels to 181 families across Halton. The organisers have currently stated that they are at capacity because they do not have sufficient food supplies to provide for all the people in emergency need of food.

Four Estates also provide free toast in the morning from the community centre for children on their way to school and during the school summer holiday they provided 766 free packed lunches to children to compensate for the loss of the free school meals during the holiday period.

It is clear from the work of Four Estates that some families require longer term support beyond the acute shortage of food addressed by the established food banks.

There was a perception amongst the workers and volunteers interviewed for this report that benefit changes, in particular the sanctioning regime, had caused a significant increase in the number of families in food poverty.

Although the Four Estates scheme is open to residents across Halton it is inevitable access may be restricted for those who live outside the Runcorn area. Therefore it is recommended that the council, CCG and health partners examine opportunities to increase access to redistribution schemes across Halton.

2.5 Previous Community Schemes to improve food access

2.5.1 Halton Food Co-Operative

This initiate ran for over 10 years but closed in around 2005. It was initially run by volunteers who purchased fruit and vegetables from market based on pre-orders from members of the scheme. The food was distributed via community centres. It was reported to be popular and demand grew over time. However the project ultimately closed. Prior to closure the project had benefited from SRB funding and had expanded and a manger had been appointed.

2.5.2 New Shoots

Following the Food Co-Op the “New Shoots” scheme started in 2010 with the first club in Kingsway Ward. The scheme was similar to the food co-op with members of the scheme being able to purchase seasonal fruit and vegetables. A small bag cost £2 and a large bag cost £4. The scheme grew to 7 new shoots clubs across the borough based in community and children’s centres. The new shoots club formed into a Community Interest Company (CIC) but closed in 2014. Additional funding was found from Halton BC and other organisations to continue the scheme but it closed permanently around 12 months later.

There are some anecdotal reports that that the scheme was not as popular as the food co-op as there was less choice. The fruit and veg bags were seasonal and members did not always know in advance what they were going to get and this made overall meal planning difficult. There was also some reports that on occasion the quality of produce was poor.

2.5.3 Lessons learned

This has not been a detailed study of the successes and failures of previous schemes and so no criticism of the schemes or those involved is intended. Both schemes were popular and appeared to thrive as small scale, local initiatives with some external funding and the support of volunteers. However it would appear the schemes failed - despite the benefit of further external funding - once they were scaled up and the overheads of staff, management and transport were factored into costs.

What seems clear is that both schemes were not sustainable as a standalone purchasing co-operative without the subsidy of external funds. Such a co-operative in Halton is unlikely to generate sufficient membership to enable fruit and vegetables to be purchased on a wholesale scale that can compete with the retail price in major supermarkets particularly with the emergence of discount chains such as Aldi and Lidl to challenge the existing “big 4” supermarkets on quality and price.

2.6 Commentary - Market Forces and local retail provision

The demise of the food co-op and new shoots suggest market forces have a strong role to play in the success or failure of any co-operative purchasing scheme.

It is also important to comment that price is only one component of value and that consumers also demand quality and choice and that for a scheme to be successful it must address all these factors.

The constraints on public funding mean it is unlikely a food co-operative could be subsidised in future. A self-sustaining alternative is required. As will be discussed in the conclusions to this report one option might be to be to facilitate permanent improvements to the local environment by improving retail provision in areas of lower food availability.

Price and availability of items including fruit and vegetables within a market are a function of supply and demand. During the course of the research for this study it was often stated that fruit and vegetables are not sold in certain areas because people do not buy them. However the analysis in chapter 1 indicates that in some areas retail provision of fruit and vegetables is very good inferring there must be good demand in that area for those goods. There is no correlation in the availability of food and areas of deprivation. Some areas of high deprivation have good availability of fruit and vegetables. So it cannot be inferred that because the area is more deprived the demand is low. One factor that may influence demand where provision is poor is price and the wholesale purchasing power of the retailer in that locality. Larger retailers are likely to be able to purchase at an economy of scale that ensures the retail price is affordable to people within that locality. Whereas a smaller retailer with less purchasing power will have higher wholesale costs that must be passed on to the

consumer in the retail price. It follows that the produce will be less affordable and demand at that price will therefore be low. That does not mean demand is not there – it would return if the quality was acceptable and the price was more affordable.

2.7 Community Shop

One option that is being investigated in Halton is a partnership with Community Shop CIC. Community shop purchase bulk surplus stock from major manufacturers and retailers which enable them to sell the products at a discount to members. Membership is limited to people who live locally and receive universal credit. Negotiations with Community shop are taking place with a view to locating a branch of community shop in Halton.

2.8 Community Assets

In addition the food bank network there are a number of key assets across Halton that currently support families and households and can be used as a focus for future for initiatives.

2.8.1 Community Centres

There are 5 community centres across Halton at; Castlefields, Murdishaw, Grangeway, Ditton and Upton. With the exception of Ditton all the centres operate a community café. The cafés are popular with community groups and local residents and whilst healthy options are available they cater for the demand of their customers and so some of the popular meals may not be considered healthy options. The café's provide an important community resource and provide a venue for people to meet and socialise but they must be self-sustaining and to be successful they do have to meet their customer's needs.

The centres provide a venue for a number of community groups and clubs with a comprehensive programme of activities throughout the week including weight watchers, sports and dance classes. Kitchens and rooms are available to support healthy food and cooking initiatives in the future. Castlefields community centre has also hosted a market.

The community centres provided valuable assistance with the distribution of the survey that is discussed is chapter 3 of this report.

2.8.2 Children's Centres

There are 8 Children's centres across Halton.

Widnes:

Ditton, Upton, Warrington Road and Kingsway

Runcorn:

Windmill Hill, Brookvale, Halton Lodge and Halton Brook.

The centres operate a number of initiatives to help promote healthy eating and support access to a healthy balanced diet.

A number of the centres operate community cafés with healthy options. The centres distribute healthy start vitamins and promote and support breastfeeding.

The children's centres deliver their own family cook sessions "fun with food" which includes healthy lifestyle advice and cooking on a budget. In addition Halton's Health Improvement Team deliver "fit for life" and "family cook and taste" programmes at the centres.

The children's centres provided a distribution outlet for the new shoots scheme and are referral agents for the food banks.

The centres provided a venue and significant support for the focus group sessions that will be discussed in section 3 of this report.

2.8.3 Community lunch clubs

In addition to the children's and community centres there are numerous lunch clubs in social clubs, community centres and church halls that provide nutritional meals and opportunities to socialise for older people.

Chapter 3

3.0 Introduction

The final stage of the project was a more in depth study of residents' experiences and opinions around accessing healthy food.

This part of the study had two phases.

3.1 Focus Groups

The first phase was a series of focus groups with residents who shared similar demographic characteristics. The 3 groups chosen for this study were:

- Families with young children
- Housing Association tenants
- Older People

The focus group phase was carried out with significant assistance from a post graduate student from Chester University who used the families with young children focus group as the basis for a dissertation to satisfy the requirements of an MSc in Public Health Nutrition. The dissertation focussed on the barriers to accessing healthy and affordable food for parents with children under the age of 5 in two areas of Runcorn and Widnes. The post graduate student recruited participants, devised the format and conducted the focus group sessions. Although the university were only actively involved in the family's focus group the format was used as the basis for the other focus group sessions.

The focus groups were semi structured in that five broad open ended questions were posed to explore the five key factors that influence how individuals and families obtain their food;

- Availability
- Access
- Affordability
- Awareness
- Appropriateness

Further supplementary questions were posed in response to comments made by participants to help fully understand an issue or comment raised. Care was taken not to ask leading questions and the facilitators ensured no comments or opinions of their own were put forward. This ensured that the content of the discussion was a genuine, authentic representation of the participant's views and experiences.

Participants for the family's focus group were recruited through Windmill Hill and Upton Children's centres. In total 4 focus groups were held (2 Runcorn and 2 Widnes) with 13 participants in total. Participants for the housing association study were recruited with the assistance of Liverpool Housing Trust, Riverside Housing Trust and Halton Housing Trust. In total 6 participants agreed to take part but on the day of the focus group session only one participant attended. Although the facilitators proceeded with the focus group session the content could not be considered representative of this group. However the personal circumstances of the individual attending was consistent with the participants in the Children's centre's group and so the results will be considered alongside the findings from the families with young children group.

With regard to the older peoples group an existing older people's community group on Windmill Hill was used for the group session. 10 members of that group took part in that study.

3.2 Results

3.2.2 Families with young children

The results of the focus groups were grouped into 4 key themes that represented the perceived barriers that inhibited access to healthy food. Whilst some of the issues raised may reflect the locality of the participants they can be considered representative of areas with similar characteristics and circumstances. To illustrate some of the points made some direct quotes from participants will be included.

Theme 1: High cost to access healthy food locally.

In both Runcorn and Widnes the cost of healthy food available locally was considered a key barrier to purchasing it. The retailers available within the immediate locality of the participants was considered a key barrier to purchasing healthy food. The retailer available locally was considered as one of the more expensive shops when compared with other retailers.

> *"it's like local [brand of shop] everywhere and most people can't afford to use them"*
>
> *"even if you just go to the local [brand of shop] it's dear to go in there and get anything"*

The cost of home delivered food from the main supermarkets was discussed as a means to overcome the cost of food locally however this was perceived to be expensive which presented a barrier to buying food this way.

> *"I started using [brand of shop] and [brand of shop] delivery but it is so expensive …you have to reach a certain amount and I was buying crap"*
>
> *"[brand of shop] do deliver online but they charge extra for the delivery"*

It became apparent that the short shelf life of fresh produce and fruit and vegetables going off quickly was a key barrier to purchasing healthy food and this became a sub theme of the cost to accessing healthy food locally. Households did not want to waste money purchasing food that would not keep.

> *"You can spend like £10 on just getting chicken breast and some veg and fruit in the house or you can go to [fast food brand] for a couple of quid can't you – so you obviously end up having stuff left over but then it's like are you going to have time to reuse the stuff you've got left over"*

It was clear that affordability and shelf life were less of an issue if households were not reliant solely on local retailers and had access to a range of supermarkets – in particular the newer discount supermarkets such as Aldi and Lidl were popular with participants.

> *"There's only [brand of supermarket] that's really cheap for fruit and veg you can get like a punnet of strawberries for a pound…..but you go elsewhere and you can pay 2 pound 2 pound fifty for small box of strawberries"*

Theme 2 Transport and mobility

One of the key circumstances that influenced access to healthy food was lack of own transport and difficulties with using public transport.

> *"It's getting to the supermarket. I will admit sometimes I have just brought microwave meals for convenience…even fed my daughter them…and I don't think I should have to do that…I prefer fruit and veg but it's getting out to get it"*

> *"They've got a lot of shops in the shopping city anywhere will do anything you need – but it's getting up there".*

Whilst bus routes were described as frequent with convenient stops there were issues with using the bus particularly for families with young children.

> *"It's baby space its [the bus] only got one baby space"*

"I have to go into town.. I shop.. but it's like getting the bus with a three year old and the pram…and all the bags getting them back home and its quite inconvenient"

"You don't want to get on it (the bus) around 5pm because you'll never get on it….I remember when I didn't have my car I had to wait until the 4th bus. I was just standing there for an hour because I had the baby in a pram and you're only allowed two prams on (the bus)".

In addition the difficulties of using public transport with young children and the cost of public transport was also highlighted.

I don't pay for the baby but for me to take [name of 2nd child] on the bus – its 6 pounds for us to go to shopping city.

Theme 3 High prevalence of unhealthy food v cost of healthy food.

Both Runcorn and Widnes focus groups highlighted the high prevalence of takeaway food in the area and the relatively cheaper cost of takeaway and convenience foods when compared to healthy food.

"I'd rather eat a healthy meal but when you are so busy it's more convenient to order fast food"

"It's far too easy to order a takeaway"

"I got Pizza [from supermarket] for 25p – so I went back and got another 4!".

Theme 4 Inadequate support and guidance with healthy diet.

All participants were able to demonstrate an understanding on the components of a healthy diet without prompts from the facilitators. However there was some confusion expressed about the consistency of healthy eating messages.

"They're on about five a day and all of a sudden it was supposed to be seven a day"

"I think there a lot of things that people think are healthy and good for you that aren't…even things that are low in fat – they're full of sugar".

"You just don't know what you should be having and what you shouldn't".

The groups talked about the availability of weight loss groups but these were perceived as expensive and inconvenient for people with young children.

Some participants felt more could be done to support families which was a surprising outcome given the support already available in children's centres.

> *"no one put their hand out to say you know "if you need any help or support with this – this is where you'd come"*
>
> *"Even if they do a couple of cooking sessions it's not promoted"*

Some participants suggested improvements that might help them.

> "*…like ideas on recipe cards you could pick from places – so if you've got ideas and recipes you haven't got to think about it….even here [children's centre] or doctors or wherever it is – just more promotion about it"*

> *"It would be nice if you could go somewhere and do like a bit of a course or something…I heard someone talk about cooking on a budget …I'd be interested in that".*

The participant from the housing association focus group largely picked up on the same themes. However the locality of the participant was different in that she had a greater choice of food shops in her locality and so she could purchase an adequate amount of food locally. However she also highlighted the increased cost of fruit and veg in her local shops compared with the larger supermarkets which were much cheaper. However this would require a bus journey with two children and the participant again highlighted the cost of the bus fare and the difficulty of taking two children on the bus. So although she had good access to food – her access to fruit and vegetables was limited by the increased cost locally and the difficulty of getting to more affordable shops on public transport.

The participant also highlighted the same perception from the children's centres focus groups that less healthy convenience foods are often considered cheaper and better value than healthy food.

> *"A lot of people have said to me it's cheaper to eat crap than it is to eat healthy – I do try and eat healthy but I notice the difference – I think it's cheaper to get frozen it works out cheaper than making it from scratch"*

3.2.3 Older People's focus group

The older people's focus groups took an established community group on Windmill Hill as participants. Whilst the views will naturally reflect their local circumstances these opinions and experiences are likely to be representative of residents in similar circumstances.

Interestingly the themes that came out of the older people's focus group were very similar to those that came out of the families with young children focus group. However

in addition to the barriers that inhibited access to healthy food, older people reported a key factor that facilitated their ability to shop, cook and eat healthy.

Theme 1 Cost locally compared with supermarkets

The participants reported a good availability of healthy food in their local shop but that it was more expensive than the supermarkets.

"..the [local supermarket] provide reasonably healthy food – but it's dearer

"It's very expensive in [local supermarket]"

"I wouldn't say it very expensive – it is more expensive"

Participants reported that the discount supermarkets Aldi and Lidl were a good source of cheap healthy food.

However this led onto the 2nd theme.

Theme 2 Transport and Mobility

Those that had their own transport or family with transport were able to drive to shopping city or elsewhere.

"Well the likes of Aldi's and Lidl's – they do a lot of cheap veg and fruits but a lot of people can't get to them"

"You either shop in the [local supermarket] or you get a taxi"

Other participants without their own transport reported getting the bus to shopping city where availability was good. However some stores were still a considerable walk from the bus station. Also participants who got the bus reported difficulties carrying large amounts of shopping.

"When you are up there you can get everything you need – healthy food you can get it – but it's carrying it back".

For some participants who used the bus walking to and from the bus stop was also a difficulty.

Internet shopping was discussed as an alternative to overcome the barriers identified in themes 1 and 2. Whilst some had experience through family members who ordered for them few of the participants ordered online for themselves. Many participants reported not owning or knowing how to use a computer.

"*The other route is going on the internet and ordering it for delivery – but most people haven't got computers"*

"*I wouldn't know how to turn one on!"*

Participants reported a strong preference for being able to select their own produce and did not trust what the internet order pickers selected.

"I always think you don't get the freshest (with internet delivery) – you get what's convenient - what they pick up quickly you know – whereas if you go in yourself you would look at the dates and look at the produce and make sure it was fresh"

As an alternative to the bus some participants reported using a taxi to do their shopping. Whilst this has the advantage of being door to door and easier to carry and transport their shopping it was far more expensive than the bus.

"The taxi is nearly £10 from shopping city each way. If we go to shopping city with a taxi it costs us £20 pound on top".

The food box scheme (discussed in chapter 2) that has previously operated out of the local children's centre was discussed as being one option to improve access to fruit and vegetables. It was clear the scheme had been popular and well used initially however the quality and choice of produce declined and people stopped using it.

"Some weeks – it was excellent (the quality of produce) and other weeks it was starting to go"

"we did use it – but once again the quality started to drop off especially the fresh fruit".

Theme 3 Food knowledge and budgeting skills

The third theme that developed with the older people's group was considered a factor that facilitated their ability to shop and eat healthy. It was clear that the respondents had no problems with the affordability of healthy foods and being able to cook and prepare healthy food at home as long as they could get to the shops. They considered it a generational issue and that they had been provided with the necessary skills earlier in life – skills that they perceived a younger generation lacked.

"I think personally we older people eat easier than younger people – like we buy a pound of mince – does us two good meals – whereas young people would go and buy a ready meal thing – we do our own cooking".

"In our days there was home economics – all the girls learned how to bake and how to cook and the boys did woodwork"

> *"They were taught how to prepare food – I mean I was a war baby – you were on rationing – so you had to eat healthy – I mean vegetables – kids don't eat vegetables now because parents don't put them on their plate – they don't bring then up eating vegetables because they can't cook themselves – that's the whole problem".*

Clearly these views reflect the generation of the participants – however the point about home economics classes was not that they should be offered based on gender but that young people would benefit from cooking and budgeting skills on the curriculum and the older people perceived that they had benefited from those classes when they were younger.

Theme 4 Time

The other area that older people perceived to be an advantage to them was time. They currently had more time to cook and prepare food at home but also as younger people bringing up their own families they had more time.

> *"To give them (young people) their due – some of them are working full time – that's why they are buying stuff that is easy"*
>
> *"There is another social aspect – the majority of women go out to work now – which in our day we didn't – that was our job"*
>
> *"..but now everyone is working".*

Again these views reflect their generation. Clearly the participants were not advocating that women should stay at home and prepare food – but they were making the broader point that society had changed and the modern economy and cost of living demand that all adults in a household need to work – which will obviously impact on the time available to the household to shop for and prepare food.

3.3 Residents Survey

3.3.1 Method

The 2nd stage of the consulting the community phase included a comprehensive survey of the public to examine their experiences and opinions around accessing healthy and affordable food.

The survey questions have been adapted from interview questions used as part of the more comprehensive Low Income Diet and Nutrition Survey (Food Standards Agency 2007)

The Halton survey was undertaken online and as a paper version to ensure that individuals and groups without convenient access to a computer were also able to take part. The survey was distributed online with a link circulated via the councils established social media platforms, community groups and partner organisations.

The paper version of the form was distributed by Halton Open an older people's support group and through Halton's community centres.

The results of both paper and online versions were collected and analysed and the results of some of the key questions will be examined below. The results of the survey were further categorised into two significant groups. Older people and universal credit recipients. These groups were chosen for additional analysis as they figured significantly in the survey and were two groups likely to have the most difficulty accessing healthy food. A third significant group "younger people" was also examined in further detail where the results indicated a significant difference with other groups.

Overall 479 responses were received – of these 137 were from older people (over 65) and 189 from recipients on universal credit.

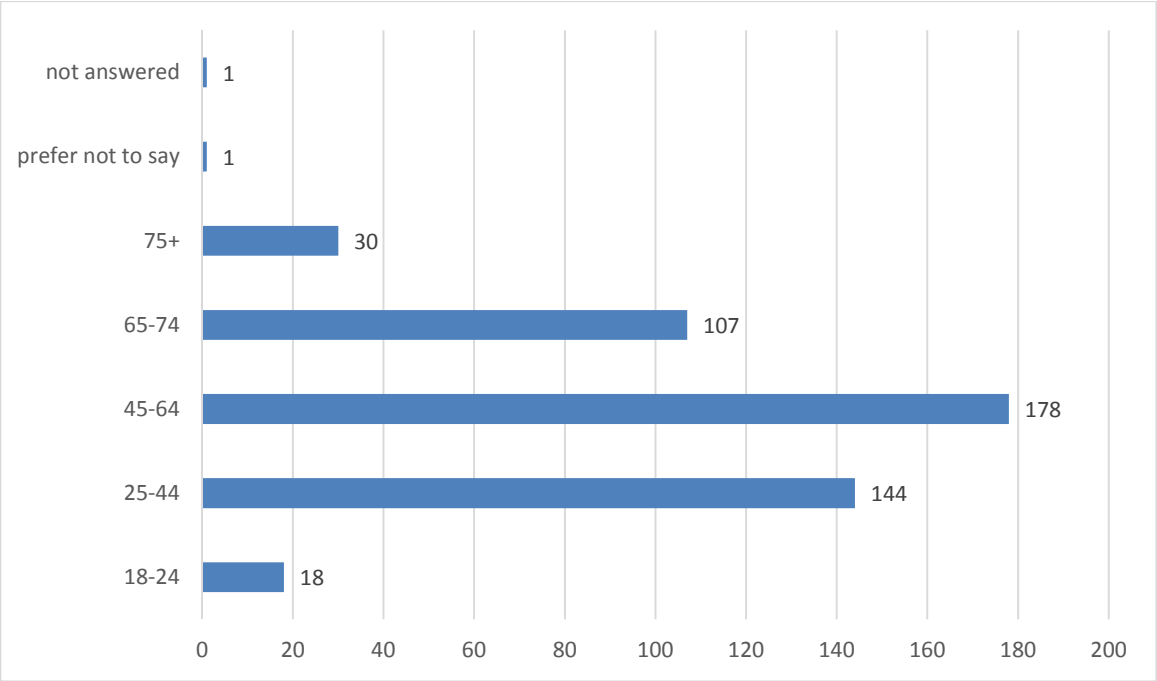
Whilst the number of survey responses is not sufficient to be statistically significant it is considered a very good response rate for a survey of this type. However some groups were under represented and they will be discussed with the results below.

3.3.2 Age

The majority of respondents 89% are aged between 25 and 74.

Only 4% of respondents were young people aged under 24. Therefore young people were unfortunately under-represented in the survey and the results may therefore not be representative of this group. The survey results for young people have only been considered in detail where they differ significantly from other groups.

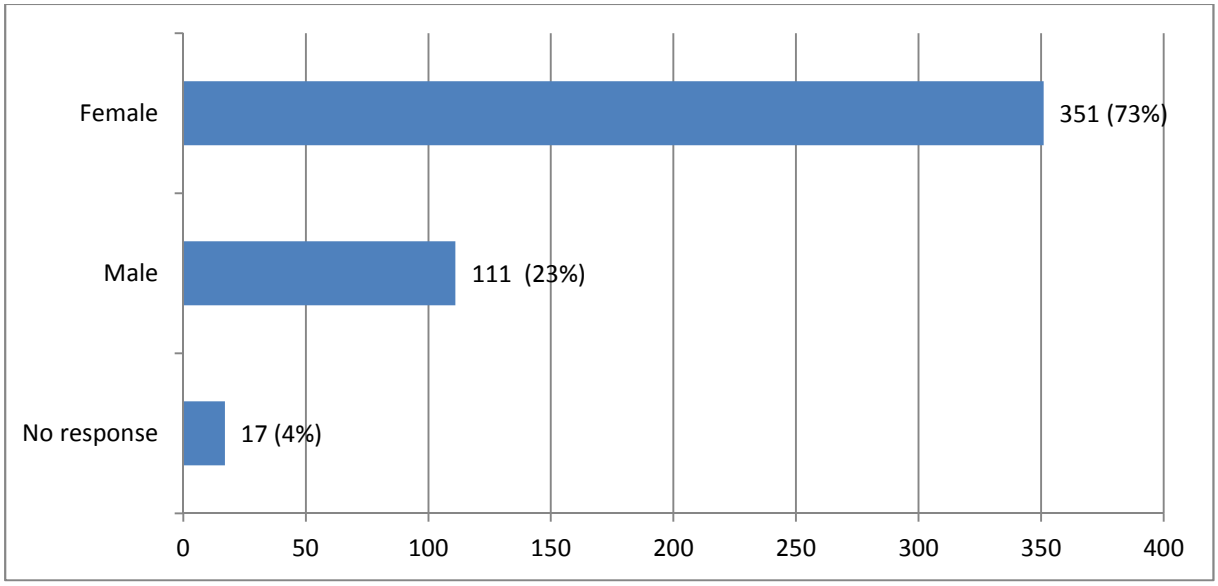
Chart 1 Survey Respondents by age



3.3.3 Gender

73% of respondents were female. Therefore male respondents were heavily under-represented in this survey. This is consistent with similar surveys conducted elsewhere. Whilst males were under-represented – respondents had been asked to answer the question on behalf of their households and therefore the results of the survey should be representative of household circumstances irrespective of the respondent's gender.

Chart 2 Survey Respondents by gender

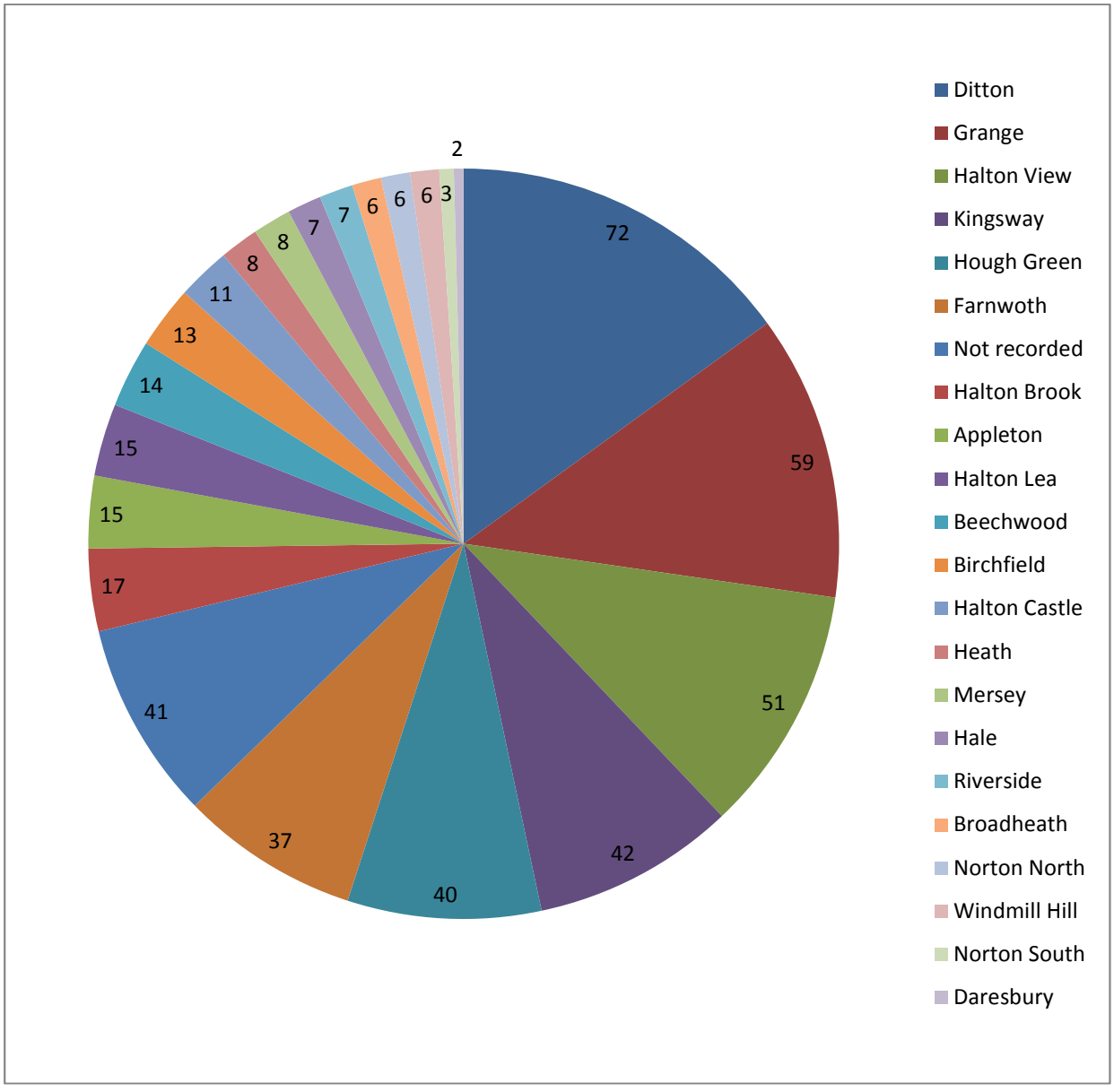


3.3.4 Location

62% of respondents were from Widnes with 29% of respondents from Runcorn. 9% of respondents did not respond or did not know which ward they lived in.

Ditton in Widnes (15%) and Grange in Runcorn (12%) had the largest number of responses.

Chart 3 Survey Respondents by location



3.3.5 Household make up

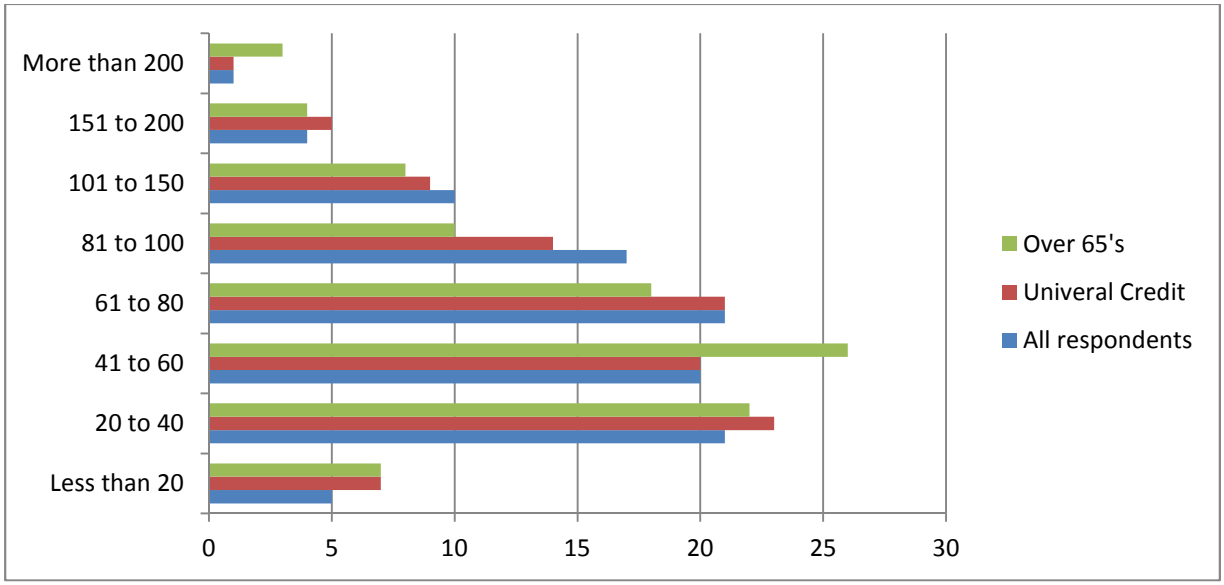
43% of responses were from households with children and 40% were in receipt of universal credit.

3.3.6 Spend per household

The analysis of spend per household indicated a wide range of spending per week per household – however when the results are analysed spending between groups is consistent.

67% of households spend less than £80 per week. Of those that are on universal credit 71% spend less than £80 per week. Older people – as may be expected with smaller household size spend less with 73% spending less than £80. This suggests that whilst spend per household on food is similar across all groups those on universal credit will be spending a greater proportion of their income on food.

Chart 4 Spend per household - £ per week by % of respondents

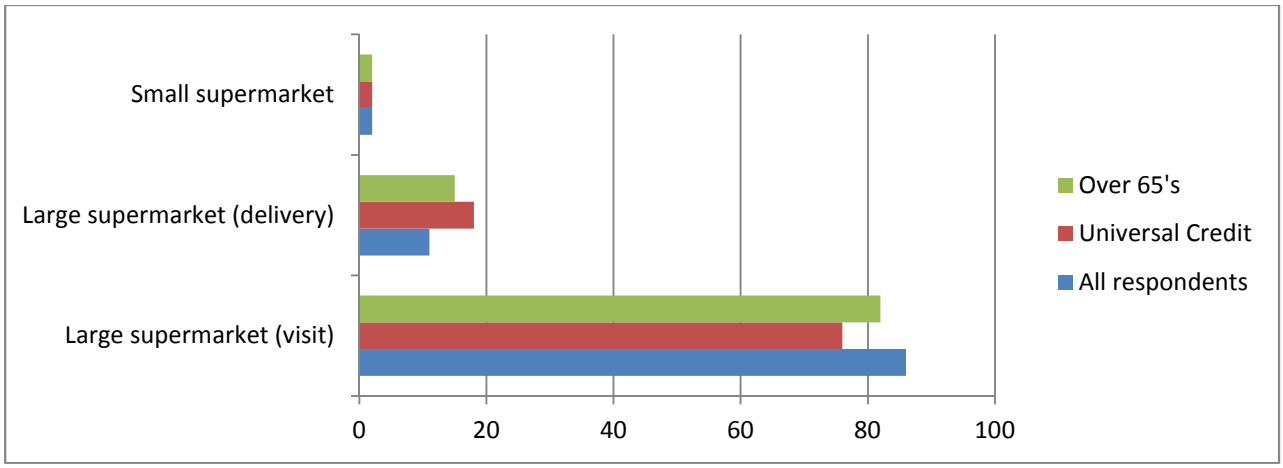


3.3.7 Main shop

97% of respondents used one of the large supermarkets for their main shop with 11% choosing home delivery and 86% visiting in person.

There was no significant difference in main shop preferences between groups – however more universal credit recipients (18%) and older people (15%) used internet delivery – this may indicate some households are using internet delivery as a means of overcoming transport or mobility issues.

Chart 5 Main Shop Type by % of respondents

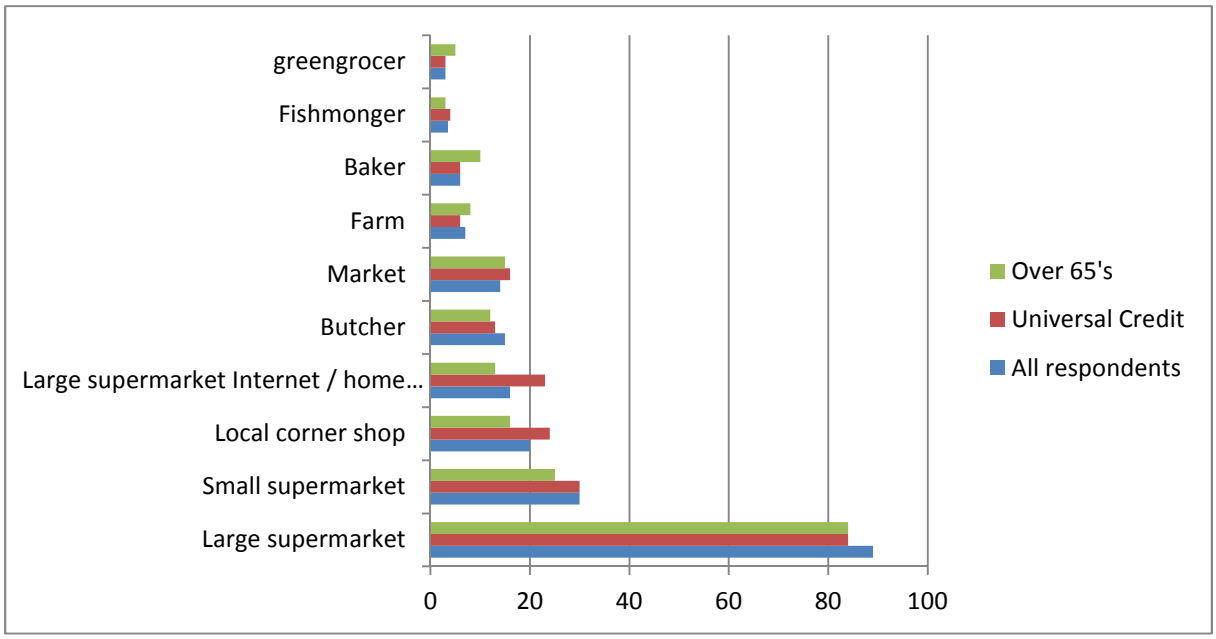


3.3.8 Other shops

The main shop question above asked respondents to record where they did their main weekly shop. However the survey also asked which other shops people used throughout the week. The survey indicated a considerable range of other shops visited for food.

30% of respondents used smaller supermarkets and 20% used local corner shops. 15% of respondents reported using a butchers shop and 15% of respondents reported using the market.

Chart 6 Other types of shops used by % of respondents

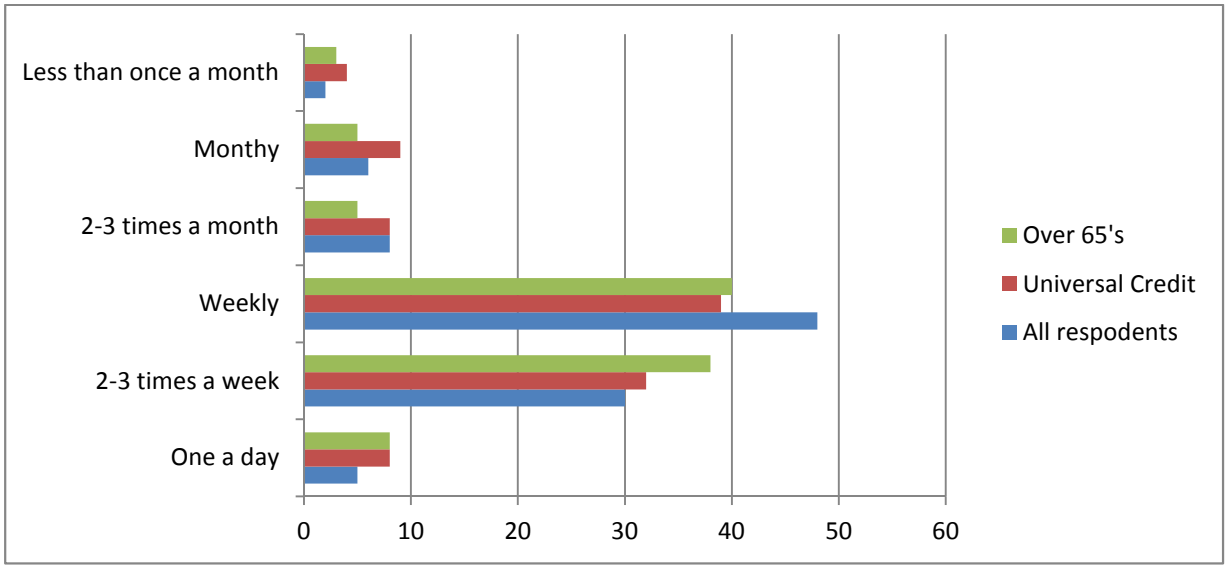


3.3.9 Shopping frequency

The majority of households (83%) shopped at least once a week – with 35% of respondents shopping more than once a week. This data when compared with the types of shops visited suggests that most people do a single main shop once a week at large supermarket and then "top up" as necessary at smaller stores closer to home or work.

There was no significant difference in shopping frequency between groups. Although 46% of over 65's shopped more than once a week – more than any other group – this may reflect this group have more spare time available to them. A higher proportion of universal credit recipients 9% - did their main shop once per month. This may suggest some households find it easier to budget by reducing transport costs and ensuring they have an adequate supply of food at the start of the month. However it also suggests greater reliance on frozen and longer shelf life products as perishable food will not stay fresh for that period of time.

Chart 7 Main shop frequency by % of respondents



3.3.10 Travel and Transport

Of all the survey questions, responses to this question demonstrated the most significant range of responses and differences between groups.

It is therefore worth examining the responses to this question in some detail as it indicates that transport is one of the key factors that influence local food access.

Overall 52% of people use their car – which is lower than might have been expected – but this may reflect that some areas of the borough have low car ownership.

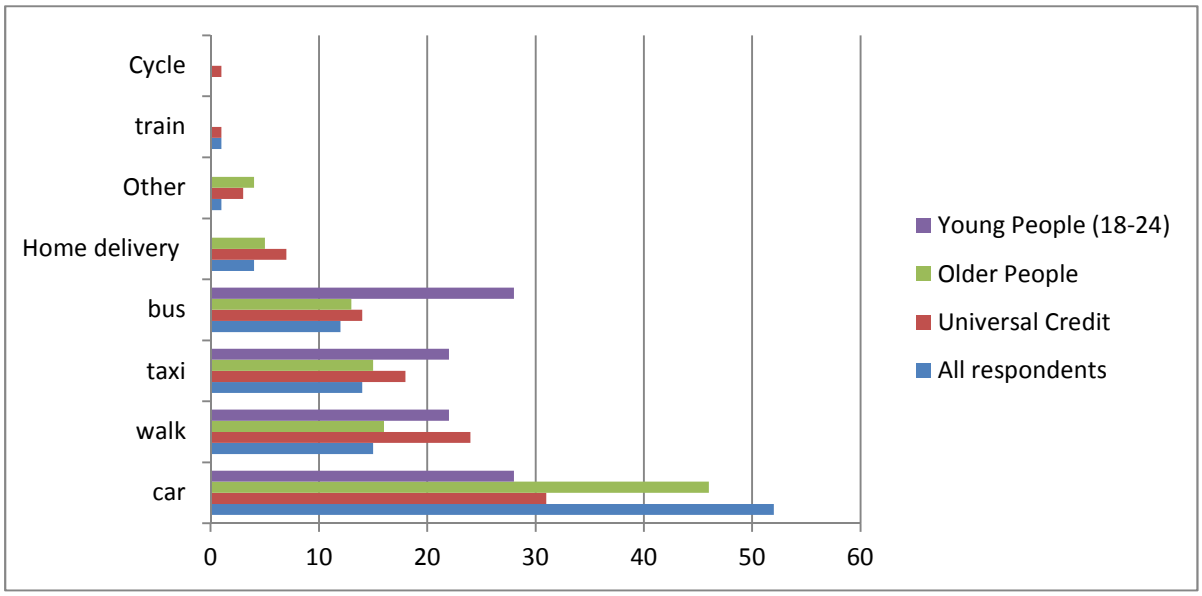
A much lower proportion of households on universal credit – 31% used a car – and a higher proportion – 24% walked to their main shop whilst 18% took a taxi. The percentage of people taking taxis to their main shop is higher than expected across all groups.

Overall 69% of universal credit recipients used a means other than their own car to reach their main shop. This indicates low car ownership but also highlights how the cost of taxis or public transport limits the disposable income available to spend on food.

The responses for young people all demonstrated a significant difference compared to other age groups. It is important to emphasise that young people were under represented in the survey and so the results may not be representative of that group. However the results appear to suggest there is low car ownership amongst young people and that they are more reliant on taxi's and public transport to get to the shops. This appears to confirm some of the issues discussed and highlighted in the focus groups with parents of young children.

The relatively high number of people who walk to the shops particularly amongst universal credit recipients is indicative of low car ownership – however a more positive interpretation is that shops are easily accessible. This appears to confirm the analysis of geographical mapping data discussed in chapter 1 that 77% of the population live within 500m of a shop with good food availability. The results also demonstrate the benefits of having supermarkets within our town centres where they are more accessible than out of town locations.

Chart 8 Mode of transport to main shop by % of respondents



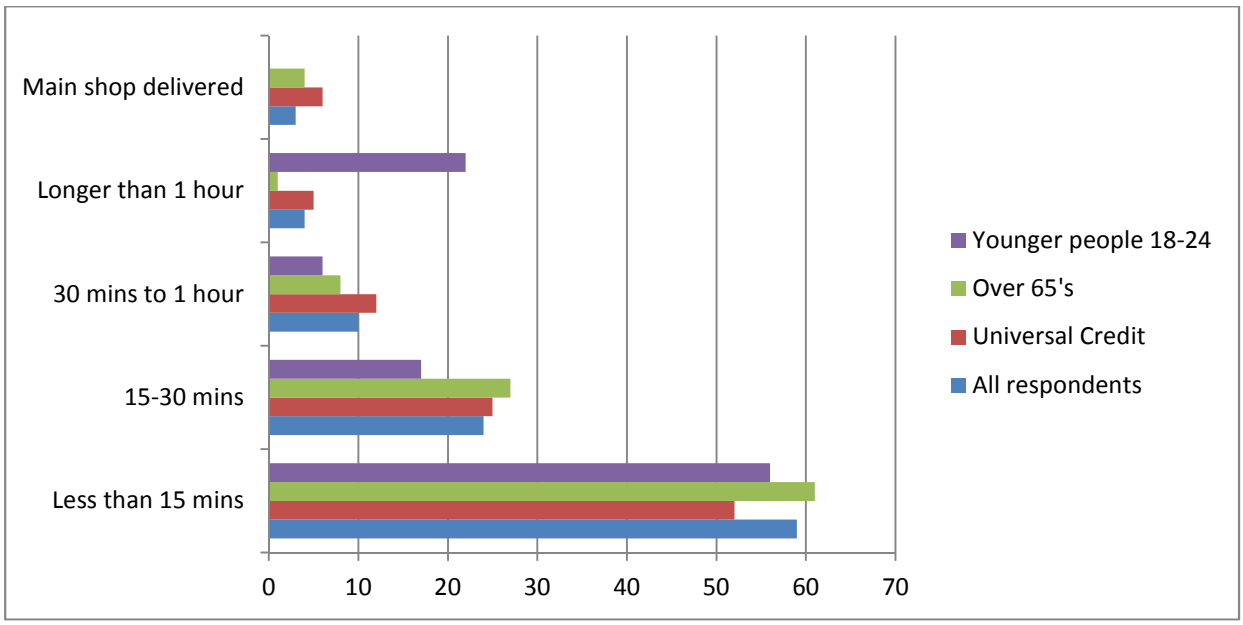
3.3.11 Proximity of shops – journey times

The good availability of shops in the area is further reflected in the journey times for people to reach their main shop.

The majority of people – 59% can reach their main shop in less than 15 minutes and overall 83% of respondents can reach their main shop within half an hour.

However a higher proportion of younger people (22%) took over an hour to reach the shops when compared with other groups. This is consistent with the higher usage of public transport identified in the previous question.

Chart 9 Journey time to main shop by % of respondents



3.3.12 Takeaway food consumption

Overall the majority (60%) of households use takeaways once a month or more. However only 15% of households use a takeaway once a week and only 4% of households use a takeaway greater than once a week.

These findings do not suggest habitual takeaway usage as an alternative to cooking and preparing food at home.

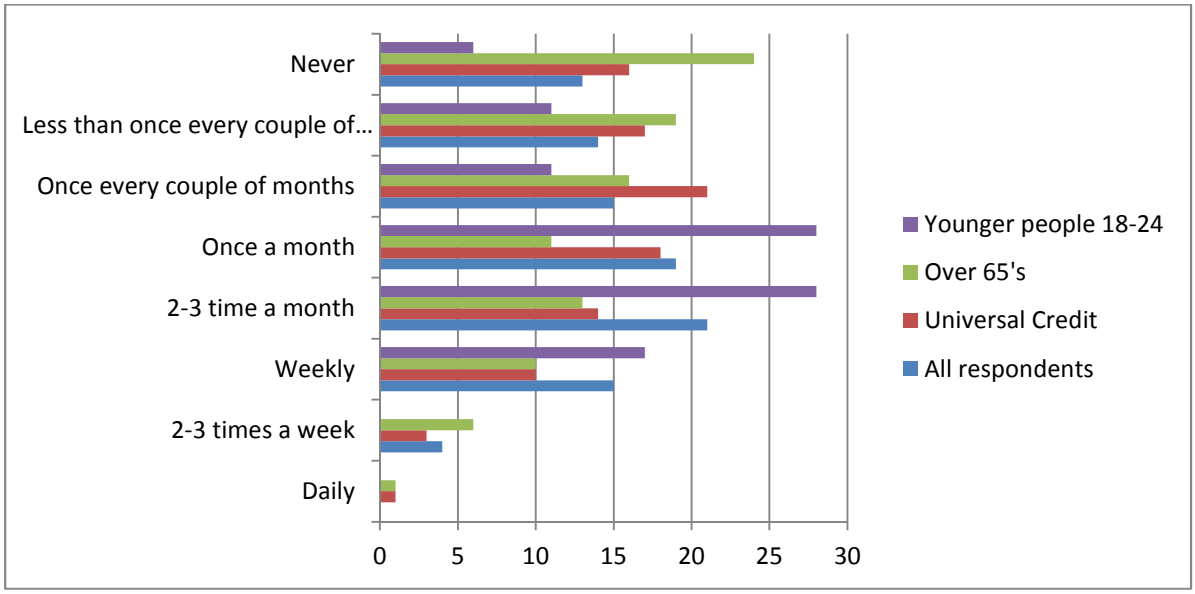
The results for universal credit recipients suggest that this group used takeaways less than the overall group with 72% using a takeaway once a month or less.

However a higher proportion (72%) of young people use a takeaway at least once a month. Also fewer younger people report never using a takeaway compared with the overall responses and other groups.

As with the previous questions that have examined the responses for 18-24 yr olds the results need to be treated with some caution because of the low sample size.

However the results appear to suggest there may be a higher prevalence of takeaway usage amongst young people

Chart 10 Frequency of takeaway usage by % of respondents



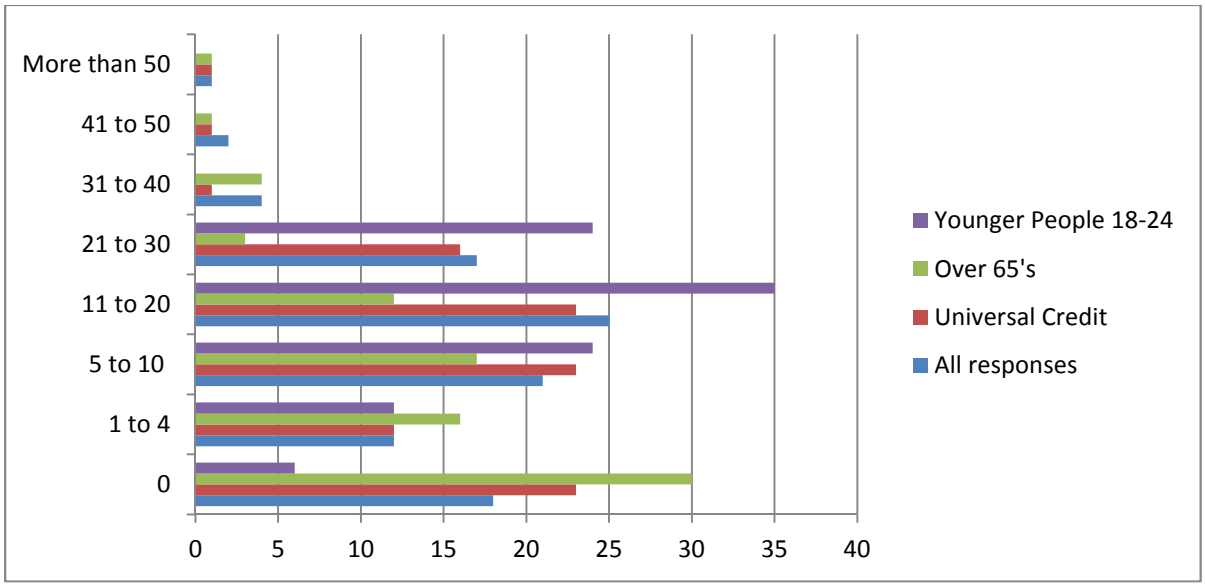
3.3.13 Takeaway spend

The results for takeaway spend were consistent across all groups and reflected the low takeaway usage reported in the earlier questions.

Overall 51% of households spent £10 or less a week – the results indicate universal credit recipients and older people spent less on takeaway food. 58% of universal credit recipients and 63% of older people spent less than £10 week on takeaway food in a week.

Younger people appear to spend more than any other group on takeaway food. This is consistent with the higher usage of takeaways reported by this group.

Chart 11 Takeaway spend per week by % of respondents



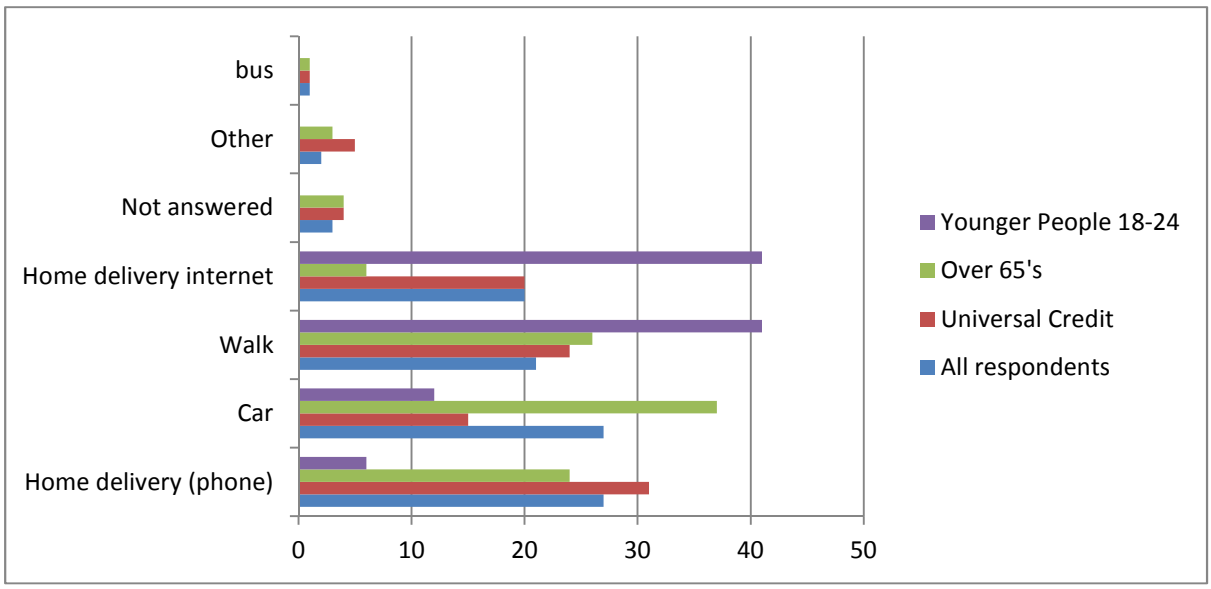
3.3.14 Transport to preferred takeaway

The results for this question indicate a significant proportion of people - 47% - don't actually visit the takeaway and either order over the internet or by phone. Only 21% of people walk to the takeaway while 27% use the car.

Overall this indicates that 79% of people do not walk to their preferred takeaway and suggests that the physical proximity of a takeaway to an individual's home is a less significant factor than might have been thought.

A far higher proportion of younger people (41%) use internet ordering facilities compared with other age groups.

Chart 12 Mode of Transport to takeaway by % of respondents



3.3.15 Food knowledge and awareness

Confidence in cooking and lack of food knowledge is often perceived to be one of the key barriers to healthy eating.

However the results of the survey indicated that confidence and awareness was relatively high.

Respondents were asked to score their confidence in being able to cook a meal from raw ingredients and following a simple recipe on a scale of 1 to 10 with 1 being not very confident and 10 being highly confident.

Overall 81% of respondents reported a score of 7 or higher for confidence in cooking from raw ingredients. 85% reported a score of 7 or above for confidence in following a simple recipe. Younger people appeared slightly less confident cooking from raw ingredients or following a simple recipe and perhaps this reflects less experience of independent living amongst this group.

These results were consistent for both Male and Female groups.

Chart 13 Confidence cooking from raw ingredients – self-selected score (10 highest confidence to 1 lowest confidence)

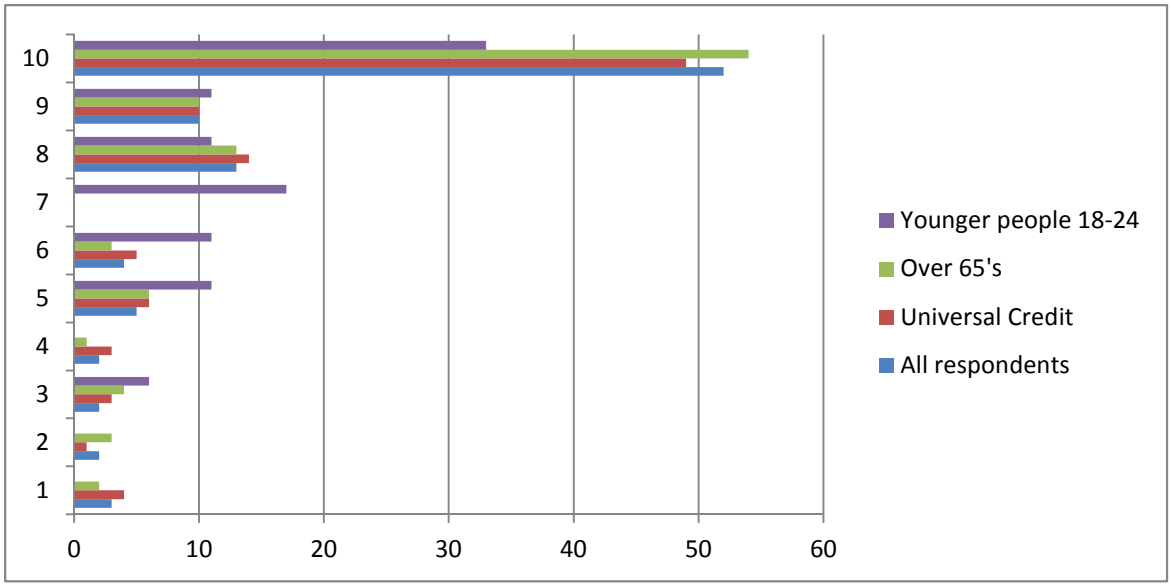
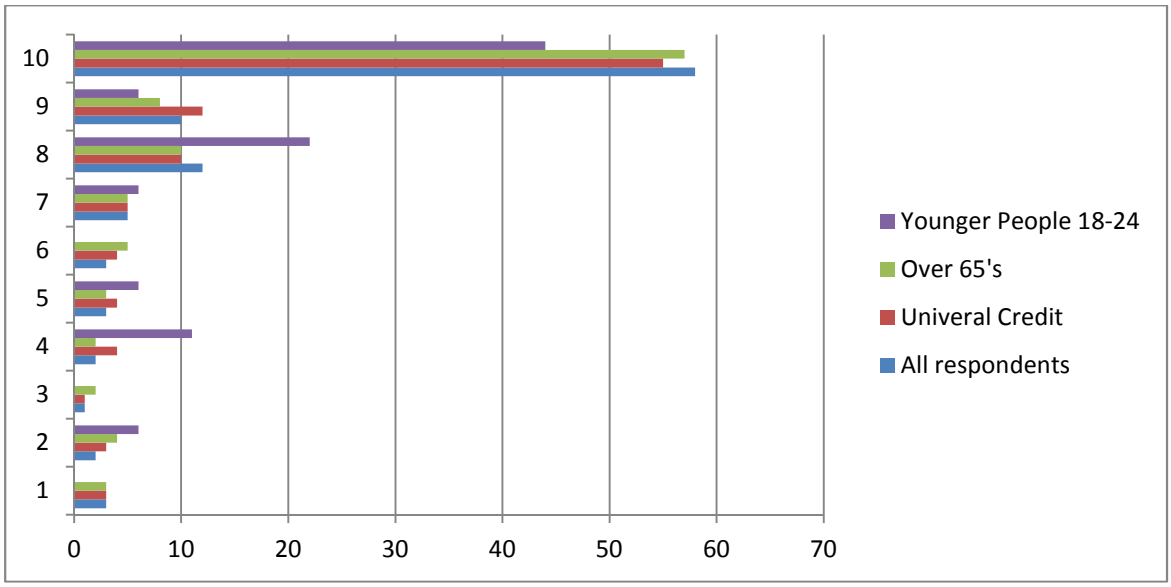


Chart 14 Confidence following a simple recipe - self-selected score (10 highest confidence to 1 lowest confidence)



3.3.16 Fruit and vegetable consumption

With hindsight the survey design for this question does not allow for an easy assessment of whether people are consuming at least 5 portions of fruit and vegetables as the survey asked separate questions in relation to fruit and vegetables.

Whilst it was clear that some people are eating plenty of fruit and veg with 68% eating 3 or more portions of fruit and 51% eating 3 or more portions of vegetables. It is clear that a significant number are eating less than the recommended number of 5 portions of fruit and veg a day.

Chart 15 Fruit Consumption – number of portions by % of respondents.

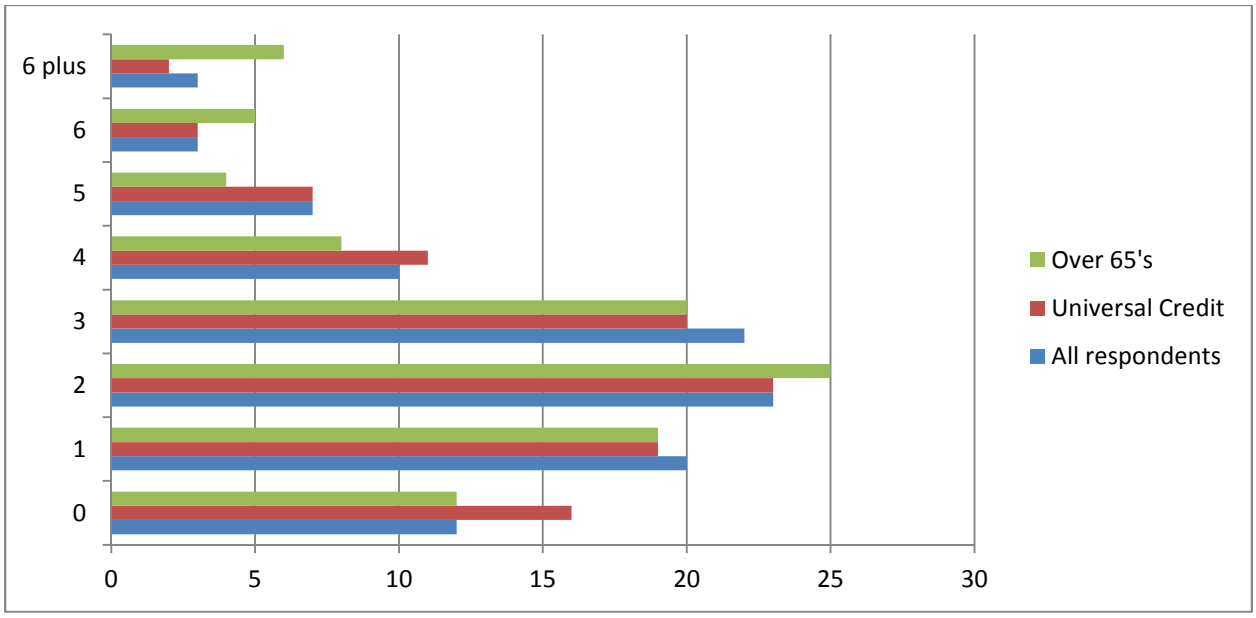
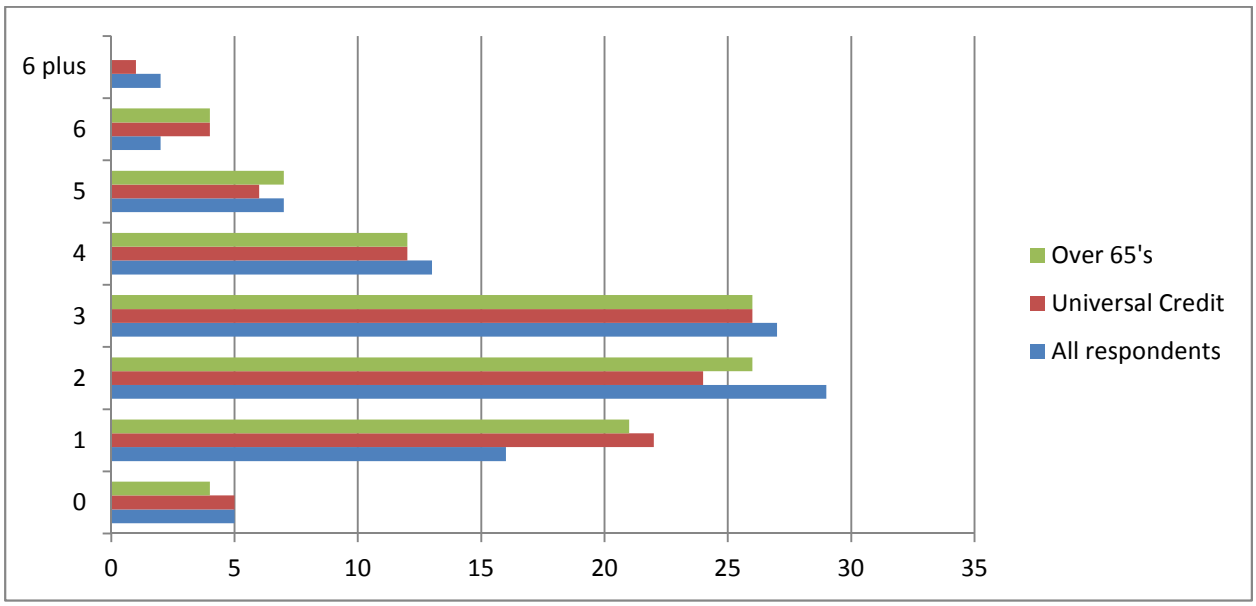


Chart 16 Vegetable Consumption – number of portions by % of respondents.



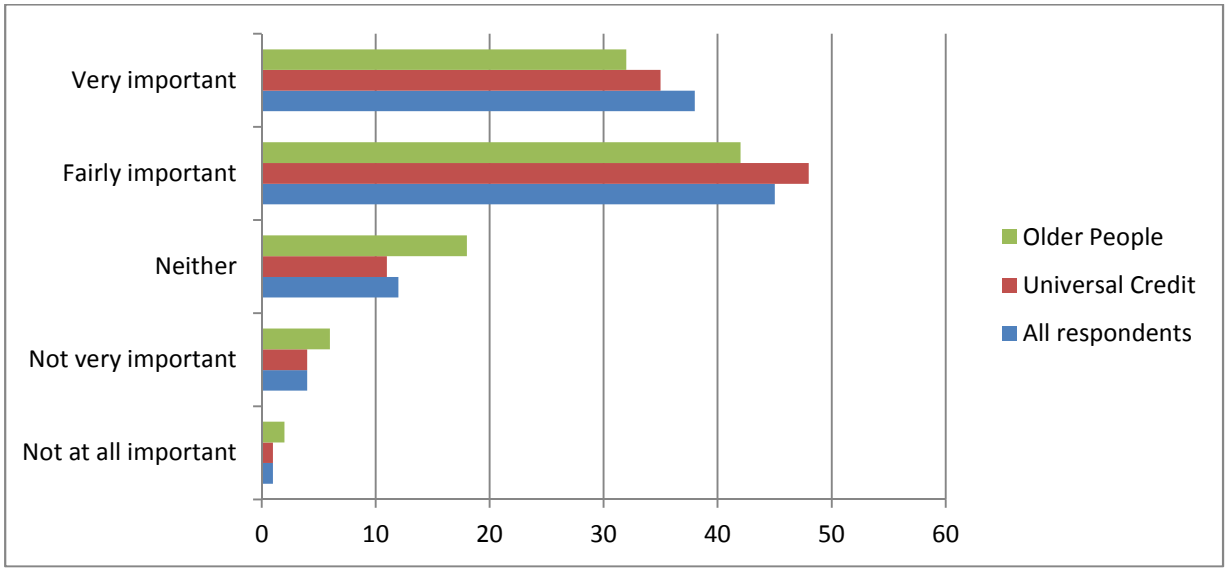
3.3.17 Attitudes to healthy eating

83% of respondents reported healthy eating being fairly or very important to them with the result being consistent across all groups.

This indicates a strong recognition amongst respondents of the importance of healthy eating.

The majority of respondents – 86% felt they ate healthily some or most of the time – with 84% saying they would like to eat healthier than they do currently.

Chart 17 Attitudes to healthy eating – by % of respondents



3.3.18 Barriers to healthy eating

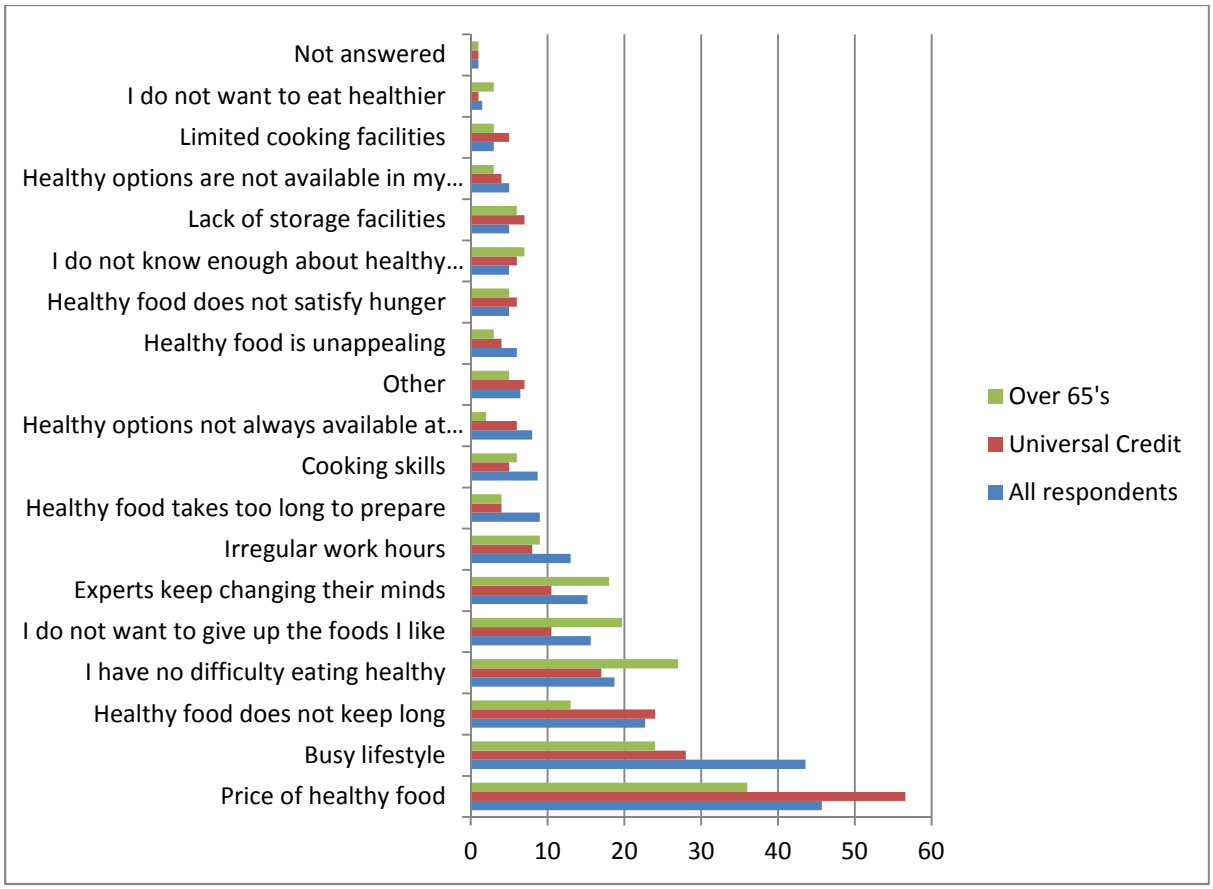
The survey examined in detail the barriers to healthy eating by asking respondents to select all the major difficulties they experience when trying to eat healthier.

Across all groups price of healthy food was the most significant barrier with 45% of respondents overall reporting this as an issue. However price was more significant factor for universal credit recipients with 56.6% of reporting this as a barrier. Overall the next most significant barrier was busy lifestyle with 43.6% of respondents reporting this as a factor – although this was less important for universal credit recipients and older people.

The third most significant factor was “healthy food does not keep long” with 22% of respondents citing this as a difficulty in trying to eat healthier. This was consistent with the experiences of participants in the focus group survey who also reported that fresh food did not keep and they were reluctant to purchase food that they may end up wasting. Overall 18% of respondents reported that they had no difficulties eating healthier.

Interestingly some of the factors often cited as reasons for unhealthy eating did not feature significantly in the survey. Only 8% of respondents overall reported cooking skills as a factor whilst 3% reported limited cooking facilities and 5% a lack of storage facilities.

Chart 18 Barriers to Eating Healthily by % of respondents



3.3.19 Choice and affordability

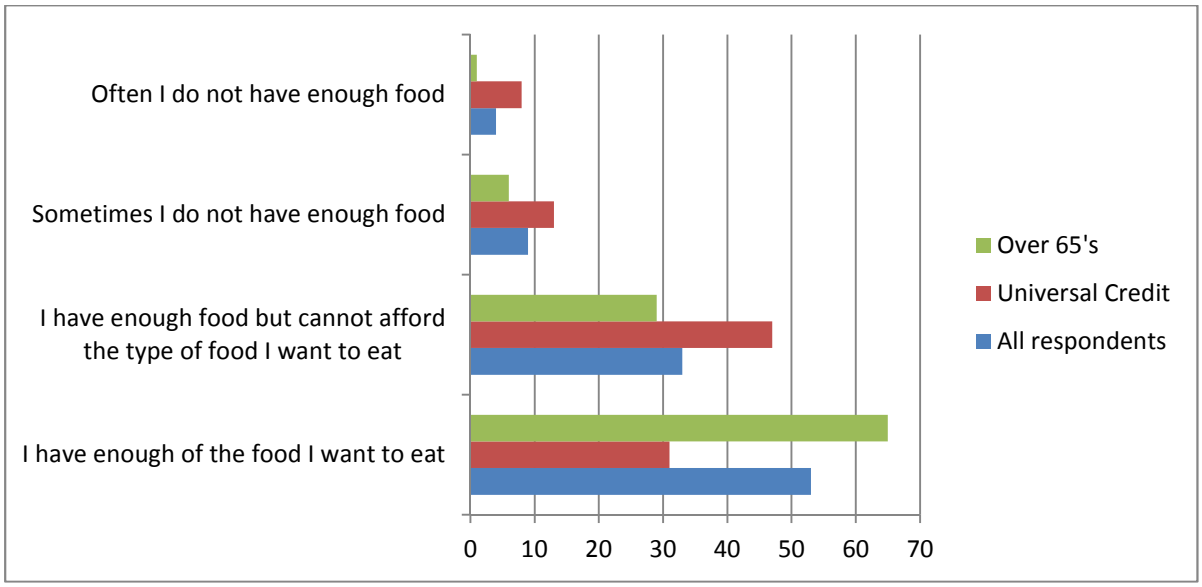
The survey results for choice and affordability showed a clear difference between the survey groups and indicated that those on lower incomes frequently had difficulty affording enough food. Families with children were rationing their own meals as a means to ensure there was enough food for their household.

53% of respondents overall and 65% of older people reported having enough of the foods they wanted to eat. However this was only the case for 31% of universal credit recipients.

47% of universal credit recipients reported that they have enough food but cannot afford the types of food they want to eat. This was the case for 37% of the overall survey group and 29% of older people.

21% of universal credit recipients reported either sometimes or often not having enough food compared with 13% overall and just 7% of older people.

Chart 19 Response to question: Which of these statements best describes the food eaten by your household over the last 12 months - by % of respondents.

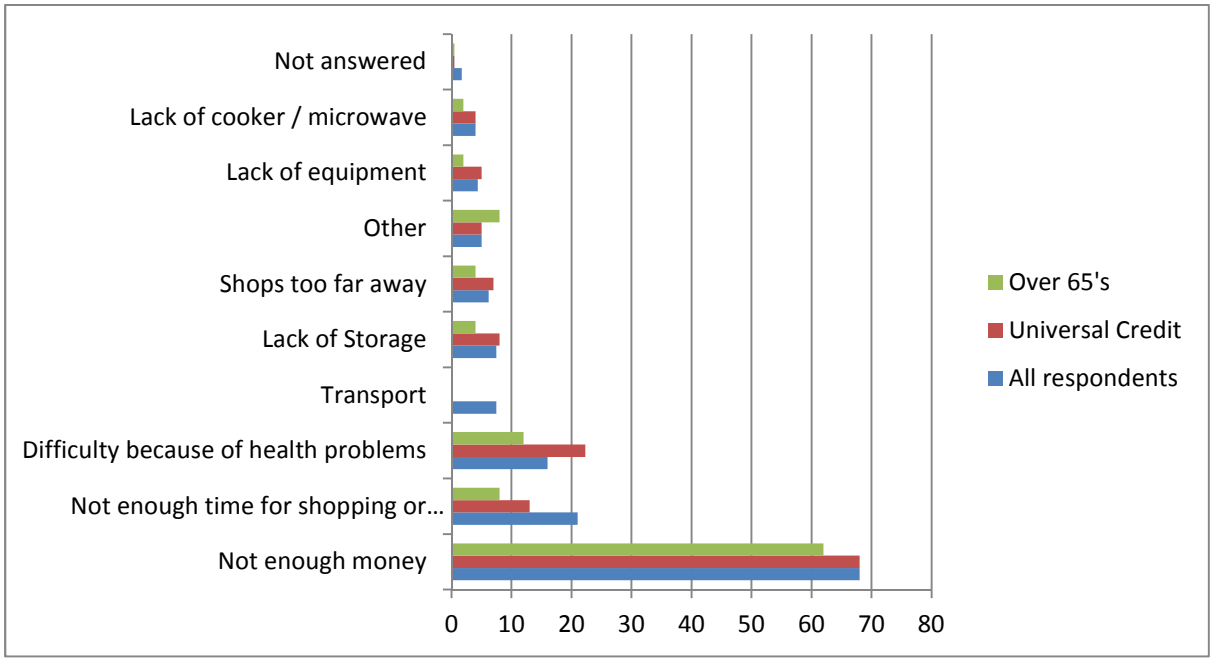


The survey examined the reasons why respondents may not have enough food or the quality or variety of food they would like to eat.

Overall - and this was consistent across all groups – 68% of respondents reported “not enough money” as the principal reason followed by “insufficient time” - 21%.

Health problems were also cited by a significant proportion of respondents on universal credit with 22% reporting that this prevented them from having enough of the food they want to eat. Interestingly this was a less significant issue for older people with only 12% citing this as a reason. This suggests a higher proportion of residents on universal credit are suffering from health problems or disabilities that limit their ability to shop for and prepare food.

Chart 20 Response to question: What are the reasons why you may not have enough food or the quality and variety of food you would like – by % of respondents

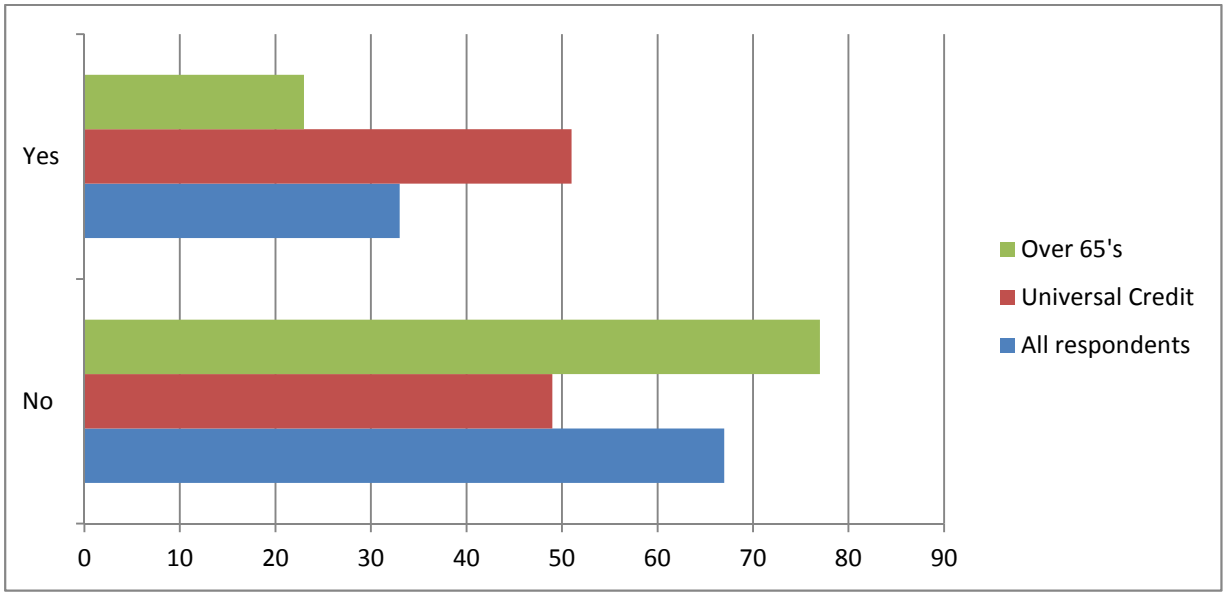


3.3.20 Running out of food

The survey asked respondents whether in the last 12 months adults in their household had ever brought food that did not last and then they did not have enough money to buy more.

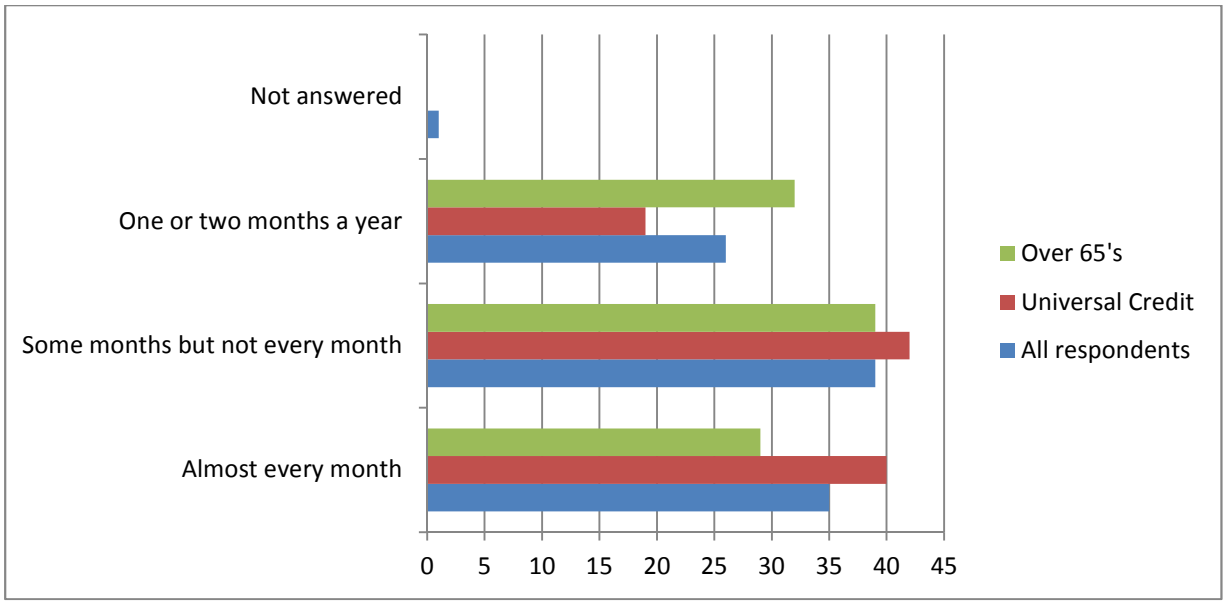
Overall 33% stated of respondents stated that they had run out of food and did not have enough money to buy more - however this was much higher for universal credit recipients with 51% reporting this had happened to them.

Chart 21 Responses to question by % of respondents: In the last 12 months have you ever bought food that did not last and you did not have enough money to buy more?



Of those that reported running out of food, overall 35% reported that this happened once a month, 38% stated some months but not every month and 26% reported this happened one or two months a year. The rates of respondents reporting this happening every month were higher for universal credit recipients (40%).

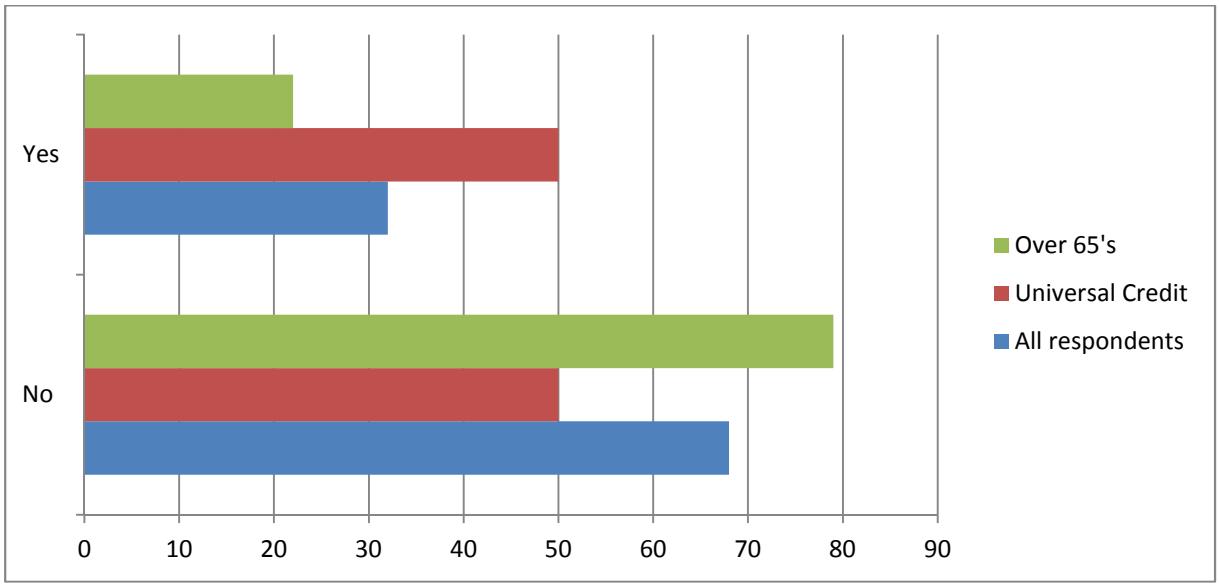
Chart 22 Frequency that respondents ran out of food and did not have enough money to buy more by % of respondents.



3.3.21 Skipping meals

Overall 32% of survey respondents reported that in the last 12 months they had either reduced the size of their meals or skipped meals because they did not have enough food. However this rose significantly to 50% of universal credit recipients.

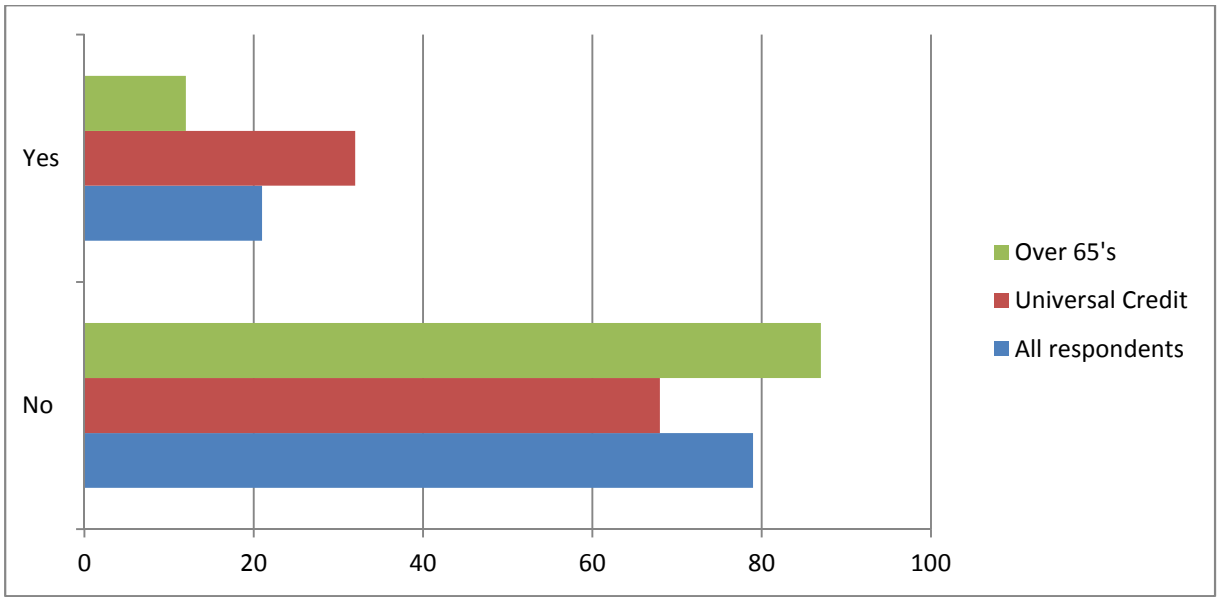
Chart 23 Response to question by % of respondents: In the last 12 months did you ever reduce the size of your meal or skip a meal because there wasn't enough money to buy food.



3.3.22 Hunger

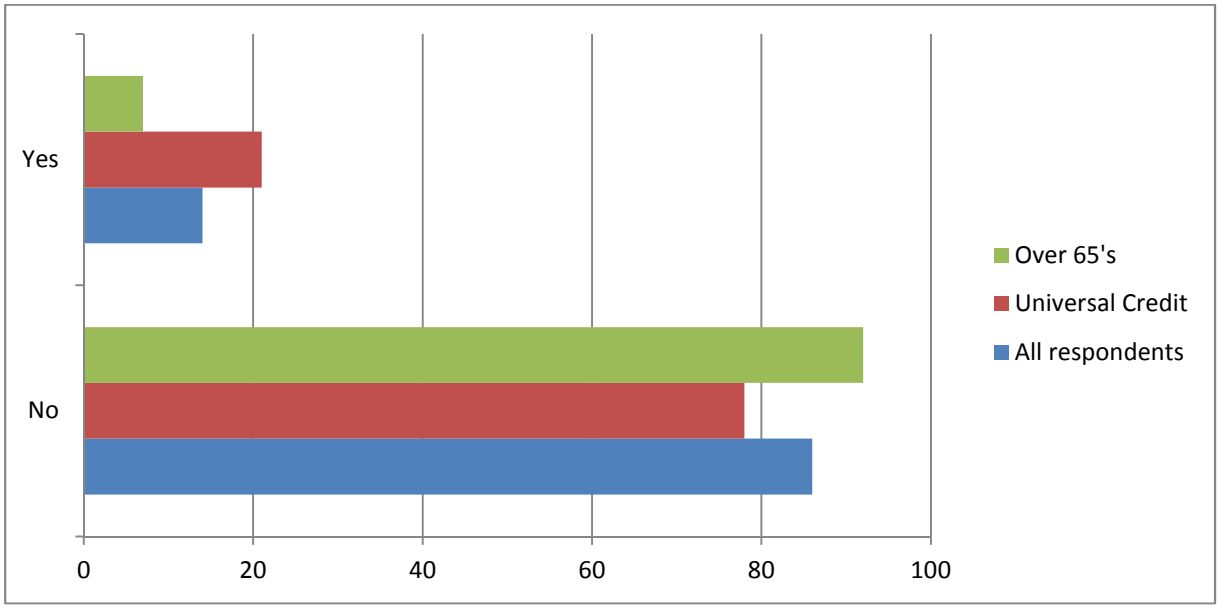
Overall 21% of respondents and 12 % of older people reported that in the last 12 months they had been hungry but didn't eat because they could not afford enough food – but this rose to 32% of universal credit recipients.

Chart 24 Response to question by % of respondents: In the last 12 months were you ever hungry but didn't eat because you couldn't afford enough food?



Overall 14% of all respondents and 7% of older people reported not eating for a whole day – but this rose to 21% of universal credit recipients.

Chart 25 Response to question by % of respondents: In the last 12 months did you ever not eat for a whole day because there wasn't enough money for food.

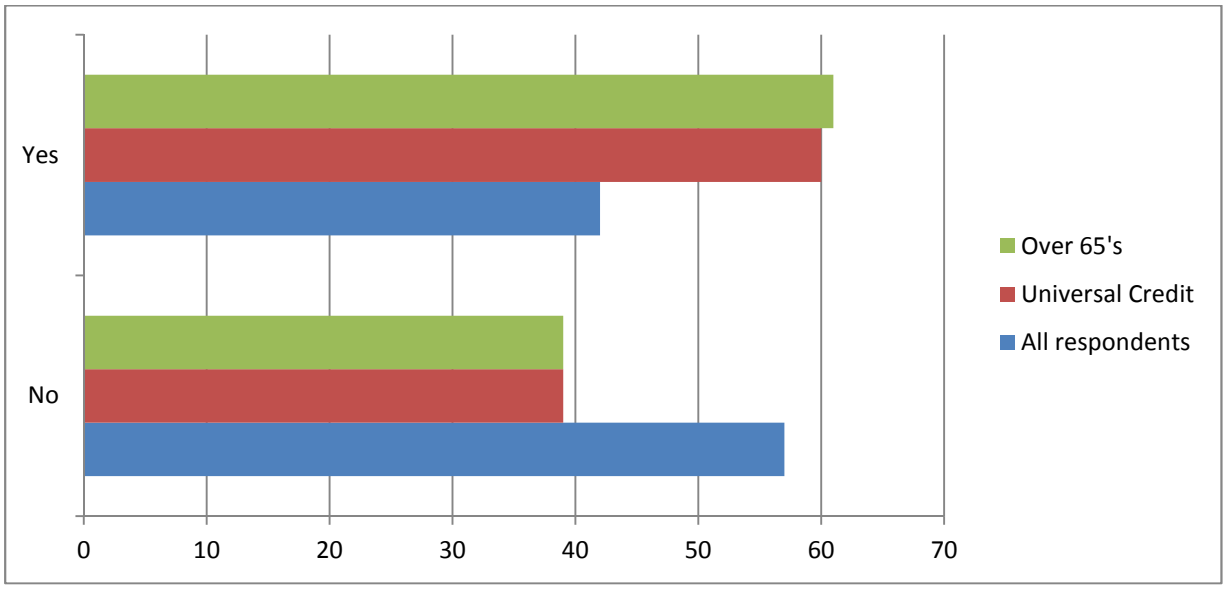


3.3.23 Children

Households with children were asked in the last 12 months whether they ever reduced the size of their own meal or skipped a meal to ensure there was sufficient food for their children. Overall 42% of respondents with children in the household reported this

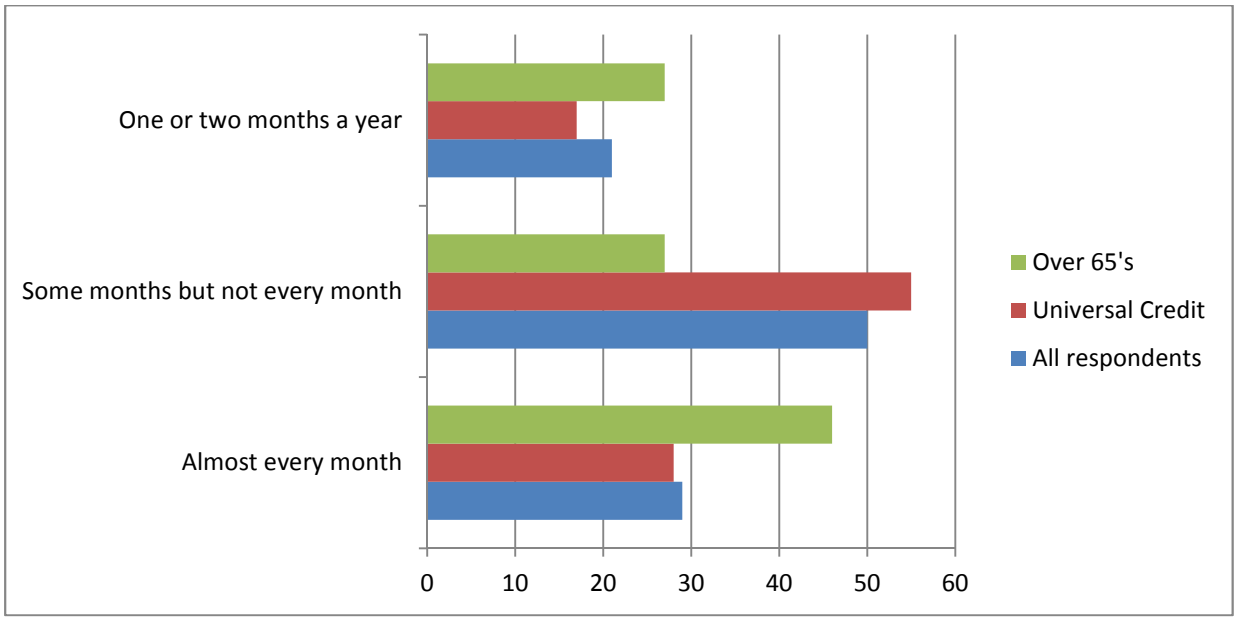
had happened to them but this rose to 60% of universal credit recipients. Unexpectedly, 61% of older people with children living in the household also reported reducing the size of their own meal to ensure there was sufficient food for their children. On further examination a small number of older people (13% of the over 65's cohort) reported that they had children in their household. What is not clear – due to the survey not being specific about the age of children - is whether these are younger children (under 18) or grown up adult family members who are still living at home. It is also likely that some older people may have grandchildren living in their household. Because the number of respondents is small the results need to be treated with caution but it does suggest that some older people who still have dependent children at home are having to reduce the amount of food they eat to ensure other people in the household do not go hungry.

Chart 26: Response to question by % of respondents: In the last 12 months did you ever reduce the size of your own meal or skip a meal to ensure there was sufficient food for your children



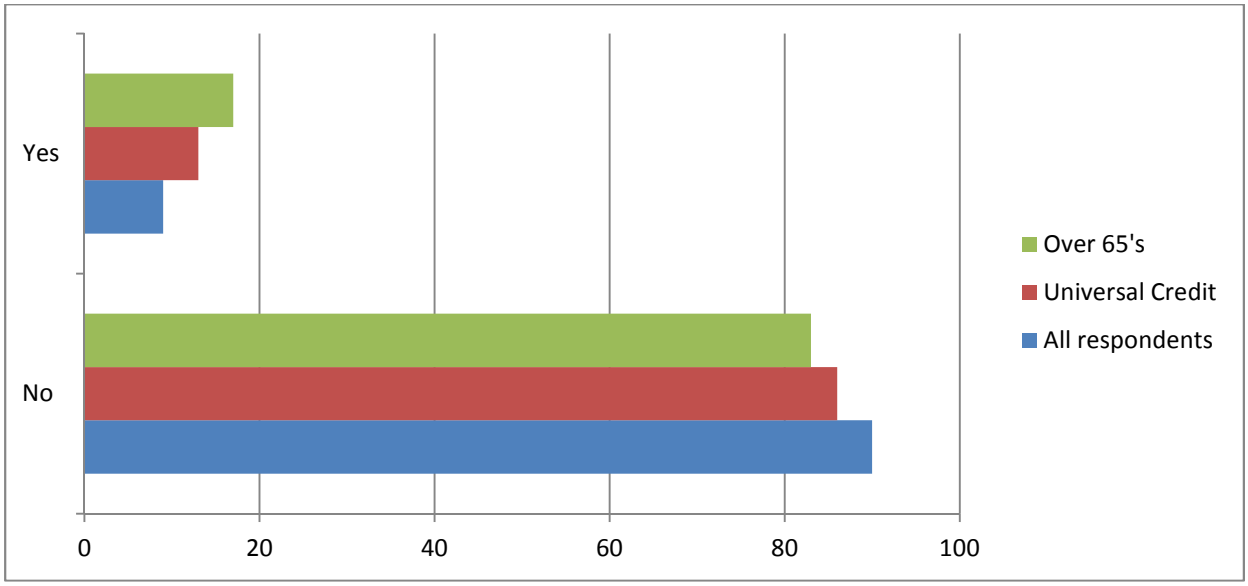
Respondents were then asked how frequently this happened. Overall 27 % of respondents – including universal credit recipients reported that this happened almost every month. However this increased significantly to 46% of older people who had children living at home. Again these figures need to be treated with some caution because of the low sample size.

Chart 27 Response to Question by % of respondents: How often did this happen



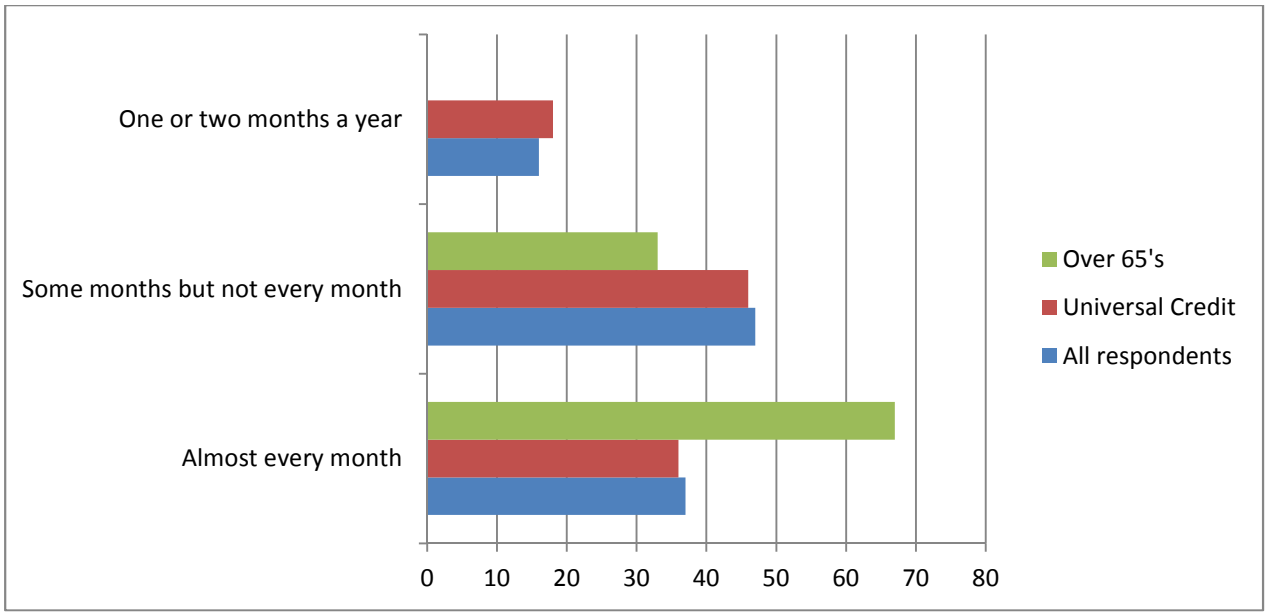
Households with children were then asked whether they had ever cut the size of their children's meals because there was not enough money for food. Overall 9% of families reported that this happened to them rising to 13% of universal credit recipients and 17% of older people. Again the result for older people was unexpected as it suggests a significant proportion of older people with children in the household have difficulty providing enough food for themselves and their family. However as previously discussed the results must be treated with some caution due to the low sample size.

Chart 28 Response to question by % of respondents: In the last 12 months did you ever have to cut the size of your children's meals because there wasn't enough money to buy food.



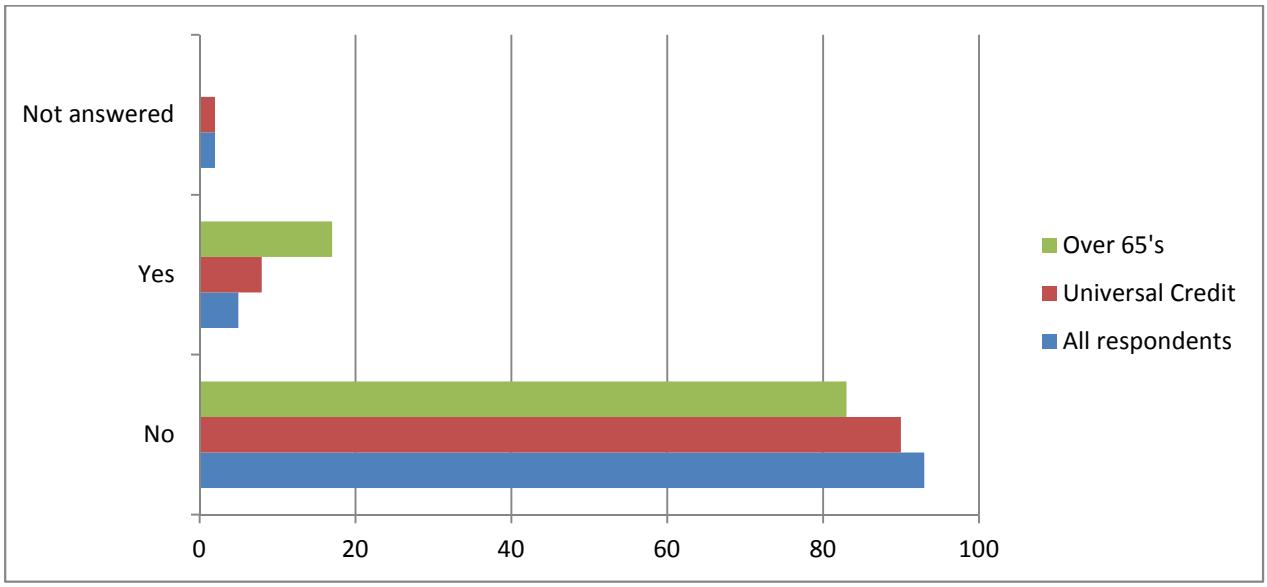
Overall of those households with children who reported having to cut the size of their children's meals 36% of them reporting this happened almost every month. However a significantly higher proportion of older people – 67% reported this happening to their families. This again suggests older people with children living at home may experience difficulty providing sufficient food for their families.

Chart 30 Response to Question by % of respondents: How often did this happen?



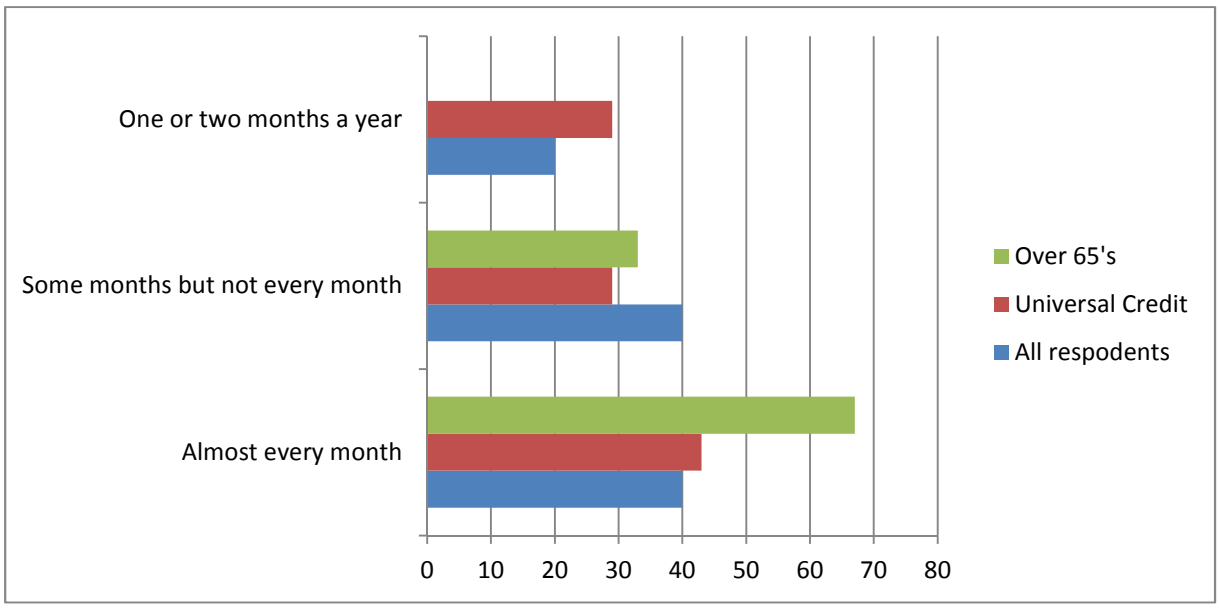
Finally respondents were asked whether in the last 12 months their child had ever skipped a meal because there wasn't enough money for food – overall 5% of respondents reported that this had happened to them – this rose to 8% of universal credit recipients and 17% of older people with children in the household.

Chart 31 Response to question by % of respondents: Did your children ever skip a meal because there wasn't enough money for food



Overall 40% of respondents who reported their children having to skip meals stated this happened almost every month. However this rose to 67% of older people with children living at home.

Chart 32 Response to question by % of respondents: How often did this happen



Chapter 4 Conclusions and recommendations

This chapter sets out the conclusions of the study and the recommendations that those conclusions support. An action plan to address these recommendations will be produced as a separate document that will develop over time.

4.1 Retail Provision

Retail provision in Halton is generally very good. 77% of households live within 500m of a shop where they can purchase at least 50% of the items that comprise a healthy weekly menu for a family of 2 adults and 2 children. However when fruit and vegetable availability was examined in more detail it was found that only 57% of households live within 500 m of a shop where 50% of the fruit and veg items on the standard menu can be purchased. Overall a third of local centres had low availability of fruit and vegetables.

97% of people reported doing their main shop at one of the larger supermarkets which suggests that local retail provision is less significant – however the fact that only 52% of people use a car to do their main shop indicates that local provision will also be important.

There was no direct correlation between areas of deprivation and low car ownership and food provision. Some areas with low car ownership had good availability such as Windmill Hill and Castlefields whilst some had lower availability.

The following areas have been identified as a priority for action to improve retail access. These areas have been identified using the following criteria

- less than 50% of the fruit and vegetable items available in that local centre area
- No alternative location with good availability within walking distance
- Low car ownership (more than 30% of households with no car)

Priority areas for improving retail provision

Bechers (Widnes)
West Bank (Widnes)
Halton Brook (Runcorn)

Cost premium at local shops

Overall the healthy basket of shopping for a family of 4 could be purchased for £54.00 in one of the town centres of Widnes or Halton Lea. However the average cost of purchasing the same basket in a local centre area where all the items were available was £69.68 – a difference of 29%

This difference is further illustrated by an analysis of the cost difference for particular items. The total cost of 10 key items purchased from the shop that sold that item for the cheapest price was £14.79 whereas the cost for the same 10 items purchased

from the shop that sold that item for the most expensive price was £43.47 – a difference of 294%

This indicates that those people who are less mobile and find it more difficult to get to a town centre location will pay a premium for their shopping.

Retail provision and deprivation

No correlation could be drawn between areas of deprivation and food availability. Availability was simply a matter of the quality of retail provision in each area. Some lower income areas had good availability of food locally whilst in some comparable areas the availability was low. Some of the areas where availability was low were more affluent areas of low deprivation and high car ownership indicating that the majority of residents in those areas have the resources to access healthy food even though it is not immediately available in their locality.

By prioritising areas based on low car ownership, poor local availability of fruit and vegetables and no nearby alternative, 3 areas were identified were retail provision should be improved to facilitate access to healthy food for residents in those areas.

Recommendation 1: The Council's future development plans should consider options to improve retail provision in Bechers and West Bank in Widnes and Halton Brook in Runcorn.

4.2 Affordability and Food Poverty

The most significant barrier reported by residents to accessing healthy and affordable food was money.

Overall 53% of respondents reported having enough of the food they wanted to eat. However only 31% of universal credit recipients reported having enough of the foods they wanted. This indicates that irrespective of circumstances a significant proportion of residents are struggling to provide their households with enough of the foods they want to eat – but the problem is most significant for those in receipt of universal credit. Older people seem to fair better with 65% of older people reporting having sufficient food. This may reflect the policy of successive recent governments to protect the incomes of older people. However those older people who reported having children still living at home appeared to struggle to provide sufficient food for their family.

There is no agreed or established definition of food poverty and so it is not possible with any certainty to quantify how many people in Halton are in food poverty. Food poverty should be viewed as a spectrum. Those that are in emergency need of food provision who without assistance would go hungry are at the extreme end. However those at the other end of the spectrum who are not hungry but still cannot afford the components of a healthy balanced diet can also be considered to be in food poverty.

Overall 37% of respondents reported having enough food but not being able to afford the types of food they wanted to eat. However this rose to 47% of universal credit recipients.

At the most extreme end of the spectrum are those households that require emergency food aid from the food banks and other charitable providers. The food banks have seen a significant increase in demand since 2012-13. By far the greatest reason for people seeking support was a sudden change in circumstances due to a benefit delay or sanction. The fact that job centres are one of the most significant distributors of food bank vouchers further illustrates the impact of the benefit and welfare changes.

Three significant changes, the removal of the "spare room subsidy" (more commonly known as the "bedroom tax") from social housing tenants, the introduction of the benefits sanctioning regime and the introduction of universal credit have had the effect of reducing disposable income for benefit recipients and have also created the risk of a "cliff edge" scenario which can result in a sudden, dramatic loss of income for those affected.

As discussed in Chapter 2 in addition to the established food banks the "11 O'clock" club run by Four Estates in Runcorn to redistribute surplus food is providing longer term support to individuals and families who are struggling to provide their household with sufficient food.

The issues at the heart of food poverty and the acute hardship that is causing the most extreme cases relate to policies of central government and this makes it less easy for the local authority to respond with its own policy measures.

Recommendation 2: The Council build on its existing work with partners such as the local housing trusts, CAB and Job Centre plus to provide advice, guidance and support to universal credit recipients to ensure they are maximising their benefit entitlement and also to help recipients avoid the circumstances that may result in a sanction.

Recommendation 3: Whilst the Trussell Trust food banks provide an essential service to those in acute food poverty - the Council and partners such as the CCG should investigate options to facilitate access to additional surplus food schemes for all Halton residents who require longer term assistance with access to sufficient food. The 11 O'clock club on Halton Brook could be used as a model.

Recommendation 4: The proposed community shop should be supported by the council. The shop should be centrally located to facilitate access for all residents of the borough who require longer term assistance with access to food.

Recommendation 5: Currently 73% of eligible households take up healthy start vouchers. The council and partners should work to further improve this high level of uptake.

4.3 Transport

Transport was a further significant influence on food availability.

Overall only 52% of respondents used a car to get to their main shop. This reduced to 31% of universal credit recipients. However journey time to shops was low with 59% of respondents being able to reach their main shop within 15 minutes and 83% within half an hour.

A positive interpretation of these results is that the good availability of food means that people are in close proximity to good shops which mitigates some of issues around lack of transport.

However those without transport did report that this impacted on their ability to easily shop for the foods they wanted to eat. In particular parents with infant children reported a significant difficulty using the bus with a push chair as most buses had very limited room for push chairs. Older people also reported that carrying their shopping home on the bus was a difficulty. A significant number of younger people were also reliant on public transport to get to the shops.

Many people used taxi's to overcome this difficulty – with 18% reporting using a taxi to do their shop. However this was relatively expensive and inevitably reduces the money they had available to spend on food.

Recommendation 1 above will help to reduce the impact of mobility issues by improving retail provision in areas where it is currently inadequate and car ownership is low.

4.3.1 Transport and affordability

It is clear from the survey results that household in receipt of universal credit are more likely to report not having enough food. Those households are also more likely to report cutting portion sizes or skipping meals and in some cases going hungry due having insufficient food.

Of greater concern is the reports of children having to skip meals because of a lack of food in the house.

The survey also demonstrates that those households on universal credit will be more likely to rely on walking in order to get to the shops. If those households live near the town centre they will have access to a choice of retailers and will be able to secure the best value food for their money. However those households that do not live within walking distance of a town centre will have their options limited to the more expensive shops within their immediate locality.

The study also found that many households on universal credit use taxis to get to the shops and so are spending more of their disposable income on transport instead of food.

Unless they live close to the town centres many households in receipt of universal credit will be paying a “poverty premium” to access sufficient food. In many cases this “premium” results in some households being unable afford sufficient food.

Recommendation 6: The Council’s future transport plans could consider options to improve access to town centres for parents with infant children, older people and low income households.

4.4 Takeaways

Despite perceptions that might suggest otherwise – Halton actually has one of the lowest takeaway densities in the North West at 91 premises per 100,000 population. However because geographically the borough is small 70% of households live within 500m of a takeaway.

There is a perception that there is a high prevalence of takeaways in Halton – but this perception is probably due to the high concentration of takeaways within the town centres of Runcorn and Widnes. There are 19 takeaways in Runcorn town centre and 20 in Widnes. Elsewhere in the borough takeaways are spread evenly and are based within established local centres and high streets

The survey results indicated that the location of takeaways is not as influential on usage as might be expected. 47% of people using takeaways did not actually visit the takeaway and either ordered online or over the phone. 27% used their car and 21% walked. The survey results did not indicate habitual takeaway usage with most respondents using takeaways once a month or less.

There was no obvious correlation between deprivation and takeaway density – however some of the boroughs more deprived wards are within close proximity to the town centres of Runcorn and Widnes. These wards would benefit from measure to prevent the over concentration and clustering of takeaways.

Recommendation 7: The existing supplementary planning document on Hot Food Takeaways should be applied in relation to all new applications for change of use to prevent the over concentration and clustering of takeaways.

4.5 Knowledge, Skill and Attitude

Overall 83% of respondents reported that healthy eating was either fairly or very important to them and suggests the majority of residents with adequate resources would like to eat healthily.

The study also suggested that overall residents have a good food knowledge and are confident being able to cook food from fresh ingredients and follow a simple recipe. However the study also indicated that young people were less confident than other groups. This was also reflected in the focus group sessions at children’s centres.

Some parents indicated that more support would be welcome particularly in relation to cooking on a budget. Some parents also indicated that they would welcome being able to pick up recipe cards to help them plan meals.

It is recognised that many of these initiatives are already available through children's centres. However the comments indicate that some residents either were unaware of the sessions or had been unable to attend.

It is therefore recommended that the council and partners offer workshops to residents at a higher risk of food poverty to provide them with the knowledge and skills to prepare healthy food on a budget.

Recommendation 8: Develop a series of workshops and associated menus and recipe cards on preparing and cooking healthy food on a budget. The workshops should be available to all household in receipt of healthy start vouchers.

Appendix 1

Local and Town Centre locations for geographical food mapping

1 Alexander Drive (Widnes)

2 Ascot Avenue (Runcorn)

3 Bechers (Widnes)

4 Beechwood (Runcorn)

5 Brookvale (Runcorn)

6 Castlefields (Runcorn)

7 Cronton Lane (Widnes)

8 Ditchfield Road (Widnes)

9 Farnworth (Widnes)

10 Grangeway (Runcorn)

11 Greenway Road (Widnes)

12 Hale Road (Widnes)

13 Halebank (Widnes)

14 Halton Brook (Runcorn)

15 Halton Lea Town Centre

16 Halton Lodge (Runcorn)

17 Halton Road (Runcorn)

18 Halton View Road (Widnes)

19 Halton Village (Runcorn)

20 Hough Green (Widnes)

21 Ivy Farm Court (Hale)

22 Langdale Road (Runcorn)

23 Liverpool Road (Widnes)

24 Moorfield Road (Widnes)

25 Murdishaw Local (Runcorn)

26 Palacefields (Runcorn)

27 Picton Avenue (Runcorn)

28 Preston Brook (Runcorn)

29 Queens Avenue (Widnes)

30 Runcorn District Centre

31 Russell Road (Runcorn)

32 Upton Rocks (Widnes)

33 Warrington Road (Widnes)

34 West Bank (Widnes)

35 Weston Point (Runcorn)

36 Widnes Town Centre

37 Windmill Hill (Runcorn)

REPORT TO: Health and Wellbeing Board

DATE: 10 July 2019

REPORTING OFFICER: Chief Executive

PORTFOLIO: Health and Wellbeing

SUBJECT: One Halton - Update Report

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an update on matters relating to the development of One Halton, including the work of the One Halton Forum, the Integrated Joint Commissioning Group and the Provider Alliance.

2.0 RECOMMENDATION: That

1) the contents of the report be noted; and

2) authority to spend the One Halton budget be delegated to the Chief Executive/One Halton Senior Responsible Officer in consultation with the Chair of the Health and Wellbeing Board and the Portfolio Holder Health and Wellbeing.

3.0 SUPPORTING INFORMATION

Budget Summary

3.1 One Halton has a dedicated budget of £966,570 available for 2019-20

3.2 The majority of the funding comes from Cheshire & Merseyside Health Care Partnership (C&M HCP) and there is a requirement to provide quarterly reporting back to them.

3.3 Additional funding was secured from the NW Leadership Academy following a successful bid for monies. A breakdown of the funding is shown below:

Description	Amount
Halton Integrated Frailty service (C&M HCP)	£490,570
Infrastructure carry over from 18/19 (C&M HCP)	£39,000
0.2% Place Based Allocation (C&M HCP)	£425,000
Leadership Funding (NW Leadership Academy)	£12,000
Total Budget	**£966,570**

3.4 The majority of the funding is already committed; as shown below:

Committed Expenditure	Notes	Amount
Halton Integrated Frailty service	All funding is expected to be spent on this service during its pilot.	£490,570
Named Social Worker Project	All funding will be spent in year.	£92,000
Communication & Engagement	Anticipated all funding will be spent in year.	£25,000
Leadership Funding	Anticipated all funding will be spent in year.	£12,000
One Halton Staff	Funding is committed.	£73,801
Total Committed Spend		**£693,371**

3.5 This leaves a balance of £273,199 that has not been allocated to any specific scheme and is currently available for One Halton to invest.

3.6 The Health and Wellbeing Board is the decision-making body for One Halton, therefore oversight of the budget will sit with the Board.

3.7 It is recommended that the Board delegates the authority and management of the budget to the Chief Executive/One Halton Senior Responsible Officer in consultation with the Chair of the Health and Wellbeing Board and the Health and Wellbeing Portfolio Holder.

3.8 This would allow decisions regarding spend to be made in a more timely manner, meaning projects can be initiated quicker.

3.9 All spending decisions would be reported to the Health & Wellbeing Board.

Communication and Engagement

3.10 At the final One Halton Board on 24th April 2019 it was agreed that a dedicated person was required to provide One Halton with Communication and Engagement support.

3.11 It was agreed to use up to £25,000 of the One Halton Place Based funding from Cheshire & Merseyside Health Care Partnership to finance this.

3.12 The One Halton Board asked that a paper be submitted to the Health and Wellbeing Board detailing the planned spend and if any further funding was required this would need to be sought from the Health and Wellbeing Board.

3.13 A detailed breakdown of how the funding will be spent is not yet available at this time and will be shared with the Health and Wellbeing Board at the next meeting. It is anticipated that £25,000 should be sufficient for 2019-20 and any underspend would go back into the One Halton Place Based funds.

3.14 Cheshire & Merseyside Health Care Partnership have indicated this role may need capacity up to three days per week. Initially, One Halton will resource the capacity at least one day per week and review periodically. This capacity will be provided by a Communications Officer from Halton Borough Council. If further capacity is required this would be provided from any of the One Halton partners or a formal recruitment process may be considered.

3.15 The £25,000 is anticipated to be spent on:

- One Halton Communications and Engagement Manager
- Commissioning engagement activity from organisations such as Healthwatch or Voluntary Community Sector
- Engagement Events
- Advertisement costs such as radio.

3.16 The Communications and Engagement Manager role is anticipated to undertake the following:

- Creating and implementing a One Halton Communications and Engagement Strategy.
- To support the communication and engagement work required in relation to the One Halton Five Year Plan.
- Establishing a Halton network across Providers and Commissioners to ensure consistent communications.
- Attendance at the Halton Engagement & Involvement Group.
- Attendance at the Cheshire & Merseyside Healthcare Partnership Communications Network meeting.
- Supporting One Halton Projects to produce communication and engagement plans.
- Communicating to staff and residents in Halton the purpose of One Halton and their role as part of it.
- Providing information for any relevant websites.

3.17 The Board are asked to note the contents of this update, a more detailed communications and engagement update will be provided at the next meeting.

One Halton Forum Terms of Reference

3.18 The One Halton Forum Terms of Reference have now been produced and outline its purpose and expectations. The Terms of Reference are included as Appendix 1 for noting.

4.0 POLICY IMPLICATIONS

n/a

5.0 FINANCIAL IMPLICATIONS

5.1 As documented in the supporting information, One Halton has its own discreet budget available for 2019-20 totalling £966,570.

5.2 One Halton funding is used to provide resource and capacity as well as investing into new schemes. Funding from the Cheshire & Merseyside Health Care Partnership is received with guidance/caveats for how it should be spent. One Halton will ensure any funding received is used for its intended purpose and reported back through the appropriate channels.

5.3 The Health and Wellbeing Board have oversight over all One Halton spend.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

One Halton supports the Council priorities for a Healthy Halton and the Health and Wellbeing Board Priorities.

6.1 **Children and Young People in Halton**

One Halton supports the Council priorities for Children and Young People

6.2 **Employment, Learning and Skills in Halton**

None in this report

6.3 **A Healthy Halton**

One Halton supports the Council priorities for a Healthy Halton

6.4 **A Safer Halton**

None in this report

6.5 **Halton's Urban Renewal**

None in this report

7.0 RISK ANALYSIS

No risk analysis is required for the recommendations in this report.

8.0 EQUALITY AND DIVERSITY ISSUES

One Halton supports the Council priorities to deliver equality and diversity in Halton.

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

None under the meaning of the Act.

Appendix 1 – One Halton Forum Terms of Reference

1. **Purpose:**
   The purpose of the Forum is to;
   - provide a mechanism whereby Commissioners and Providers can meet together for dialogue.
   - allow horizon scanning, to assist with addressing the overarching objective to deliver the aims of One Halton.
   - review and seek to resolve issues as a system.
   - provide the opportunity to discuss and challenge prior to the Health & Wellbeing Board.

2. **Meetings**
   Forum meetings will take place quarterly prior to the final deadline for Health & Wellbeing Board papers.

   The agenda and associated papers will be sent out one week in advance of the meeting.

   Notes will be taken to summarise key points and actions.

   The Forum is not a decision-making group.
   Decisions will be made at the Health & Wellbeing Board.

   The Forum has no official reporting lines from the Integrated Commissioning Group or the Provider Alliance, nor does the Forum report into any group.

3. **Membership**
   - One Halton Senior Responsible Officer
   - One Halton Provider Alliance members
   - One Halton Integrated Commissioning Group members
   - VCA Representative
   - Health & Wellbeing Portfolio Holder
   - One Halton Programme Director
   - One Halton Project Manager
   - One Halton Project Administrator
   - NHS England

   Membership for the Forum will be inclusive and reviewed after 6 months. There are no quoracy requirements, however there must be representation from both Provider Alliance and Integrated Commissioning Group in order for a forum to take place.

4. **Members Roles & Responsibilities:**
   - Members are able to voice the opinions of the organisation or group they represent.

- Members will ensure they are fully briefed, informed and are able to share information from their organisation or sector whilst also reflecting confidentiality and data protection issues.
- Members are expected to display consistency and honesty, within and outside the Forum
- Discussions should be open and transparent
- Members are treated as equal and their contributions are respected and valued.
- Members are encouraged to challenge opinions and actions of other members where this will lead to an improvement in Halton.
- Members to contribute to agenda items.
- Members will take responsibility for communicating messages across their own organisations, other partnerships and public.

REPORT TO:	Health and Wellbeing Board
DATE:	10 July 2019
REPORTING OFFICER:	Leigh Thompson Chair of One Halton Integrated Commissioning Group and Chief Commissioner NHS Halton CCG
PORTFOLIO:	One Halton
SUBJECT:	Integrated Commissioning Group Update Report June 2019.
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is for the One Halton Integrated Commissioning Group to provide an update to the Health and Wellbeing Board.

2.0 RECOMMENDATION: That

1) **the report be noted; and**
2) **the Board approves the Terms of Reference for the Integrated Commissioning Group. (Appendix 1)**

3.0 SUPPORTING INFORMATION

3.1 **Purpose of Integrated Commissioning Group**

The purpose is to provide oversight of commissioned services on behalf of One Halton. It will not make decisions that impact separate commissioning authorities and it will not commit resources that are not within the One Halton budget allocation.

3.2 **Membership**

Representatives include Clinical Commissioning Group, Public Health, Adult Social Care and Children's Services.
Other commissioners, such as NHS England are to be invited as required.

3.3 **Governance**

The Integrated Commissioning Group will meet every 6 weeks. They will report directly into the Health and Wellbeing Board who will hold them to account to ensure commissioned services address Health Inequalities across Halton. Each member remains accountable to their respective organisation.

The Integrated Commissioning Group have drafted Terms of Reference which are shown in Appendix 1.

The Commissioners will meet at least quarterly with the Providers at the One Halton Forum.

3.4 **Meetings**

In total the Integrated Commissioning Group have met three times, 20th March, 15th May and 11th June.

- Integrated Commissioning for Better Outcomes (ICBO) has been shared, next steps/recommendations are being considered.
- The creation of a One Halton Commissioning Plan was agreed through a Task and Finish Group. See Appendix 2 for latest version.
- Priorities have been mapped against Health and Wellbeing Board priorities.

3.5 **Place Five Year Strategic Plan**

There is a requirement from Cheshire & Merseyside Health Care Partnership for each place to write a five year strategic plan that considers the NHS Long Term Plan as well as the Health Care Partnership Programmes. This plan needs to be drafted by 30th August 2019 and signed off by the Health and Wellbeing Board prior to 29th November 2019.
The One Halton plan will be produced collaboratively with Providers and a specific workshop will be held to undertake this.

3.6 **Place Based Matrix**

Cheshire & Merseyside Health Care Partnership have shared a Place Based Matrix which is recommended to be completed by each place (One Halton) to self-assess against excellence. The matrix will be completed by both Provider Alliance and Integrated Commissioning Group to produce a collaborative response back to Cheshire & Merseyside Health Care Partnership.
A copy of the blank template is shared as Appendix 3.

4.0 POLICY IMPLICATIONS

n/a

5.0 FINANCIAL IMPLICATIONS

The Integrated Commissioning Group has £4,000 allocated from the NW Leadership Academy which was given to One Halton to specifically invest in the development, leadership and collaboration. This money will be spent during this financial year.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

Commissioning plans will include Children and Young People.

6.2 **Employment, Learning and Skills in Halton**
None

6.3 **A Healthy Halton**
None

6.4 **A Safer Halton**
None

6.5 **Halton's Urban Renewal**
None

7.0 RISK ANALYSIS

n/a

8.0 EQUALITY AND DIVERSITY ISSUES

None

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

None under the meaning of the Act.

Appendix 1 – Terms of Reference

Terms of Reference

One Halton Integrated Commissioning Group

Operative Date: June 2019

PURPOSE

The One Halton Integrated Commissioning Group will:

- be responsible for providing oversight of commissioned services on behalf of One Halton, through review, planning, co-ordination and collation of Halton Borough Council plans and Halton CCG commissioning intentions and operational plans;
- provide advice and guidance on priorities and their alignment with the JSNAs;
- to ensure commissioned services address Health Inequalities and that no service increases disparity;
- determine the parameters, framework and outcomes to support the work of the provider alliance;
- support commissioning organisations in the development of their budget allocations for jointly commissioned services;
- inform commissioning intentions for One Halton;
- support the appropriate commissioning body in the development of service modules, service specification and new models of care developments.

The Integrated Commissioning Group will not:

- act as a commissioner;
- make decisions that impact on or make liable separate commissioning authorities for services, unless instructed to so do;
- commit resources that are not within the One Halton budget allocation.

ACTIVITIES

a) Will develop the systems and processes for safe and effective integrated commissioning across One Halton;

b) Will ensure the JSNAs inform commissioning intentions and commissioning plans;

c) All possibilities for integrated commissioning would support the overall objective of the triple aim; *Better Health, Better Care, Better Value*;

d) Will ensure co-production plays a central part in the commissioning, design and evaluation of services with the providers;

e) Commissioners will ensure there is a sufficient assurance framework in place;

f) Will ensure commissioned services have due regard to safeguarding, prevention and promote equality of access for all regardless of their religion, ethnicity, age, gender, ability, or sexuality;

g) Will ensure financial integrity and adherence to contractual and financial rules and procedures of integrated commissioned services;

h) Will ensure the adherence to legislation and statutory guidance, which requires local health organisations and local authorities to collaborate in the provision of education, health and social care services for people across Halton;

i) Will ensure that mechanisms are in place to provide accurate and timely information between commissioners and providers and;

j) Will ensure the patient and resident voice is listened to.

LINKED GROUPS

One Halton Provider Alliance
Health and Wellbeing Board
One Halton Forum
Operational Commissioning Committee
Executive Partnership Board
Population Health Board
Children's Health Trust
Health Policy and Performance Board

LINKED STRATEGIES

The Integrated Commissioning group will link to all relevant strategies, which include, but not limited to:
Health and Well Being Strategy
Halton JSNA
Halton CCG Operational Plan & Commissioning Intentions
Halton Council Corporate Plan
Adults Social Care Commissioning Plan
Early Help Strategy
The NHS Long Term Plan
Cheshire & Merseyside Health Care Partnership Business Plan and Strategic Plan
Halton's Long Term Plan (yet to be published).

ACCOUNTABLE TO

Health and Wellbeing Board and Respective Organisations

MEMBERSHIP

The Integrated Commissioning Group shall consist of; Commissioners, Commissioning Portfolio Leads and Commissioning Support Officers from both Halton Borough Council and Halton Clinical Commissioning Group

Finance colleagues will be invited as required.

There should be a minimum of 6 representatives at each meeting to include:

- Clinical Commissioning Group x2
- Public Health x1
- Adult Social Care x1
- Children's Services x1
- One Halton x1

Each member is responsible and accountable for the dissemination of information and decisions from meeting, to their staff as appropriate.

The Chair will rotate over a 6 month period.

Minute taker is appointed and minutes and agenda to be distributed within 1 week of meeting

REPORTING

Reports to Health & Wellbeing Board

FREQUENCY OF MEETINGS

To meet six weekly from 20 March 2019

Revision Date:

December 2019

Appendix 2- One Halton Commissioning Plan
Powerpoint document submitted as additional paper.

Appendix 3 - Cheshire & Merseyside Place Based Matrix Template
Excel document submitted as additional paper. The template is shown for illustration purposes only, the completed version will be shared at a later Health and Wellbeing Board.

Draft
One Halton
Commissioning Plan

10 June 2019

One Halton Commissioning Vision

To work together to commission high quality, integrated services that meet the needs of the Halton population and improve health and wellbeing.

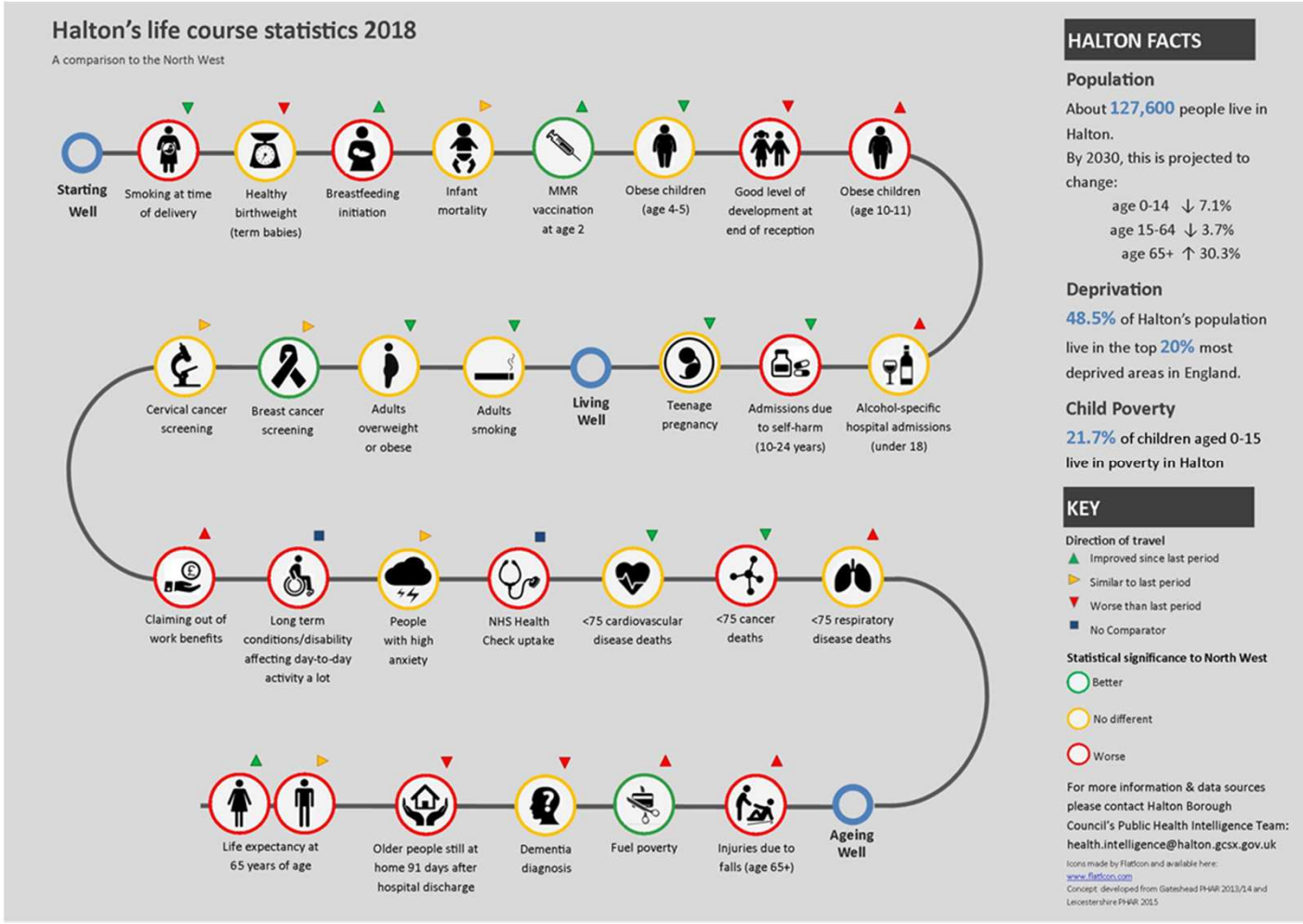
Better Health, Better Care, Better Value

One Halton
Health and Wellbeing Board Priorities

- **Children and Young People: improved levels of early child development**
- **Generally Well: increased levels of physical activity and healthy eating and reduction in harm from alcohol**
- **Long-term Conditions: reduction in levels of heart disease and stroke**
- **Mental Health: improved prevention, early detection and treatment**
- **Cancer: reduced level of premature death**
- **Older People: improved quality of life**

One Halton Partnership

The Halton Landscape



Deprivation

- Halton is the **27th** most deprived Local Authority in England (of 326)
- **1 in 4** (26.6%) of Halton's population live with the 10% most deprived areas of England

Life expectancy

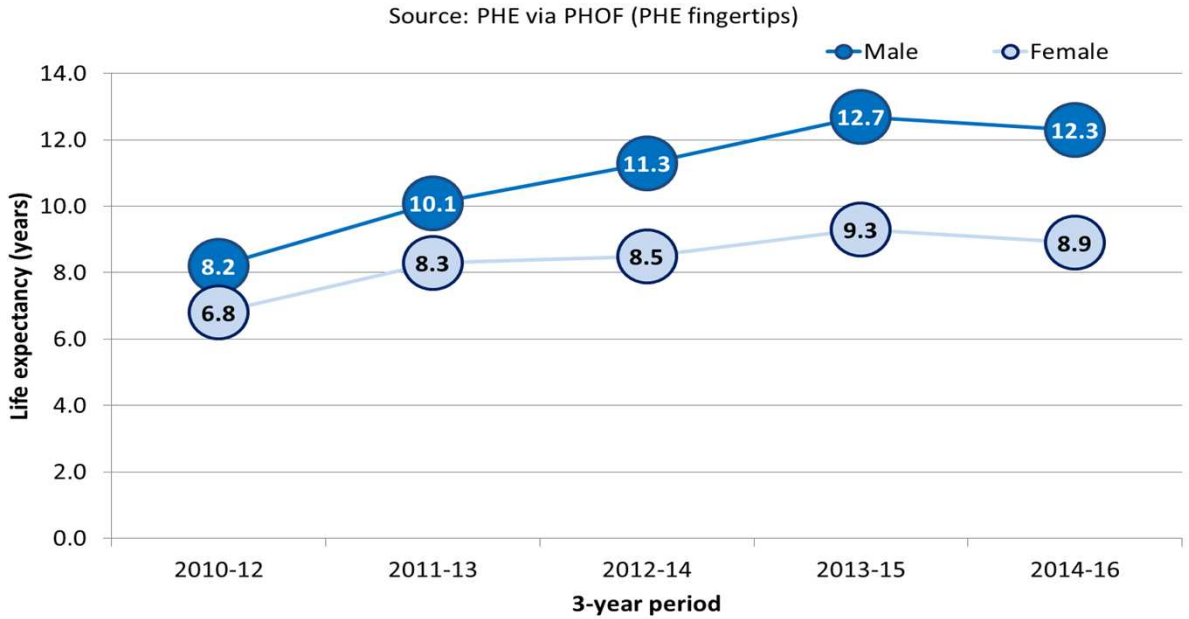
- Life expectancy at birth has improved in Halton since 2001.
  - However improvements are stalling.

- There is a gap in life expectancy:
  - between Halton and England
  - within Halton between the most and least deprived areas

1. Public Health England (2019) *Public Health Outcomes Framework (via fingertips)*

The Halton Landscape 2019

Trend in male and female life expectancy difference between the least and most deprived areas of Halton (Slope Index of Inequality)



Contribution to life expectancy gap (premature mortality)

Cancer:

- main cause of death in Halton, particularly stomach, digestive and lung
- 10th highest rate of premature mortality in England

Circulatory disease:

- Second most common cause of death: CVD, Diabetes, Dementia.

Respiratory Disease: particularly COPD and asthma (COPD main cause of premature death)

Mental disorders: the majority being dementia

Contribution to life expectancy gap (premature mortality)

Gastrointestinal disease:

- Liver disease is the main cause of death
- highest costs, poorest outcomes

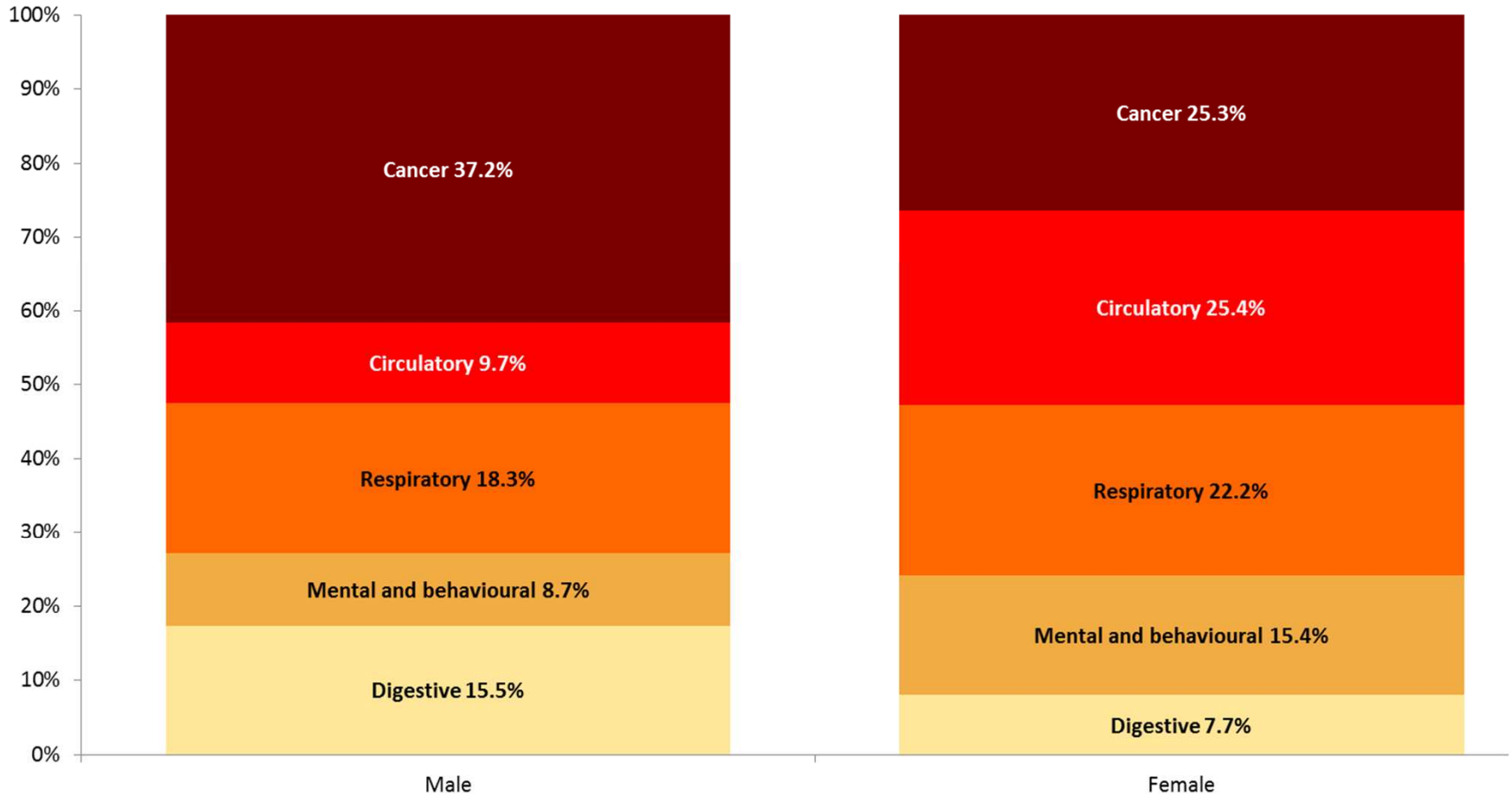
Learning Disability- die on average 20 years early

Increased gap in inequalities:

- Increased gap in inequalities related to wealth
- Those with a severe mental illness die on average 20 years earlier[2].

2. Public Health England (2018) *Health matters: reducing health inequalities in mental illness*

Contribution to life expectancy gap between Halton and England (2015-17)



Public Health England (2019) *Segment tool*

Biggest Contribution to Ill Health

- Mental Health especially low to moderate level anxiety and depression
- Musculoskeletal disorders including falls/injuries
- Gastrointestinal disorders, highest costs poorest outcomes – cancers (stomach, oesophageal, liver, pancreatic) IBS, nausea, D & V, reflux, heart burn etc.
- Urogenital/Gynae e.g. Urinary tract infections, Dysfunctional bleeding, endemitriosis
- ENT and Respiratory e.g. Coughs & Colds, 'flu, Pneumonia, Otitis

Biggest Contribution to Ill Health

- **Neurological** – headaches
- **Respiratory** – COPD and asthma
- **Unintentional injuries** - falls
- **Diabetes** – increase in illness and disability associated with diabetes has increased by 56% in Halton since 2000[3].
- **Hearing / sight loss**

The biggest risk factors for ill health are:

- Excess Weight and lack of physical activity
- Smoking
- Social isolation

Source: Institute for Health Metrics and Evaluation (2017) *Global Burden of Disease – Years lived with a disability*

The Halton Landscape

If we do not act now to radically change the way we do things, by 2025 we will have a ***significant shortfall*** *in funding for health and social care services.*

Triple Aim: *Better Health, Better Care, Better Value (NHS LTP)*

National Guidelines & Policy Context

- Meeting the priorities of the One Halton JHWBS.
- Delivering the NHS LTP.
- Emerging Green Paper for ASC
- Emerging Prevention Is Better Than Cure Green Paper
- Children's & Families Act 2014

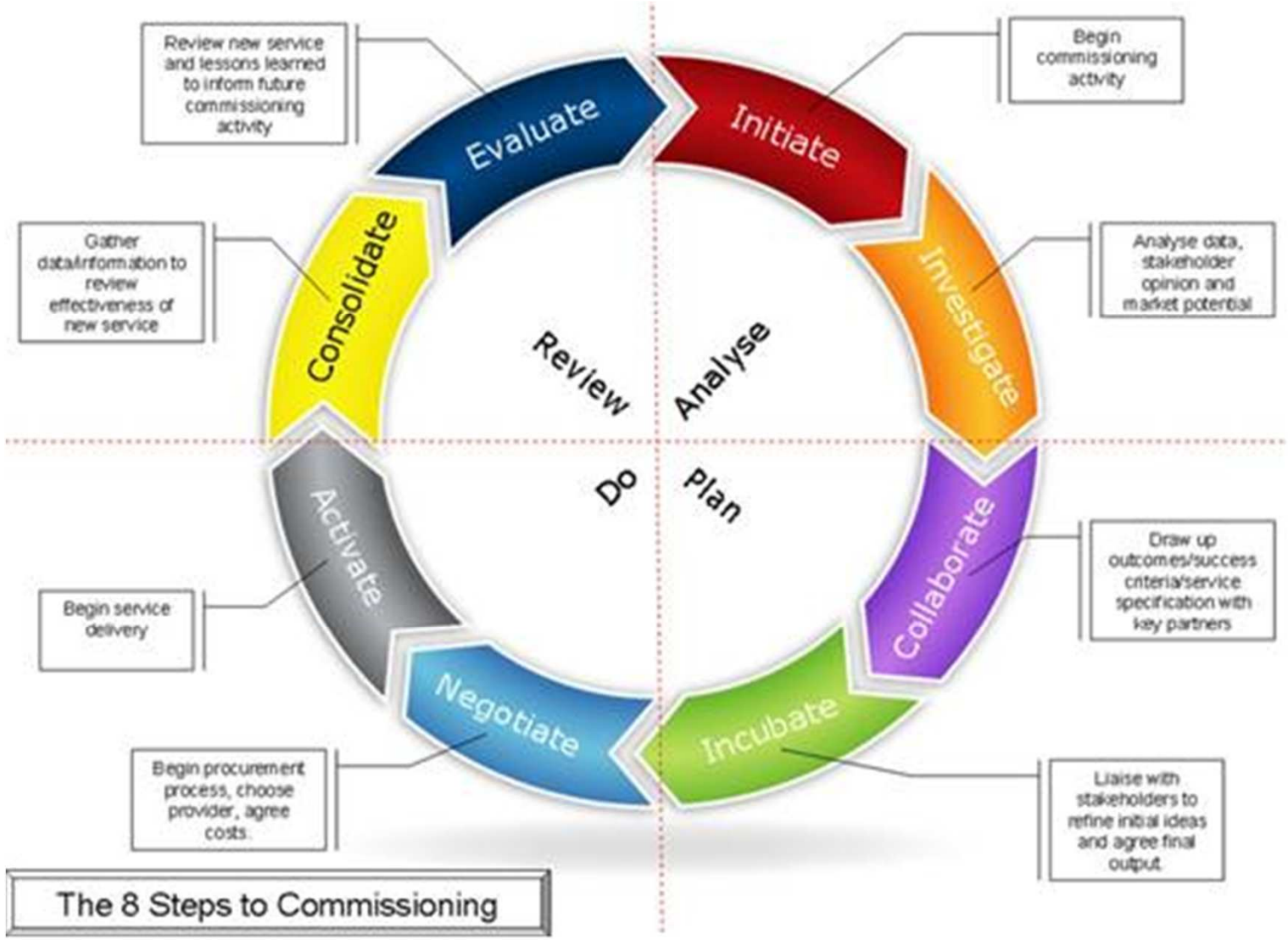
Collective Ambition

- People in Halton living healthy lives in vibrant communities.
- A radical upgrade in prevention
- Fundamental change towards people managing their own health.
- MECC & care closer to home.
- Development of local care organisations that are mostly in the community.
- Providers working together so everyone can benefit from high standards of specialist care.
- High standards across all services
- Sharing clinical and non clinical functions across lots of organisations.
- Reduced costs and improved health and social care outcomes.
- Integrated approach across health and social care
- Enabling the local population to understand what is appropriate in terms of when to access healthcare and successfully navigate local assets and care facilities (when and how)
- Person-centred care
- Collaboration not competition
- Tackling inequalities.

Joint Commissioning Commitments will:

- Focus on people and places not organisations.
- Take a life course approach
- Work in partnership to co-produce
- Be financially sustainable
- Align resources where appropriate
- Be fair
- Be innovative
- Strive for best quality services.
- Safeguard commissioning landscape as it changes.
- Be accountable and hold to account to offer assurance (system oversight) rework

Commissioning & Provider Approach



Welcome to the Cheshire and Merseyside Health and Care partnership Self-Assessment Matr
This matrix is based on the Cheshire and Merseyside Place Based Care Framework

What is this matrix for?:
Leaders of Place based care programmes will be asked to self assess themselves against eac
description of "What excellent looks like")
This will allow each Place to identify areas of strength, areas for development, inform best pra
review and collaboration across Places.
Across Cheshire and Merseyside the self assessments will be brought together into a single do
best practice across Places and also help us identify if there are any challenges and barriers

The self assessment can be repeated at regular intervals to enable Places to track progress o

What about the Programmes?
The 19 cross cutting programmes have been asked to contribute to the "what excellent looks
the interdependencies between their work.

How does the self assesment work?
On the "PLACE SELF ASSESSMENT" tab each of the core elements of the Cheshire and Mersey
These are then broken down into "sub elements"
In column F Place leads are asked to use the drop down boxes to describe the extent to whi

In column G Place leads are asked to use the drop down boxes to describe how broadly the
neighbourhoods/PCNs/hospital footprints has a more fully implemented model than others)
When scoring you should take into account the description of "what excellent looks like". To b
your area.
Place leads may want to consider buddying up with another place and using the matrix as a
good ideas/best practice
The sub - elements and the descriptions of what excellent looks like are ambitious - as they sh
care model. It is fully anticipated that places will not have full implementation across many s

References:
The 10 point plan for Place and the sub-element descriptions of what excellent looks like hav
Delivering sustainability and transformation plans: From ambitious proposals to credible plans
Programmes and Dudley Multi-Specialty Community Provider Outcomes Framework (publishe

PLACE NAME: TEST

CORE ELEMENTS		SUB-ELEMENTS	WHAT DOES EXCELLENT LOOK LIKE?	Level of implementation	Level of coverage	Narrative (inc barriers, opportunities, challenges)
Collaborate and integrate	1.1	There is a governance system that supports integrated change and is endorsed by your Health and Wellbeing Board	There is a written MOU or integration agreement that sets out the shared vision and how the partners will work together to deliver this vision. The system has mechanisms that allow providers and commissioners to disinvest and reinvest to support the new care model. This will include methods to make decisions and mitigate risks collaboratively. Partnership includes VCSE representation. Places understand their representation on C&M HCP Programme Boards and have a mechanism for making decisions on their recommendations.			
	1.2	There are pooled budgets to maximise the local £	The local authority and CCG have a pooled commissioning budget to support the delivery of integrated care. This will be wider than the minimum Better Care Fund and will support the true integration of health and social care services. The local authority and CCG have a pooled budget for commissioning care packages for people with Learning Disability and/ or Autism. There will be an integrated infrastructure to oversee this pooled budget with robust analysis of the impact of spend. There is acceptance of the concept of invest to gain and agreement on a mechanism for providers and commissioners to invest back into parts of the system when there are savings. There is an integrated infrastructure to consider where spend can be reduced (eg reduction in costly OOA packages) and look to bring care closer to home. This includes planning for services within local catchment such as Supported Living/ Residential Care to meet more complex needs. Personal health budgets are promoted within this system.			
	1.3	There are joint strategies and delivery plans (agreed between the CCG, Local Authority, and all significant local providers - including the independent, voluntary and third sector)	CCG, Local Authority and all significant local providers have agreed strategies and delivery plans that underpin the vision for place based care. Strategies and plans at place level refelct the priorities of C&M wide programmes and, where appropriate, translate these into local delivery.			
	1.4	There is a collaborative leadership approach that includes mechanisms for staff and citizen engagement	There are mechanisms to make changes and improvements that include input from patients, community, clinicians and non-clinical staff Transformational delivery plans include a comprehensive programme of involvement from relevant service users. All staff with a role in planning, commissioning or delivering services in your Place have an opportunity to 1) understand what your proposals are, how they will impact them and their ways of working 2) engage and influence decisions. There is work with your local Healthwatch and VCSE, building on existing local relationships and the connections you have in different communities to ensure that a diversity of views are captured, including marginalised communities and those groups seldom heard. Places have a plan for using media and social media activity, a series of engagement events and a regular flow of communication updates using the range of channels across the constituent organisations keep people informed about local plans and provide an opportunity to take part and share experience and expertise. There is co-production with people who use services spans service design, decision-making, mobilisation and monitoring. A key element of this is ensuring that representation is found from people with lived experience (eg CYP for CYP projects).			
	1.5	There is a specific plan to develop a collaborative culture	A cultural and organisational diagnostic will have been undertaken. A live development plan will be underway and senior leaders held to account. There is a specific communication and engagement strategy that encourages cross organisational working			

	1.6	There is a shared culture of continuous improvement	Monitoring and evaluation is embedded. A learning culture is established with leadership using evaluation to inform decisions There is an agreed approach for change that is recognised and adopted across the system There is a common language for system change and agreed data sources to generate a single version of the truth. Programmes use all opportunities for shared learning at local, regional and national level- with investment in evaluation of programmes to demonstrate improvement			
	1.7	There is a jointly agreed engagement plan for your place	A co-produced place wide plan has been developed, to maximise local capacity. As well as colleagues from CCGs and Trusts, this means working with local authority colleagues, patient groups, charities and VCSE organisations. There is agreement on when engagement is happening, how it will feed into the decision-making process, and how you will feed back on the involvement that has taken place. A substantial plan is agreed with your council to ensure it is fully involved in the development of the Place Plan. Members are regularly informed of your thinking and involved in decisions via agreed channels and early on in the process. There is a process to ensure that the views of people who use services are taken into account			
2	1.8	Health needs of the whole population are understood, through population health segmentation, predictive modelling and wider actuarial analysis working in accordance with relevant information governance	Understanding population health need will include use of JSNA, and aggregated data drawn from all significant local providers. This can be matched with service activity to enable the integrated system to invest resources where it can have the biggest impact. There is a clear focus on reducing health inequalities. The system has access to BI and analytics skills to interpret this data and to undertake population health intelligence and analytics.			
Establish neighbourhood hubs						
	2.1	There are identified hubs/neighbourhoods/primary care networks that broadly cover a population of 30-50k	There are groups of GP practices, working with other providers of care to provide coordinated and anticipatory care. These groups use a multi-disciplinary approach that crosses organisational and professional boundaries. Groups of GP practices have "cancer champions" who are skilled at providing non-urgent care to people affected by cancer and have strong links with MDTs GP practices should have a supportive care register which includes people at end of life. (this should be c. 1% or practice populaton) Personalised support care plans are in place for people on this register. GP Practices making best use of LD Health Facilitators and training around reasonable adjustments, Annual Health Checks and STOMP. GP Practices are working to become autism-friendly			

	2.2	Neighbourhood Hubs coordinate care delivery spanning physical, mental health and social care.	Standardised protocols are fully implemented across all primary and community services and are operational within the care model. They are evidence based informed by best practice and shared learning across the sites, designed by clinicians and social care professionals across the site footprint. Implementation is supported by rapid feedback cycles and professional governance to ensure timely adaptation and reaction to performance of protocols and pathway GPs, ideally 24/7 incorporating out of hours cover for on the day appointments Primary and community care teams work as one team with fewer boundaries and handoffs and colocation where possible. Health and wellbeing staff including: health visitors, school nurses, social prescribing link workers, youth workers, drug and alcohol staff, social workers, mental health staff, as required, be part of the Primary Care Networks and the Multi-Disciplinary Team model Neighbourhood hubs will provide a route for new primary care roles Nurse and Nurse prescribers picking up the walk in treatment Paediatric early morning and afternoon cover to reduce the 50% unwarranted A&E attends from children Social worker presence to ensure any social needs are covered/guided at source. Third Sector navigators (or social prescribing link workers) to ensure the direct route to social prescribing. Rehab and Physio staff offering community treatment to avoid re admission			
	2.3	Hubs act as a route for delivery of secondary services in the community	There is access to geriatrician support to support direct access avoiding A&E or potential admission (including from care homes) There is a fully interoperable data set meaning clinicians will have access to the summary care record, care plans and patient notes wherever they are treating patients. This will include information on cancer and EOLC treatment and care plans. Streamlined referral pathways into specialties ensure that cases are appropriately triaged and diagnostics are prepared. Hospital specialists have a more holistic understanding of patients by linking into Primary Care Networks and participating in MDTs, offering phone advice, electronic advice and delivering training.			
	2.4	Wider public services are included within networks	Networks are in place which include wider public services like housing, education, employment, fire and police and all combine to support patient self-care			
4	2.5	Hubs are supported by fully interoperable technology systems	We have a digitally mature system with shared care records so health issues are identified sooner and people are treated more effectively. Hubs can access an interoperable record to enable seamless care.			
Improve access to primary care resources	3.1	Primary care networks have been implemented	https://www.england.nhs.uk/gp/gpfv/redesign/primary-care-networks/ Links with Primary Care Networks to develop referral pathways, learn from service information to ensure secondary care services are focused on patients with greatest acuity and that primary care are supported effectively to support their patients as much and as long as safe and effective. Appropriate use of Advice and Guidance and eReferrals There is a process for ongoing shared learning on inappropriate referrals and late presentation of disease to secondary care.			
	3.2	People can access a digital first offer from primary care	All GP practices offer patients the opportunity to book online appointments, request repeat prescriptions and have access to electronic records. Using local beta access to national NHS programmes where relevant Reasonable adjustments are in place to support individuals who struggle with digital and telephone access. Patient Portal apps as Patient Centred Record			

5	3.3	Enhanced primary care that offers convenient access to GP appointments	A range of appointments for patients to access same-day, including telephone consultations, e-consultations and walk in clinics, as well as face to face appointments. No patient is attending A&E because they cannot get an appointment with the GP 100% coverage of GP Extended Access, compliance with all seven core standards, and direct booking available though NHS 111.			
Mobilise community assets						
	4.1	There are established partnerships with schools and workplaces to promote healthy eating and physical activity, using all community buildings and assets such as sports teams, emergency services, housing and local leaders.	Community programmes focusing on healthy eating, physical actvity and health promotion include cancer awareness messgaes and encourgae uptake to national screening programmes. Smoking cesssation is a key priority. We use an assets based approach making the most of local amenities, people, community groups and talents to embed prevention. We are also offering Mobile Health Kiosks the community use. All local places have health improvement services in place that we co create with.			
	4.2	Workforce health charters are in place in your large local employers	Work with local health partners and local Chambers of Commerce to support this			
	4.3	The strategic estates strategy identifies and facilitates the disposal of surplus land and buildings	All assets mapped across each system with a target utilisation of key buildings at 80% by March 2021. Key sites identified for disposal and land disposal opportunities will be actively managed at a system level and in line with our fair shares regional target. Carter targets to reduce non-clinical space in key acute sites will be managed at a system level in line with the Estates Strategy metrics. Place estates plans will be reviewed and updated annually to reflect local priorities and include any planned capital spend or future requirements.			
6 **Promote self care and prevention**						
	5.1	An effective population health framework is embedded in local strategic and delivery plans	The Cheshire and Mersey Population Health Framework provides a detailed and comprehensive approach to delivering Population Health effectively The framework has been adopted by the collaborative leadership group. The framework has been cross referenced with local place development plans to understand where the principles of population health can be adopted. Mental health features highly in health frameworks as a continuing area for improvement in C&M			
	5.2	Make Every Contact Count (MECC) training been delivered to all neighbourhood hub teams	Contractual levers incentivise roll out of MECC training for all staff groups. Brief interventions re; smoking cessation and the importance of screening are included. Trusts deliver Prevention of Ill Health CQUINS.			
	5.3	There is a plan in place to increase % of population who have had NHS Health Check	There is a plan in pace to increase uptake of the 3 national cancer screening programmes There is a plan in place to increase the number of people with SMI receiving physical health checks. Promotion of eye screening All places sign up to Cheshire and Merseyside Prevention Pledge			

	5.4	There is a mechanism in neighbourhood hubs to offer signposting to non-clinical services (social prescribing)	There is a registry or map of community assets to underpin social prescribing Neighbourhoods have people who are able to signpost to services There are clear and easily navigated pathways to link people to the appropriate community assets, developed in partnership with the voluntary, faith and community sector Neighbourhoods have people who are trained in coaching and active listening skills to support people to embed new activities and behaviours. These people have awareness of cancer and are able to identify those with cancer specific needs. There is a plan in place to increase the number of people accessing social prescribing Social prescribing includes access for people with LD & autism with some specific resources for those with more complex needs who may not be able to access the universal offer.			
	5.5	Person centred care has been implemented	People with long term conditions (including cancer) and low knowledge, skills and confidence (activation) are systematically identified and supported to take control of their own health and wellbeing, tailored to their level of knowledge, skills and confidence. People with LD and/ or Autism who have long term conditions are systematically identified and supported to take control of their own health and well being. This is particularly important due to the possibility of premature mortality. There are in house training and education programmes for staff, patients and clients on self-management, health literacy, behaviour change, MECC and specialist topics. The 3 key steps for person centred care are: 1) identifying needs through: • Patient Activation Measure (PAM) or a suitable alternative approach to measure level of activation (eg eHNA) • care and support planning conversation to understand needs and preferences – using for example the personalised care & support planning tool – Think Local Act Personal; A systematic approach, to support early indetification of people in the last 12 months of life, e.g using a clinical search tool 2) providing tailored support through: • self-management education – including generic and condition specific courses, reflecting the needs of the local population. Examples include the			
	5.6	There is a model of anticipatory care - using population health analytics, case finding and risk stratification to identify people at risk of deterioration or exacerbation and put mitigation in place.	The model draws from a wide range of data sources and will use evidence based algorithms or disease registries to identify individuals at risk of a sub-optimal outcome. These systems need to generate lists of individual names that can be considered at hub/neighbourhood or practice level neighbourhoods/hubs need the skills to interpret/tailor this analytics in response to local need. There is systematic use of a supportive care register at practice level to review people at end of life & enables proactive care management There is a clear pathway back to secondary care for patients who relapse or are experiencing consequences of their cancer and its treatment. Safety netting is in place to pick up patints with signs of deterioration whilst on routine surveillance- eg. MyMedicalRecord remote patient management system Clinical audit into high intensity user pathways are carried out There is a clear pathway to community LD teams for people who may require additional support. Neighbourhood hubs have arrangements in place to identify people who miss annual health check/GP appointments and ensure follow up			

7 **Actively support people with long-term health and care needs**	5.7	Patients can access their own records	There is roll out of NHS app or other patient portal.			
	6.1	Integrated care records are in place to ensure effective monitoring and to support decision making	All relevant professionals are able to access a longitudinal health record that brings together treatment information from all providers to enable joined up care. The record contains contemporaneous and as near to real time information as possible There should be a single (trusted) assessor process and a single care plan that all appropriate professionals can access There is a mechanism to bring in information from regional and tertiary providers as well as local orgs. There is a consent model that gives the individual control over what information they want to share There is an Electronic Palliative Care Coordinating System (EPaCCS) which works with all local providers enables a longitudinal health record			
	6.2	Use of technological applications, where appropriate, to prevent or signal deterioration	Digital tool are in place to enable symptom reporting outside of clinical settings eg falls sensors, patient reporting their own symptoms, telemedicine and telemonitoring Digit@LL enhance / empower workstream and EPR/HSLI developments with providers are fully implemented Telehealth, apps and patient portal to assess, record and escalate are explored Digital tools enable and support self care and effective self management			
	6.3	Health and wellbeing staff in primary care hubs and multi-disciplinary team for complex care	MDTs design and deliver shared care plans. They wrap about GPs and provide care for those with long term conditions and those at highest risk of developing a complex condition MDTs are formed at the locality or neighbourhood level preferable at 30,000-50,000 people as this is the most effective unit for these teams to operate across MDTs regularly review patients that have been identified as being at the greatest risk of developing complex needs as well as those who already need high levels of support MDTs have access to mechanisms that facilitate ongoing and unscheduled conversations remotely so that patients cases are discussed in real time and they can access support and advice in a timely and efficient manner. This may include linking hopsital specialists into the out of hospital MDT to enable the team to manage complications, seek advice and change treatments without the need for a hospital referral. MDTs at neighbourhood level are skilled and equipped to deal with the specific needs of people with cancer. Advance care planning and understanding preferred place of care reduces the number of patients in hospital at end of life. Primary care professionals can access specialist advice 24/7 Patients identified as being in the last 12 months of life should be managed through a supportive care register in primary care and have a personalised support care plan. Residents in care homes identified in care homes should have the same equity of review, support and personalisation for their individual preferences and needs to be met and hospitilisation avoide MDTs at neighbourhood level are skilled and equipped to deal with the specific needs of people with LD/ autism, including skills around forensic issues			

	6.4	Shared decision making is embedded in all settings	The named clinician or MDT designs the care plan with the patient and carer. This is person-centred and based on positive risk taking. The care plan is shared with providers across the system and implemented by MDTs. The patient will be supported by a single named co-ordinator and a personalised care and support plan developed including anticipatory care ,do not resusitate information, preferred place of care and preferred place of death. The PCSP will be shared using EPaCCS Realistic shared decision making to ensure patients are fully prepared and aware of the benefits and limitations of interventions; to provide informed choice. Hospital specialists and Community Trust specialists increasingly run joint ambulatory clinics in the community and be part of primary care Multi-Disciplinary Teams			
	6.5	The enhanced health in care homes model is implemented	https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf			
8	**Care closer to home - hospitals without walls**					
	7.1	Professionals deliver services at home as an alternative to inpatient care to avoid admission to hospital, e.g. Hospital at Home	Outpatient clinics - assessment, preconsultation and dignostics are available in the community rehabilitation and reablement is available in the community. Specialists, including consultants, are integrated physically and virtually into community teams providing advice without the need for referrals chemotherapy at home continues to roll out as an option. People with cancer can access rehab in the community. Patients can be seen as an outpatient in the local hospice, this includes elective admission as a daycase for symtom management such as blood transfusion Crisis Resolution Home Treatment Teams meet core fidelity The CCG and LA (working with education and providers) use Dynamic Support Databases to identify people with LD/A at risk of hospital admission (all ages). Amber or Red assessment triggers a well-being MDT or C(E)TR. Intensive Support is provided to people at Amber/ Red in their own homes to address escalating needs. This is currently available for adults, and is a development action for CYP. Home treatment such as home dialysis for kidney failure is considered in all projects, supported by telehealth and apps Guidance to staff to share information on clinical and lifestyle risks in referral and discharge summaries to ensure that prevention is addressed at all points in pathways and that patients are included on relevant disease registers as early as			
	7.2	There is access to diagnostic equipment in the community	Use of appropriate diagnostics in primary and community care to support specialty pathways			
	7.3	Interoperable systems linked with Acute settings to ensure speedy results, XRAY, Bloods etc.	C&M Share2Care programme and connect workstream are fully implemented Acute Trusts to be linked by a collborative Picture Archiving Commuication System (PACS) this enables radiology images to be viewed at each Trust regardless of where in the network the image was captured. Digital pathology is implemented that: o Ensure equity of access for all patients in Cheshire and Merseyside to specialist expertise, in whichever hospital the patients have their biopsy and the pathologists work o Facilitate inter-laboratory referrals o Facilitate intra-laboratory consultations between colleagues o Move towards a more standardised method of reporting cancer cases using structured data capture and use o Provide essential infrastructure to allow the implementation of algorithms to assist decision making Interoperability to ensure results are shared across the entire system, between primary / community care and across specialty care to avoid repeat testing. Particularly relevant for haematology, orthopaedics and nephrology Technology systems on site to pick up BP/AF with direct response for treatment or relevant intervention			

	7.4	Proactive case management is in place to provide alternatives to hospital-based intervention in order to prevent unnecessary admissions and ensure earlier discharge	Trusted assessors carry out a holistic assessment of need on discharge Coordinated discharge planning by an integrated team based on joint assessment processes and protocols. The care plans are transferred to community care team Discharge to access is implemented providing short term care and reablement in people's homes or through using "step-down" beds to bridge the gap between hospital and home Trusted Assessors should identify patients at end of life and expedite discharge especially those patients identified as being in the dying phase Person-centred discharge planning is in place for all inpatients, supported by timely Care (education) and Treatment Review for people with LD Up-to-date risk assessments are used to support decision-making, based on positive risk-taking. Transition is carefully planned to suit individual needs, with clearly identified actions to ensure the legal framework, care provider training and any housing adaptations are progressed. Adopt holistic approaches to history taking to address lifestyle and other risk factors and use this information in care planning and include in discharge			
9	**Integrated urgent care and single point of access**	.				
	8.1	An Urgent Treatment Centre (or equivalent) established	UTCs designated, in line with the national requirements for access, providing a clear third option in addition to A&Es and PCHs, with evidence of efficacy being established. These include: access to diagnostics and x-ray third sector support, social navigation and information portal to borough assets A rapid diagnotic centre model for patients with vague symptoms suggestive of cancer is fully implemented			
	8.2	Urgent Care Centres are established to provide integrated services for populations of 100k plus	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres–principles-standards.pdf			
	8.3	A Child Health Hub incorporated into UTC	Community clusters established acting as a bridge from hospital to home, supporting the development of personalised, family centred care through a network of teams working in localities and neighbourhoods.			
	8.4	Integrated discharge and reablement	There is an integrated model of discharge and reablement that supports early appropriate return to normal place of residence.			
	8.5	There is a rapid response service to quickly assess, treat and support patients at risk of hospital admission in their own home, step up services are available as appropriate	There is a rapid response service with advanced skills to assess, provide some immediate treatment, discharge or refer/deliver care to patients in the community, this may include paramedic practioners There is an acute oncology service across the whole Alliance that meets NICE guidelines and provides 24/7 support for people at risk of complications of treatment. This includes support for low risk neutropenic patients to be treated at home. The CCG and LA (working with education and providers) use Dynamic Support Databases to identify people with Learning Disability / Autism at risk of hospital admission (all ages). Amber or Red assessment triggers a well-being MDT or C(E)TR. Intensive Support is provided to people at Amber/ Red in their own homes to address escalating needs. This is currently available for adults, and is a development action for CYP.			

	8.6	There is a 24/7 single point of access to enable appropriate signposting to an on-the-day response to services to keep people well at home.	There is a fully integrated 999, 111 and Clinical Assessment Service offer, with NHS 111 usage at or above the national average This includes: A single phone number to access a triage hub which has real time data showing capacity and utilisation of place based assets clinical triage - through a clinical assessment service access to interoperable patient record to enable safe handovers and prevent people repeating information Hub can access services in GP (inc GP out of hours), adult social care, safeguarding, therapies, third sector and some specialist services (eg acute oncology) A single point of access at locality level for the assessment and triage of cancer related issues. This utilises recognised risk assesssments such as the UKONs triage tool A crisis care model for C&M in development which includes NHS 111. This to be implemented in all places once developed.			
	8.7	Effective signposting to appropriate treatment centres in the event of a crisis	There is a programme of engagement to support people to understand what options are available in the event of a crisis			
	8.8	Patients are directly booked, from the first contact, into the most appropriate service	This includes: out of hours, in hours or at an urgent and emergency care hub or patients are booked into a planned appointment on a future date if their need is not urgent. All people undergoing treatment for cancer have certainty of the next steps in their pathway and access to a named key worker By March 2020, ensure providers: 1) describe and publish all mental health GP Referred Services in the NHS e-Referral Service through a Directory of Service, offering choice of any clinically appropriate team led by a named Consultant or Healthcare Professional, as applicable; and 2) ensure that all such services are able to receive Referrals through the NHS e-Referral Service. 3) make the specified information available to prospective Service Users through the NHS Choices Website, and must in particular use the NHS Choices Website to promote awareness of the Services among the communities it serves, ensuring the information provided is accurate, up-to-date, and complies with			
Engagement Framework to Develop Place 5 Year Plans	9.1	Local Engagement Plan	An engagement plan developed together, as a Place, to maximise local capacity. As well as colleagues from CCGs and Trusts, this means working with local authority colleagues, patient groups, charities and VCSE organisations. You agree when engagement is happening, how it will feed into the decision-making process, and how you will feed back on the involvement that has taken place.			
	9.2	Elected representatives	A substantial plan is agreed with your council to ensure it is fully involved in the development of the Place Plan. Members are regularly informed of your thinking and involved in decisions via agreed channels and early on in the process.			
	9.3	Staff	All staff with a role in planning, commissioning or delivering services in your Place have an opportunity to 1) understand what your proposals are, how they will impact them and their ways of working 2) engage and influence decisions.			
	9.4	Community and patient voice	You work with your local Healthwatch and VCSE, building on existing local relationships and the connections you have in different communities to ensure that a diversity of views are captured, including marginalised communities and those groups seldom heard.			
	9.5	Public	Media and social media activity, a series of engagement events and a regular flow of communication updates using the range of channels across the constituent organisations keep people informed about local plans and provide an opportunity to take part and share experience and expertise.			

REPORT TO:	Health and Wellbeing Board
DATE:	10 July 2019
REPORTING OFFICER:	Simon Barber, Chair of the One Halton Provider Alliance and CEO at North West Boroughs NHS Foundation Trust
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Provider Alliance Update Report June 2019
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is for the One Halton Provider Alliance to provide an update to the Health and Wellbeing Board. To provide assurances, document decisions made and where applicable seek approval.

2.0 RECOMMENDATION: That

1) **the report be noted;**
2) **the Board notes the six priority areas (workstreams) identified by the Provider Alliance; and**
3) **the Board approves the Terms of Reference for the Provider Alliance.**

3.0 SUPPORTING INFORMATION

3.1 **Provider Alliance Purpose:**

The purpose of the Provider Alliance is to bring about effective collaboration across the whole of the health and social care system in Halton and for the system to support an end to competitive behaviour between providers.

3.2 **Provider Alliance Membership:**

The Provider Alliance is made up of the most senior leaders from:

- GP Health Connect (Primary Care Network)
- Widnes Highfield Ltd (Primary Care Network)
- Bridgewater Community Healthcare
- North West Boroughs Healthcare
- St Helens & Knowsley Teaching Hospital
- Warrington and Halton Hospitals
- Adult / Children's Social Care; Halton Borough Council
- Public Health; Halton Borough Council
- Two Voluntary Sector Representatives (includes Housing Sector)

3.3 Voluntary sector representation is expected to commence from July 2019, following a structured nomination process managed by Halton & St Helens Voluntary and Community Action.

3.4 In January 2019 it was agreed by all of the Providers that the lead for the Provider Alliance should be the GP Federations (now Primary Care Networks) and it was incumbent on the other providers to equip them to take on that role, recognising it would take time to embed. Simon Barber, Chief Executive of North West Boroughs was asked by the Primary Care Networks to Chair the Provider Alliance for at least six months.

3.5 **Governance:**

The Provider Alliance is a decision making group that reports directly into Halton Health and Wellbeing Board. A note of all decisions made will be shared with the Health and Wellbeing Board.

3.6 The Provider Alliance will discuss proposals and ideas with Commissioners as required, but as a minimum they will come together quarterly at the One Halton Forum as a way of information sharing and ensuring Provider and Commissioner are in agreement on all matters One Halton.

3.7 The Health and Wellbeing Board is expected to hold the Provider Alliance to account for the delivery of services as part of One Halton.

3.8 **Meetings:**

Since the last Health and Wellbeing Board, the Provider Alliance has met three times on 3rd April, 1st May and 5th June. A full day workshop took place on 31st May to consider priorities for Halton and how working collaboratively the Provider Alliance might focus on delivering improved outcomes through key priority areas.

3.9 **Key Decisions Made:**

- Terms of Reference were agreed. (Available as Appendix 1)
- Halton Integrated Frailty Service has experienced some delays with the service start date; the £500,000 investment from Cheshire & Merseyside Health Care Partnership is planned to be spent in full, recruitment has commenced. It was agreed quarterly reporting will be required. The service will need to be evaluated in year, to ensure it is part of 2020/21 contracting discussions to seek recurrent funding.
- One Halton has received £12,000 development funding from NW Leadership Academy. £4,000 has specifically been identified for the Provider Alliance and has so far been used to facilitate the Provider Alliance Workshop. The remaining funding is still being considered; it will be spent during this financial year.
- Cheshire & Merseyside Health Care Partnership Place Based Matrix has been issued for Place to self-assess against excellence. Providers will review and comment to form part of the final submission from One Halton.

- The Provider Alliance had been tasked by the One Halton Board to review all of the One Halton projects and determine which ones should remain as One Halton. The current projects were reviewed in June; it was agreed to rationalise the number of projects and focus on the priority areas/workstreams identified. The work is ongoing.

3.10 **The priority areas/workstreams are:**

1. **Frailty** - This would include the delivery of the Halton Integrated Frailty Service. There would be a focus on older people and working collaboratively on this cohort group. The intention is now to involve more providers from the Alliance in the shape and delivery of the model.

2. **Place Based Integration** - Providers working collaboratively together towards an integrated and collocated model of service delivery aligned to the Primary Care Networks. The integration will focus on multi organisational rather than individual multidisciplinary teams and will now involve more providers from the alliance in the shape and delivery of the model.

3. **Primary Care Networks** - Establish Primary Care Networks in Halton to support the delivery of the NHS Long Term Plan. These are currently led by the GPs, however will encompass wider Primary Care, Community and Social Care.

4. **Population Health/Prevention** - There will be a focus on the Making Every Contact Count training and approach, specifically expanding the scheme across all of the providers in Halton.

5. **Workforce** - This has been identified as a priority, not an enabler. This would involve capitalising on the strengths of the individual providers in order to promote employment opportunities across providers and across Halton, with schemes such as rotational roles across Halton employers, career promotion in schools and creating a healthy workforce.

6. **Information Management** - This priority is cross cutting across the other five areas and would be embedded in all work areas to provide ease of data sharing across Halton.

3.11 **Warrington & Halton Hospitals NHS Foundation Trust / Bridgewater Community Healthcare NHS Foundation Trust.**

The two organisations have demonstrated their increased collaboration throughout Provider Alliance Meetings and at the Workshop. A detailed update of their closer working arrangements will be provided at the Health & Wellbeing Board 10th July 2019.

4.0 POLICY IMPLICATIONS

n/a

5.0 FINANCIAL IMPLICATIONS

3.1 The Provider Alliance will need financial investment into some of the workstreams/projects. This will be formalised through Project Initiation Documents over the coming weeks to identify specifically what is required, when and potentially where from. It is expected that this funding will come from the Place-based funding that has been approved by the Cheshire & Merseyside Health Care Partnership.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**
The Provider Alliance will strive to improve outcomes for Children and Young People in Halton. It will move away from individual organisations focussing on specific conditions, to a population health focus delivered in a collaborative approach.

6.2 **Employment, Learning and Skills in Halton**
The Provider Alliance has identified Workplace as a key priority area. To make Halton a preferred place to work, Providers have agreed to adopt shared workforce roles which could see employees working across multiple different employers in Halton whilst maintaining the one contract.

6.3 **A Healthy Halton**
The Provider Alliance priorities identify workstreams specifically to achieve a Healthy Halton. Population Health and Prevention projects will be delivered collaboratively across Halton.

6.4 **A Safer Halton**
None

6.5 **Halton's Urban Renewal**
None

7.0 RISK ANALYSIS

n/a

8.0 EQUALITY AND DIVERSITY ISSUES

n/a

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

None under the meaning of the Act

Appendix 1 – Terms of Reference

One Halton Provider Alliance Terms of Reference

PURPOSE

1. The Provider Alliance is established and constituted to provide the Health & Wellbeing Board with an update on the activities of and the decisions taken by the Alliance in order to advance the aims of One Halton.

2. The Provider Alliance will bring about **real and effective collaboration** across the whole of the health and social care system in Halton and for the system to support an end to competitive behaviour between providers.

3. The **Provider Alliance will** work towards a Provider Alliance model so that the commissioners in the borough can identify with a lead of the Provider Alliance

REPORTS TO: Halton Health and Wellbeing Board.

CONFLICTS OF INTEREST

4. To ensure that the meeting is managed effectively for conflicts of interest, the following principles will be adopted:

    - Chairs must consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
    - Members must take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
    - The Vice Chair (or other non-conflicted member) must chair all or part of the meeting if the Chair has an interest that may prejudice their judgement.

5. If a member has an actual or potential interest the Chair must consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

    - Requiring the member to not attend the meeting.
    - Excluding the member from receiving meeting papers relating to their interest.
    - Excluding the member from all or part of the relevant discussion and decision.
    - Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
    - Removing the member from the group or process altogether.

6. The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

DUTIES/ FUNCTIONS:

7. The functions of the group can be categorised as follows**:**

- **Governance**
  - The Provider Alliance shall have regard to the work of the Integrated Commissioning Group recognising that there is a role for BOTH the providers and commissioners in achieving the purpose of the Provider Alliance and the aims of One Halton
  - The Provider Alliance is a decision making group and reports directly to the Health & Wellbeing Board.
  - The statutory sector providers in the Provider Alliance will work with the Primary Care Networks to equip them to take on the role of **lead for the Provider Alliance.**

- **Management & Assurance**
  - The Alliance shall oversee the work programmes of One Halton that relate to provision of services in order to gain assurances that the business of each programme is being conducted effectively.

MEETINGS

8. The Provider Alliance will meet once a month.

MEMBERSHIP

9. The group shall be comprised of:

- Board Chair; GP Health Connect
- Managing Director; Widnes Highfield Ltd
- Chief Executive; Bridgewater Community Healthcare
- Chief Executive; North West Boroughs Healthcare
- Chief Executive; St Helens & Knowsley Teaching Hospital
- Chief Executive; Warrington and Halton Hospitals
- Director of Adult Social Care; Halton Borough Council
- Director of Public Health; Halton Borough Council
- Voluntary Sector Representative

IN ATTENDANCE

10. Where appropriate other members of staff may be invited to attend the meetings of the group.

QUORUM

11. A quorum shall be a minimum of 4 members consisting of at least 1 Primary Care Network representative, 1 representative from Halton Borough Council and 1 representative from the hospital/community providers.

AGENDA

12. The agenda will be agreed with the chair of the meeting and circulated in advance of the meeting

13. The minutes of the meeting will be distributed within 7 days.

14. The meeting will be administered by the One Halton Project Administrator.

REPORTING MECHANISMS

15. The group will provide a written report to each Health & Wellbeing Board meeting.

REVIEW

16. The Terms of Reference of the Provider Alliance will be reviewed annually.

Date: April 2019
Date of next review: March 2020