Public Document Pack

Executive Board

Thursday, 19 November 2015 2.00 p.m.
Council Chamber, Runcorn Town Hall

David W R

Chief Executive

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

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Members are reminded of their responsibility to declare any Disclosable Pecuniary Interest or Other Disclosable Interest which they have in any item of business on the agenda, no later than when that item is reached or as soon as the interest becomes apparent and, with Disclosable Pecuniary interests, to leave the meeting during any discussion or voting on the item.	
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Please contact Angela Scott on 0151 511 8670 or Angela.scott@halton.gov.uk for further information.
The next meeting of the Committee is on Thursday, 10 December 2015

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In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

Agenda Item 3a

REPORT TO:	Executive Board
DATE:	19 November 2015
REPORTING OFFICER:	Strategic Director, People and Economy
PORTFOLIO:	Children, Young People & Families
SUBJECT:	Proposal to Re-profile the Dedicated School Grant
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 To inform the Board on the outcome of the consultation with schools and the School Forum on the proposal to re-profile the Dedicated School Grant (DSG) to address the funding gap to ensure a sustainable and balanced budget.

2.0 RECOMMENDATION: That Executive Board

1) approve the proposal to re-profile the DSG funding for 2016/2017 and 2017/2018; and

2) support Option B.

3.0 SUPPORTING INFORMATION

3.1 On 1st October 2015 the Board agreed that a consultation could be undertaken with all primary and secondary schools and the School Forum on the proposal to re-profile the Dedicated School Grant, in order to ensure that it can be balanced over the next two financial years.

3.2 The Board agreed that the Special Schools Budgets needed to be reviewed and reduced in line with the budget available. For primary and secondary schools the proposal was to reduce the budgets in 2016/2017 and 2017/2018. A consultation document was sent to all school and they were asked whether they would prefer to see a 1.5% cut in each of the two years saving an estimated £863k each year, Option A. Alternatively, it was proposed that there could be a 1% cut in each year alongside the deletion of the pupil growth budget of £180,000 and the Additional Notional SEND funding of £108,500. This would provide estimate savings of £794k each year, Option B.

3.3 A total of 25 schools responded to the consultation by the deadline date. Six schools supported Option A, seventeen schools supported Option B. The remaining schools did not identify a preference for either option. A further four schools responded after the consultation had closed with one

supporting Option A, one supporting Option B, the two other schools did not express a preference. The responses from the schools and the comments made were circulated to all the members of the School Forum at the meeting on 12th October 2015. Following discussions on the options and the likely impact School Forum agreed to recommend approval of Option B to Executive Board.

4.0 POLICY IMPLICATIONS

4.1 A return must now be submitted to the EFA with the formula factors for 2016/2017. Towards the end of December the authority will be notified of its indicative budget for 2016/2017. On receipt of this information the final cash values will need to be calculated by the Finance Team and the Education Funding Agency pro-forma must be completed and returned by 21st January 2016.

5.0 FINANCIAL IMPLICATIONS

5.1 The DSG funding gap is estimated to have increased to approximately £2.5 million. The estimated reduction in school budgets by £794k in each of the next two financial years along with the savings from the special schools budgets should ensure that the budgets available meet the estimated level of need.

5.2 The current level of balances for maintained schools within the borough is £6.69million. In addition, balances are held by the Academies.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**

The funding changes will ensure that we have sustainable budget can meet the needs of all Halton pupils whether educated within the borough or in other LAs or independent specialist provision.

6.2 **Employment, Learning & 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

7.1 These changes will reduce schools budgets over a two year period. These losses will be capped at 1.5% through the minimum funding guarantee for primary and secondary schools. Schools with balances will be able to use these balances to cushion the impact of the budget reduction.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 It is the aim of the School Funding review to create a fairer funding system and ensure the funding is more responsive to the individual needs of pupils and students with high needs whether they are educated in the borough in mainstream provision or outside the borough in independent specialist provision. The profiling of the DSG is aimed at ensuring that there is sufficient funding available to meet the needs of all pupils.

9.00 REASON FOR DECISION

9.1 To ensure that there is a fair distribution of resources across the DSG and that the DSG is profiled so that its budget commitments are sustainable.

10.0 ALTERNATIVE OPTIONS

10.1 Consideration was given to reducing schools budget by £1.8 million to balance the budget in 2016/2017, however, the minimum funding guarantee would cap any reductions to 1.5% i.e. approximately £863,000.

11.0 IMPLEMENTATION DATE

11.1 1st April 2016.

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

Document	Place of Inspection	Contact Officer
School Funding Arrangements 2016/2017	DFE website	Ann McIntyre – Operational Director – Ann McIntyre – Operational Director-Education, Inclusion and Provision & Operational Director - Resources
Schools Funding: Moving Towards a National Funding Formula. Briefing	House of Commons Library	Ann McIntyre – Operational Director – Education Inclusion and Provision & Operational Director

Paper 6702 17th July 2015		Resources
School Forum agenda, papers and minutes 12th October 2015	HBC website	Ann McIntyre – Operational Director – Education Inclusion and Provision & Operational Director Resources

REPORT TO:	Executive Board
DATE:	19 November 2015
REPORTING OFFICER:	Director or Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Respiratory Health Strategy and Action Plan for Halton 2015-2020
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The report presents a new expanded Strategy to address respiratory health for Halton. It identifies key factors influencing respiratory health and provides recommendations for action to prevent respiratory illness, improve identification, treatments and outcomes and ensure provision of appropriate, high quality, primary, secondary and community health and social care services for all ages.

2.0 **RECOMMENDATION: That Executive Board agree the content and ratify the Respiratory Strategy for Halton 2015-2020.**

3.0 **SUPPORTING INFORMATION**

3.1 Respiratory disease is one of the key contributing factors to reduced life expectancy in Halton and is the third leading cause of death after circulatory disease and cancer.

There are significant health inequalities in Halton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Halton as a whole.

Whilst most respiratory illnesses are associated with smoking or exposure to tobacco smoke in the environment, smoking is not the only risk factor to explain the relationship between deprivation and respiratory illness. Work related conditions, housing conditions, fuel poverty, and exposure to outdoor air pollution are all associated with respiratory disease, independently of smoking.

3.2 The 2014 Halton Respiratory Health Profile[1] details the significant respiratory health issues within Halton. The key issues identified within the health profile include:

- It is estimated about 3,916 people aged 16+ living in Halton

[1] http://www3.halton.gov.uk/Pages/health/PDF/health/RespiratoryHealthProfile.pdf

had Chronic Obstructive Pulmonary disease (COPD) in 2010. By 2020 this figure may be as much as 4,420.

- There have been improvements in case finding since 2009/10 closing the gap between the modelled expected number of people with COPD and those known about on GP disease registers. However, the number of people on the asthma register remains lower than the expected number.
- The management of patients with COPD and asthma are in line with the North West and England averages
- There is significant ward level variation in emergency hospital admission rates and at GP practice level. There is also a relationship with temperature, with a greater percentage of admissions seen in the winter months.
- Death rates for COPD have been falling but are above the North West and England rates. Death rates from respiratory causes in those aged under 75 years and pneumonia are also higher than England but similar to the North West.

3.3 Early detection is vital to improve survival rates for cancer. Patients need to understand how to recognise signs and symptoms and ensure they contact their General Practitioner as soon as they suspect they may have a medical problem. There has been a significant improvement in the rate of detection of cancers in Halton. Lung cancer represents the greatest proportion of all cancers within Halton (almost 17% of all cancers)[2] and numbers of cases fluctuates unequally across the Borough. Lung cancer represents a significant burden of respiratory illness for the population of Halton.

3.4 Halton has historically high rates of smoking but has seen a significant the reduction of smoking in recent years. The most recent health profile 2015 data shows that the overall smoking rate is 18.4% and is the same as the England average. Other data from the Merseyside Lifestyle Survey suggests that the smoking rate may be higher than this in areas of deprivation.

3.5 The rate of smoking related deaths is 416 (per 100,000 population), worse than the average for England. This represents 248 deaths per year and is considerable worse than the England average smoking related death rate of 292 (per 100,000 population). Smoking results in considerable respiratory health problems and exacerbates existing conditioned resulting in increases in secondary care usage and poorer outcomes for patients. Halton has seen considerable decline in the numbers of women smoking at the time of delivery, however 19% of pregnant women continue to smoke compared to

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2 http://www3.halton.gov.uk/Pages/councildemocracy/pdfs/CensusandStatistics/General_Cancer_Profile_2013.pdf

12% as an England average. Smoking during pregnancy has considerable consequence to the growth and development of the child, not least a significantly greater likelihood of the child developing severe asthma in childhood and later life. Further improvements in smoking rates remain a key recommendation within the strategy.

The treatment and management of people with respiratory conditions represent a significant challenge on current health and social care systems

3.6 The strategy presents a single vision for respiratory health across all partners to ultimately improve the respiratory health and well-being of people in Halton, and reduce the impact that respiratory conditions have on people and services across Halton.

> Our vision is:
> **to improve the respiratory health and well-being of the population of Halton, from the start to the end of their lives.**

3.7 In order to achieve the vision, the strategy identifies a set of aims to address every element of the health and care system which impacts upon respiratory health. The strategy aims to;

I. **Prevent respiratory ill health**

Increase awareness of how to maintain good respiratory health so that people are aware how to live healthy lifestyles and make informed healthy choices to minimise the risks to poor respiratory health. Ensure that services and agencies activities support activities to prevent poor respiratory ill health.

II. **Earlier detection of respiratory diseases**

Make sure people are aware of the signs and symptoms of respiratory diseases and ensure that they understand they must seek medical attention as soon as possible. Encourage positive health seeking behaviours and ensure robust services and pathways are in place to enable access to early investigation and treatment.

III. **Primary Care and Community based support**

Provide a fully integrated approach to primary care and community based services, to ensure all community treatment and support services are aligned to best meet the needs of patients and carers, and facilitate seamless community services.

IV. **High Quality Hospital Services**

Ensure that pathways and services are in place so that people who need them receive prompt effective treatment for

their respiratory condition and have the best chance to optimise their quality of life and survival.

V. Promoting Self Care and Independence

Ensure that people are placed at the centre of their own respiratory care, able to identify their individual needs and provided with appropriate information, support and interventions to help them manage their own respiratory health issues.

3.8 The strategy provides the evidence and analysis to identify what they key issues affecting the population of Halton are in terms of their impact upon respiratory health for each overall aim. Using this data, in conjunction with key guidance, an assessment of local need and current provisions and gaps, a set of key recommendations and actions are identified in order to achieve each individual aim of the strategy and ultimately improve respiratory health and respiratory health outcomes for people in Halton. The recommendations are covered in detail in the strategy but briefly cover the following areas:

I. Prevent respiratory ill health

● Reduce smoking rates
● Increase appropriate vaccination rates
● Reduce overweight and obesity
● Measures to improve housing quality and warm homes
● Identify opportunities to further improve air quality across Halton

II. Earlier detection of respiratory diseases

● Mechanisms to improve early signs, symptoms and diagnosis of cancer
● Early case finding and rapid treatment access for COPD, Sleep apnoea and Interstitial lung disease
● Ensure risk markers are identified on patient records, known risk occupations etc.
● Consideration of needs of people with learning disability

III. Primary Care and Community based support

● Compliance to appropriate NICE Guidance and Quality Standards
● Pro Active Care programme Local Enhanced Service (2014/15)
● Review provision of pulmonary rehabilitation across Halton
● Establish integrated delivery of respiratory services across Halton
● Improve prescribing, in line with guidance[3], of respiratory

[3] Pan Mersey Area Prescribing Committee Guidelines

medication across primary care
- Improved case finding and rapid treatment access across a number of conditions

IV. High Quality Hospital Services

- Review Warrington & Halton NHS Foundation Trust Rapid Response Respiratory Team
- Review arrangements regarding Halton residents admitted to Whiston Hospital with respiratory health problems

V. Promoting Self Care and Independence

- Develop a range of interventions to support self-management
- Further develop and expand the Expert Patients Programme

3.9 The strategy will inform the continuous development of the Respiratory Action Plan which is implemented and overseen by the Respiratory Strategic group, outcomes against which are measured and fed back through to the CCG and the Health and Wellbeing board.

4.0 POLICY IMPLICATIONS

4.1 The strategy addresses some key issues relating to the provision of services to protect respiratory health and for people requiring treatment and support for respiratory illness. As such the recommendations will cover a broad scope of policy areas across the council, CCG and health and care partners.

5.0 FINANCIAL IMPLICATIONS

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

5.2 Respiratory health is a significant cause of ill health within the Borough and inequalities exist within the distribution of ill health and services which need to be addressed in order to improve respiratory health across the Borough.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
There are number of respiratory health conditions which affect

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http://www.panmerseyapc.nhs.uk/guidelines.html

children to a greater extend. Ensuring that appropriate and high quality prevention, identification and treatment and support services are in place is essential to safeguarding the respiratory health of children and young people in Halton.

6.2 **Employment, Learning & Skills in Halton**
Maximising respiratory health for the population of Halton and limiting the effect that respiratory illness has on an individual, is likely to improve life chances, including employment potential for people in Halton.

6.3 **A Healthy Halton**
Ensuring the health and wellbeing of the population is key priority. Protecting the health of Halton's population is a statutory responsible for Public Health and the Council.

6.4 **A Safer Halton**
None

6.5 **Halton's Urban Renewal**
None

7.0 **RISK ANALYSIS**

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

8.0 **EQUALITY AND DIVERSITY ISSUES**

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

9.0 **REASON(S) FOR DECISION**

The Executive Board will be required to ratify the strategy and agree the recommendations made within it to enable activities to improve respiratory health for people in Halton.

10.0 **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

None.

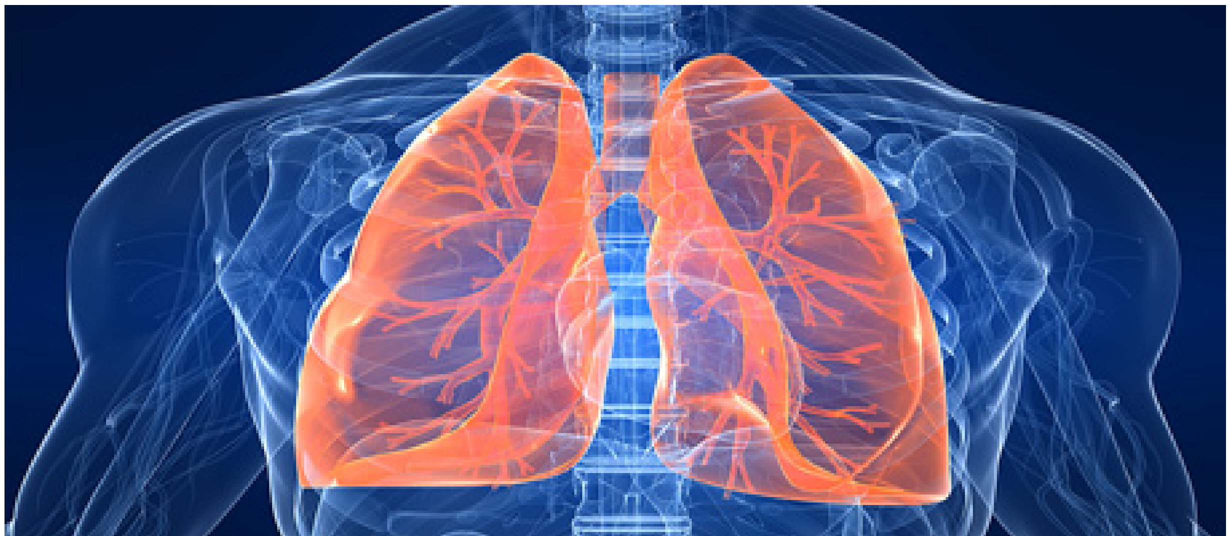
11.0 **IMPLEMENTATION DATE**

Recommendations made will be implemented immediately following Executive Board decision. Action plan development is in progress.

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

None under the meaning of the Act.

Respiratory Health Strategy for Halton 2015 – 2020



HALTON BOROUGH COUNCIL

NHS Halton Clinical Commissioning Group

myhalton living life well

Foreword

Sadly the impact of respiratory disease has no bounds – from the school child with asthma who wakens in the night and is unable to compete with his peers to the elderly COPD patient with recurrent exacerbations and subsequent admissions. Their suffering is devastating for them and their families and there is a real risk of premature death. The impact of exacerbations and poor control places a further burden on the resources of an already stretched NHS.

There are many excellent therapies and guidance but still the basics of delivering evidence-based and personalised care remains essential for effective timely intervention for these respiratory patients.

This strategy will attempt to fully integrate health and social care aspects on respiratory care and encourage a more equitable service across the Borough incorporating primary, secondary and community services. It will empower local health care & other professionals to deliver the best possible care through better organisation, use of evidence-based care, improved self-management, prevention strategies and appropriate effective therapies and interventions.

The CCG, local authority and health and community partners should all be proud to participate in the initiative to improve the health and social well-being of all respiratory patients and their carers in Halton.

Dr Chris Woodforde, Respiratory Lead GP for NHS Halton CCG

People in Halton, on average, live shorter lives than people in many other parts of the country. Respiratory disease is the third leading cause of death after circulatory disease and cancer. There are significant health inequality in respiratory diseases, people in the most deprived communities in Halton, are twice more likely to die from a respiratory illness than the general Halton population.

Smoking and tobacco smoke is a cause of many respiratory problems and is linked to deprivation, but this is not the only link; working conditions, poor housing, fuel poverty and lifestyle are all associated with respiratory disease and more greatly affect people in poorer communities. Only when all organisations and partners are working together with a single strategic vision, and across all sectors, can we deliver a full range of services to reduce the impact respiratory illness has on the people of Halton. Ensuring that we improve opportunities to delay or prevent the development of respiratory conditions, improve access to appropriate good quality health services, and support people with respiratory problems, and their carers, to confidently manage their condition(s) and achieve the best possible quality of life, are key outcomes of this strategy.

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

Executive Summary

Respiratory disease is one of the key contributing factors to reduced life expectancy in Halton and is the third leading cause of death after circulatory disease and cancer. There are significant health inequality issues in Halton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Halton as a whole.

Whilst most respiratory illnesses are associated with smoking or exposure to tobacco smoke in the environment, smoking is not the only risk factor to explain the relationship between deprivation and respiratory illness. Work related conditions, housing conditions, fuel poverty, and exposure to outdoor air pollution are all associated with respiratory disease, independently of smoking, all of which are addressed within the scope of the strategy.

The strategy presents a vision for respiratory health in Halton:

Our vision is:

to improve the respiratory health and well-being of the population of Halton, from the start to the end of their lives.

The strategy provides the evidence and analysis to identify what they key issues affecting the population of Halton are in terms of their impact upon respiratory health for each overall aim. Using this data, in conjunction with key guidance and assessment of local need and current provisions and gaps, a set of key recommendations and actions are identified in order to achieve each individual aim of the strategy and ultimately improve respiratory health and respiratory health outcomes for people in Halton. The recommendations are covered in detail in the strategy but aims and key recommendations include:

I. **Prevent respiratory ill health**
- Reduce smoking rates
- Increase appropriate vaccination rates
- Reduce overweight and obesity
- Measures to improve housing quality and warm homes
- Identify opportunities to further improve air quality across Halton

II. **Earlier detection of respiratory diseases**
- Mechanisms to improve early signs, symptoms and diagnosis of cancer
- Early case finding and rapid treatment access for COPD, Sleep apnoea and Interstitial lung disease
- Ensure risk markers are identified on patient records, known risk occupations etc.

- Consideration of needs of people with learning disability

III. **Primary Care and Community based support**
- Compliance to appropriate NICE Guidance and Quality Standards
- Pro Active Care programme Local Enhanced Service (2014/15)
- Review provision of pulmonary rehabilitation across Halton
- Establish integrated delivery of respiratory services across Halton
- Improve prescribing, in line with guidance[1], of respiratory medication across primary care
- Improved case finding and rapid treatment access across a number of conditions

IV. **High Quality Hospital Services**
- Review Warrington & Halton NHS Foundation Trust Rapid Response Respiratory Team
- Review arrangements regarding Halton residents admitted to Whiston Hospital with respiratory health problems

V. **Promoting Self Care and Independence**
- Develop a range of interventions to support self-management
- Further develop and expand the Expert Patients Programme

The recommendations will inform the Respiratory Action Plan which will be overseen and monitored by the Respiratory Health Strategy Group in order to assess progress and analyse overall outcomes.

[1] Pan Mersey Area Prescribing Committee Guidelines http://www.panmerseyapc.nhs.uk/guidelines.html

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Strategic Context

Scope of the strategy

This strategy will address the key issues around respiratory health in Halton, it will address a spectrum of respiratory illnesses, causes, treatments and outcomes. While this strategy will aim to provide a broad picture, it cannot address every aspect of respiratory ill health within the one document, a number of related issues are covered in other local Strategic documents, for example, A Cancer Strategy for Halton, 2014-2019[2],identifies specific issues and actions around lung cancer ; A Housing Strategy for Halton , 2013-2018[3] identifies the issues around warm, healthy homes which also impact upon respiratory health; Halton Health and Wellbeing Strategy 2013-2016[4] also provides detailed activity and needs around certain lifestyle issues such as smoking cessation, to which this document will refer.

The Respiratory Strategy for Halton will identify the major respiratory health issues affecting the population of Halton and sets out how Health and Social Care organisations in Halton will deliver on its responsibility to meet the needs of people at risk of developing, or affected by, a wide variety of acute and chronic lung conditions. This is a significant challenge, for individuals and their carers and the whole Health and Social Care.

While the strategy cannot cover the full extent of potential lung and respiratory conditions it will focus on conditions which cause the most significant problems for local people and where illness may be preventable or amenable to treatment and where local action could significantly improve outcomes. The strategy will include the conditions: Chronic Obstructive Pulmonary Disease (COPD); Asthma; Pneumonia; Lung cancer; sleep disordered breathing; Interstitial Lung disorders; bronchiectasis; potentially work related lung disorders and other associated conditions.

Why Do We Need A Halton Respiratory Health Strategy?

Respiratory disease is one of the key contributing factors to reduced life expectancy in Halton and is the third leading cause of death after circulatory disease and cancer.

There are significant health inequality issues in Halton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Halton as a whole.

Whilst most respiratory illnesses are associated with smoking or exposure to tobacco smoke in the environment, smoking is not the only risk factor to explain the

[2] http://www4.halton.gov.uk/Pages/health/PDF/health/HWB/ACancerStrategyforHalton.pdf last accessed 3.12.14
[3] http://www3.halton.gov.uk/Pages/councildemocracy/pdfs/housing/Halton_Housing_Strategy_2013-18.pdf last accessed 3.12.14
[4] http://www3.halton.gov.uk/Pages/health/PDF/health/Halton_Health_and_Wellbeing_Strategy.pdf last accessed 3.12.14

relationship between deprivation and respiratory illness. Work related conditions, housing conditions, fuel poverty, and exposure to outdoor air pollution are all associated with respiratory disease, independently of smoking.

The 2014 Halton Respiratory Health Profile[5] details the significant respiratory health issues within Halton. The key issues identified within the health profile include:

- It is estimated about 3,916 people aged 16+ living in Halton had Chronic Obstructive Pulmonary disease (COPD) in 2010. By 2020 this figure may be as much as 4,420.
- There have been improvements in case finding since 2009/10 closing the gap between the modelled expected number of people with COPD and those known about on GP disease registers. However, the number of people on the asthma register remains lower than the expected number.
- The management of patients with COPD and asthma are in line with the North West and England averages
- There is significant ward level variation in emergency hospital admission rates and at GP practice level. There is also a relationship with temperature, with a greater percentage of admissions seen in the winter months.
- Death rates for COPD have been falling but are above the North West and England rates. Death rates from respiratory causes in those aged under 75 years and pneumonia are also higher than England but similar to the North West.

In addition, the incidence and mortality from cancer is higher in Halton than in many other parts of the country. Lung cancer represents the greatest proportion of all cancers within Halton (almost 17% of all cancers)[6] and incidence fluctuates unequally across the Borough. While the incidence amongst men has seen a decline since the early 1990s, the incident rate amongst women continues to increase (increasing by 15.43 cancers per 100,000 population, from 1993-95 to 2009-11). Lung cancer represents a significant burden of respiratory illness for the population of Halton.

Halton has high rates of smoking. In 2014, 22.6% of the adult population smoked compared to an England average of 19.5%[7]. Other data suggests that the Smoking rate within Halton may be 30%, and up to 38% in some age groups (the NHS Merseyside Lifestyle Survey identifies that 38% of 25-34 year olds smoke). The rate of smoking related deaths was 416 (per 100,000 population), worse than the average for England. This represents 248 deaths per year and is considerable worse than the England average smoking related death rate of 292 (per 100,000

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[5] http://www3.halton.gov.uk/Pages/health/PDF/health/RespiratoryHealthProfile.pdf

[6] http://www3.halton.gov.uk/Pages/councildemocracy/pdfs/CensusandStatistics/General_Cancer_Profile_2013.pdf

[7] Halton health profile 2014 http://www.apho.org.uk/resource/item.aspx?RID=142121

population). Smoking results in considerable respiratory health problems and exacerbates existing conditioned resulting in increases in secondary care usage and poorer outcomes for patients. Halton also has a considerably higher proportion of women smoking at the time of delivery, with 18.9% of women smoking at delivery compared to 12.7% across England (2012/13). Smoking during pregnancy has considerable consequence to the growth and development of the child, not least a significantly greater likelihood of the child developing severe asthma in childhood and later life.

The treatment and management of people with respiratory conditions represent a significant challenge on current health and social care systems:

- 547 Children aged under 16 years of age presented at Whiston Accident and Emergency in 2013, 56% (305) of these were due to 'difficulty breathing'. 254 of those attending with difficulty breathing (83%) were subsequently admitted.
- CHIMAT data indicates 88 asthma admissions in 2013/2014 across Warrington & St Helens and Knowsley Hospitals.
- The proportion of people dying from respiratory disease in Halton is higher than the North West average and is significantly higher than the England average.
- Fewer people within Halton with existing respiratory illnesses are protecting themselves from the complications of flu. 89.8% of COPD patients received their annual seasonal flu vaccination compared to 92.7% across England as a whole.
- Adult Social Care records show 572 individuals registered with Care First who have asthma or COPD.
- In 2014/15, Halton CCG spend just over £3.4 million on prescribing for respiratory health. This is approximately 15% of the total prescribing spend for Halton CCG.
- The overall spend on respiratory services, prescribed drugs and patient activity for 2013/14 has been estimated to be £5.8 million within Halton.

Our Vision & Aims

We want to improve the respiratory health and well-being of people in Halton, and reduce the impact that respiratory conditions have on people and services across Halton.

> Our vision is:
>
> **to improve the respiratory health and well-being of the population of Halton, from the start to the end of their lives.**

In order to achieve our vision, this strategy aims to;

I. **Prevent respiratory ill health**
   a. Increase awareness of how to maintain good respiratory health so that people are aware how to live healthy lifestyles and make informed healthy choices to minimise the risks to poor respiratory health. Ensure that services and agencies activities support activities to prevent poor respiratory ill health.

II. **Earlier detection of respiratory diseases**
   a. Make sure people are aware of the signs and symptoms of respiratory diseases to encourage positive health seeking behaviours and ensure robust services and pathways are in place to enable access to early investigation and treatment.

III. **Primary Care and Community based support**
   a. Provide a fully integrated approach to primary care and community based services, to ensure all community treatment and support services are aligned to best meet the needs of patients and carers, and facilitate seamless community services.

IV. **High Quality Hospital Services**
   a. Ensure that pathways and services are in place so that people who need them receive prompt effective treatment for their respiratory condition and have the best chance to optimise their quality of life and survival.

V. **Promoting Self Care and Independence**
   a. Ensure that people are placed at the centre of their own respiratory care, able to identify their individual needs and provided with appropriate information, support and interventions to help them manage their own respiratory health issues.

The strategy will inform the development of a comprehensive action plan to oversee the delivery of actions to enable the achievement of the identified aims within the Strategy. The Strategy and Action plan will be overseen by the Respiratory Health Group. The multidisciplinary Respiratory Health Group will oversee and receive assurance from all partners with regards performance towards achieving the action plan objectives and outcomes. The Respiratory Health Strategy Group is accountable to Halton Clinical Commissioning Group's Service Development Committee, a multiagency group consisting of a range of health, public health, social care and voluntary sector providers.

The action plan will be reviewed at least annually and refreshed as required.

Achieving the Aims

i. Preventing respiratory ill health

Health education and disease prevention activities should inform everyday lifestyle choices for the population of Halton. Motivating people to be aware of and take action to reduce their risks of developing respiratory ill health must remain a key focus of activity within this strategy.

Smoking

In Halton:

The average smoking rate in Halton is now the same as the national average at 18.4%

Up to 30% of adults smoke in deprived areas, significantly higher than the Halton Average (18.4%)

19% of pregnant women smoke at the time of delivery, significantly worse than the England average (12%)

There are 416 smoking related deaths per 100,000 over 35 population per year, compared to 292 as an England Average[8]

Reducing the prevalence of smoking will have the greatest impact upon respiratory disease prevention. Improving access to smoking cessation services and encouraging long term quit rates would have a significant impact on reducing prevalence of a variety of respiratory disease, including COPD, lung cancer, adult and childhood asthma amongst others. Increasing work within schools and youth settings and identifying innovative and best practice techniques to prevent young people taking up the habit of smoking will help limit future impacts of respiratory ill health. There is increasing evidence that young people may be using e-cigarettes as a gateway to smoking. Targeting activities towards limiting the increasing usage of e-cigarettes, and working across agencies to limit access and lobby for legislative change could help prevent people in Halton becoming smokers in the near future.

Current data on smoking prevalence varies, with the national Lifestyle survey suggesting that smoking in Halton is the same rate as the national average but other local surveys suggest that as many as 30% of the local population (in the most deprived areas) may smoke.

Vaccination

In Halton:

In 2013/14, against a national target of 75%

[8] Halton Health Profile 2014, Public health England http://www.apho.org.uk/resource/item.aspx?RID=142121

- 73.5% of those 65 years old and over received their annual flu vaccination
- 51.9% of those under 65 but at risk received a flu vaccination
- 38.3% of pregnant women received a flu vaccination

71.2% of those 65 and over had received a Pneumococcal vaccine (national average 68.9%, 2013/14)

Uptake of childhood vaccinations is generally good, with the Halton average uptake for Pneumococcal and Pertussis vaccines by 12 months and Hib vaccine by 24months being above the 95% national target (although there is wider practice level variation)

Next to clean water and sanitation, vaccination is the most effective public health intervention of all time. Vaccinations can prevent respiratory illnesses.

Promoting and improving the uptake of appropriate vaccination programs (Influenza and Pneumococcal) amongst our target populations is essential to reduce in the burden of respiratory illness caused by influenza and pneumococcal infections amongst the most vulnerable people in our communities (the very young, older people and those with existing chronic health conditions). Achieving recommended uptake of influenza and Pneumococcal vaccination (at least 75% uptake amongst all people over 65, those under 65 with an existing health condition, and pregnant women, and achieving a 90% uptake amongst those with COPD), would make a significant contribution to reducing the number of excess winter deaths in Halton.

The uptake of primary Immunisations in childhood is good. Across Halton as a whole, the uptake of primary immunisations including those preventing respiratory diseases Pneumococcal disease, Pertussis (whooping cough) and Haemophilus Influenzae type B (Hib) were above the national target of 95%. There is some variation across GP practices, with some practices reporting 88.9% while others achieved 100% uptakes. Halton Council are working closely with Public Health England to ensure that we maximize opportunities to increase vaccination coverage across Halton.

Obesity

In Halton:

There is a higher percentage of obese adults than the England average.

35.2% of adults in Halton are obese (England average 23%).

Levels of obesity in year 6 children are similar to the national average (20.4% in Halton compared to the England average 19.1%).

Obesity can have a very serious negative impact on the respiratory system, significantly reducing respiratory health. Some of the health effects of obesity on respiratory system include diseases like:-

- Exertion dyspnoea – severe breathlessness as a result of only minor physical activity. This is a common feature among people who are obese.
- Obstructive sleep apnoea syndrome (OSA) – This condition leads to closing or narrowing of the airways during sleep leading to snoring, repeated waking and lack of adequate and restful sleep.
- COPD - a group of lung diseases that block airflow and make breathing difficult. Emphysema and chronic bronchitis are the two most common conditions.
- Asthma – Obese patients are more at risk of asthma exacerbations. The prevalence of asthma is around 38% higher in overweight patients and by 92% in obese patients. Obese patients with asthma also get more acute attacks, need more asthma medication, need more frequent visits to the emergency department (ED), and have more hospital admissions than non-obese patients with asthma.
- Pulmonary embolism – This is a serious condition where a blood clot gets lodged in the blood vessels of the lungs leading to a life threatening medical emergency. Pulmonary embolism may lead to failure and death.

Respiratory illnesses for which obesity can represent a significant cause have a great impact upon the health of people in Halton and the health services across Halton. There are estimated to be 1328 adults with moderate to severe Sleep apnoea.[9] The cost of treating all people with moderate to severe OSA would be £1,092,406 per year. In 2013-14, there were 180 emergency admissions as a result of COPD across Halton. In the same time there were 43 emergency admissions for adults aged 45-74 years of age as a result of asthma.

Encouraging people to lose weight and maintain a healthy weight through a healthy balanced diet and regular exercise is the only way in which the population of health on can stay within a healthy weight range and reduce the likelihood of obesity related respiratory ill health. Halton has a number of services to promote healthy lifestyles, diet and exercise. Current programmes range from interventions in Schools (Food and nutrition awareness, cooking skills, exercise programmes) to Adult Fresh Start programmes to encourage healthy weight loss, provide healthy food skills and supporting regular exercise programmes and opportunities across the Borough and we need to work across partner agencies and the public to a greater extent to ensure that everyone has an equal opportunity to benefit from the services available.

[9] British Lung Foundation 2015 OSA Calculator

Drugs

In Halton

According to the North West Mental Wellbeing Survey 2012/13

A local schools survey suggests that approximately 5 % of secondary school children had used cannabis in the previous year, which is generally lower than national trends.

In a sample of 500 adults aged 16 and over in Halton 11.3% reported cannabis use

Cannabis use is associated with longer-term damage to the respiratory tract, with an increased risk of chronic bronchitis, asthma and potentially lung cancer. There is also a reported association between cannabis smoking and an increased risk of developing infectious lung diseases such as tuberculosis and Legionnaires disease.

Education to reduce the levels of cannabis use, and prevent young people from using cannabis could help to reduce rates of chronic bronchitis and asthma.

Housing

In Halton

In 2012, 4841 households (9.2% of all households) were in fuel poverty, spending more than 10% of their household income on heating costs. This is not distributed evenly, in some areas within Halton, as much as 26% of households in privately rented accommodation are in fuel poverty.

Halton has seen a general increase in Excess Winter mortality over recent years (although the most recent data is lower than). Nationally, respiratory diseases account for the second highest proportion (32%) of excess winter deaths[10]. Cold homes are a considerable contributor to the excess deaths resulting from respiratory illnesses (particularly exacerbations of COPD) and fuel poverty is a significant cause of cold homes. Damp living conditions are also a major cause of respiratory illness, ranging from allergy to mould resulting in significant rhinitis, wheeze, coughs and exacerbations of asthma and COPD, to increased rates of infections ranging from flu like symptoms to significant lung damage.

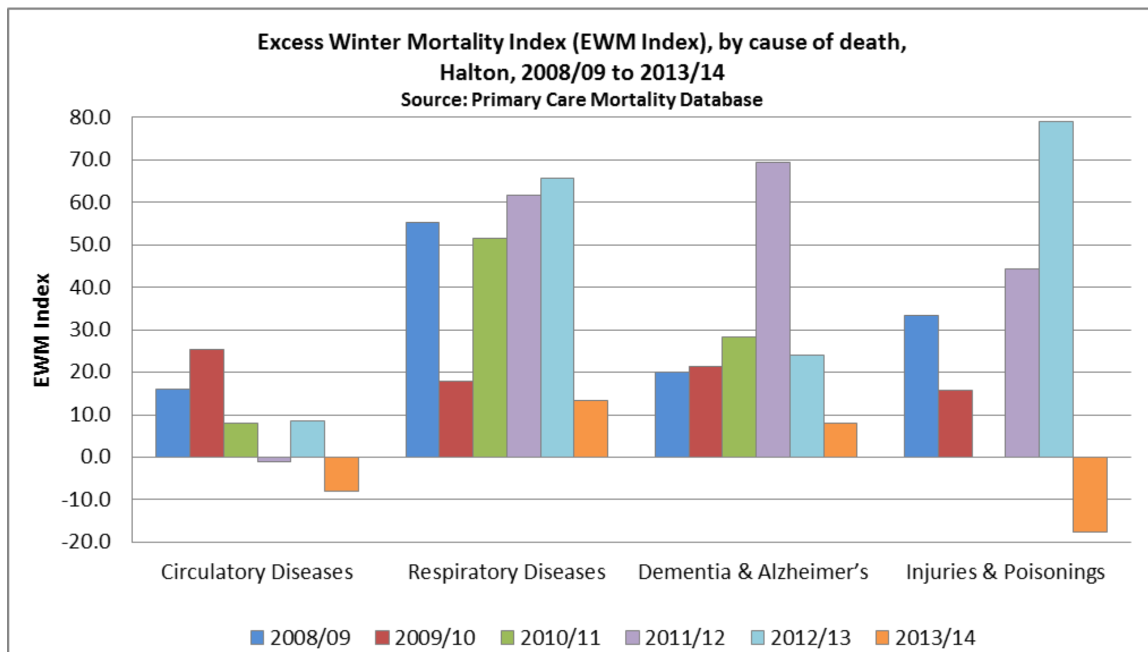
Fuel poverty and cold homes can have severe and life-long effects on children. Studies show that long-term exposure to a cold home can increase hospital admission rates for children and increase the severity and frequency of asthmatic symptoms. Children in cold homes are more than twice as likely to suffer from breathing problems and children in damp and mouldy homes are up to three times more likely to suffer from coughing, wheezing and respiratory illness, compared to

[10] Office for National Statistics (2010). Statistical bulletin *http://www.ons.gov.uk/ons/rel/subnational-health2/excess-winter-mortality-in-england-and-wales/2010-11--provisional--and-2009-10--final-/index.html*

those with warm, dry homes.[11] During 2013-14 there were 82 emergency admissions for asthma in children under the age of 14.

Figure 1 shows the proportion of Excess Winter deaths attributable to different causes, in Halton from 2008 – 2014. This shows that respiratory disease generally account for the highest proportion of these deaths,

Figure1: Excess Winter Mortality Index, by cause of death, Halton 2008/09 to 2013/14



During 2011/12 to 2013/14, of all emergency admissions for lower respiratory tract infections in 0-18 year olds, 81.5% were for those under 1 year of age (the England average was 70%) and 79% of these were for acute bronchiolitis. Bronchiolitis can be best prevented by good hygiene and living conditions. Children who are exposed to passive smoking, can suffer more severely with bronchiolitis.

Halton Housing strategy 2013-18 identifies key actions around developing the affordable warmth strategy and promoting energy efficiency and green deals to help reduce the local burden, although further multidisciplinary and health involvement would benefit the development and promotion of these interventions.

[11] Fact-file: Families and fuel poverty ; Association for the conservation of energy, February 2013 http://www.ukace.org/wp-content/uploads/2013/02/ACE-and-EBR-fact-file-2012-02-Families-and-fuel-poverty.pdf

Environment

In Halton:

Air quality as a whole has improved in Halton over the previous decades.

There are 2 Air Quality Management Areas which regularly exceed recommended emissions levels which can affect health. These are a result of high density traffic flow and congestion.

The environment that we live in can have a great impact upon our respiratory health, both indoor and outdoor environmental factors, predominantly air quality, can significantly influence our chances of experiencing good respiratory health. Breathing fine particles (those produced through burning), high levels of gases such as nitrogen oxide and sulphur dioxide, and low level ozone can all irritate the lungs. In the short term they can cause breathlessness, and exacerbate symptoms of asthma and COPD. In the long term they could lead to reduced lung function, initiation of asthma, and cause scaring and damage to the lung or causes some forms of Interstitial lung disease (a range of conditions which include most commonly Idiopathic pulmonary fibrosis).

Indoor environment

Our indoor environment plays a significant role on our health, particularly so for young children who may spend considerable amounts of their time indoors. Indoor environmental tobacco smoke is the main indoor environmental pollutant to affect peoples, especially children's, respiratory health. Passive smoking is breathing in the smoke from someone else's tobacco. Passive smoking can be either secondary of tertiary; secondary smoking is exposure to smoke from other peoples cigarettes, and tertiary smoking is exposure to residual smoke on persons, clothing and furniture etc. as a result of smoking). The predominant source of passive smoke exposure in children is smoking in the home by parents. The best way to prevent passive smoking in the home is therefore to reduce the prevalence of smoking among parents and would-be parents.[12]

Passive smoking can have a significant impact on health, increasing the likelihood of recurrent lower and upper respiratory infections, recurrent pneumonia, development and worsening of asthma, as well as a significant cause of lung cancer in smokers and none smokers:

- Smoking by the mother increases the risk of lower respiratory infections in children by about 60%, and smoking by any household member increases the risk by over 50%. Most of this increase is due to an effect on bronchiolitis,

[12] Passive smoking and children. Royal College of Physicians 2010.

which is about 2.5 times more likely to occur in children whose mothers smoke[13]

- Secondary smoking increases the risk of wheezing at all ages. Again, the effect is strongest for amongst children whose mothers smoke, with increases in risk of 65% to 77% according to the age of the child. The risk of asthma is increased by household smoking by about 50%.[14]

Other indoor environmental factors which can impact upon respiratory health include:

- Mould - Poor quality damp housing and lack of ventilation in humid places such as kitchens and bathroom can lead to the growth of mould. There are many types of mould, many of which harmless, but some people can have allergic reactions to mould or mould spores which can lead to rrespiratory symptoms including persistent sneezing, eye irritation, rhinitis (runny nose), coughing and wheezing, which can be worse in children.
- Pets – fur and feathered pets are sources of allergies. Some people are allergic to certain proteins and substances found in the skin or some secretions (saliva etc) from some animals. Pet allergies can lead to long term rhinitis, coughing and wheezing. Identifying the source of the respiratory ill health can be difficult to detect and can develop even when pets have been present for a long time.
- Dust – dust can harbour mites. Faeces from dust mites are also a very common allergen that can be a significant contributor to the development of asthma and/or triggering asthmatic attacks. Mites accumulate in or on surfaces that accumulate human skin cells or sweat etc. They also thrive in conditions of high humidity and temperature. They accumulate in bedding, pillows, mattresses, carpets and furniture. People are exposed by inhalation and can result in allergic respiratory symptoms as well as asthma.

Ensuring that the environment is clear of potential allergens, when there is a known or likely link (family history) is key to preventing poor respiratory health, and removing/ limiting contact with potential allergy sources where a respiratory allergy symptoms are present is key to preventing ongoing or worsening conditions.

Outdoor environment

Outdoor Air pollution is also a key determinant of respiratory health. There are several kind of pollutants which affect health, and are of major concern, these are pollutants for which there are national and international criteria to monitor their levels

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[13] Cook DG, Strachan, DP. Health effects of passive smoking

[14] Parental smoking and prevalence of respiratory symptoms and asthma in school age children. *Thorax*1997;52:1081–94.

and limit the impact that they have upon health. The council has a responsibility to regularly monitor, review and assess air quality as part of the Environmental Act (1995) and national Air Quality Strategy.

The Committee on Medical Effects of Air Pollution (COMEAP) estimated that air pollution accounts of 29,000 deaths nationwide every year[15]. The most recent COMEAP Report looks at the proportion of deaths in a local area that can be attributable to particulate pollution. The proportion of deaths attributable to long term exposure to manmade particulate air pollution in Halton is 5.5%, while this still represents a fraction of deaths for which preventive action must be sought, it is reassuring that Halton has no greater risk than many other areas of the country. The average attributable risk across England is 5.6%.[16]

Halton is an industrial area, with a long history of industrial processes. It has had historically poorer air quality than other areas of the country. However, with the reduction in industrial manufacturing, cleaner technologies and closer processes monitoring and permitted processes has significantly improved air quality in Halton over the decades. Halton currently collects data on air quality across the borough to regularly assess air quality. Halton is generally well within national Criterial levels for common air pollutants (particulates, Sulphur dioxide, nitrogen dioxide). However, there are 2 areas which have been identified as Air Quality Management Areas (AQMA) where nitrogen dioxide are above Air quality objective levels, both these areas are in Widnes Town Centre and are associated with high volume traffic flows.

Halton Borough Council in partnership with other agencies is working towards improving transport options, increasing sustainable transport options, cleaner technologies, assessing traffic routes and active travel options (walking and cycling etc.)

Actions for Prevention

Smoking

- Increase the number of people attending Smoking Cessation Services in Halton
- Reduce the proportion of people smoking in Halton

Vaccination

- Increase the uptake of flu vaccination amongst at risk groups, to achieve national target

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[15] The Mortality Effects of Long Term Exposure to Particulate Air Pollution in the UK. COMEAP Dec 2010

[16] Estimating Local Mortality Burdens Associated with Particulate Air Pollution. PHE, COMEAP April 2014

● Increase uptake of childhood vaccinations in lowest uptake practices.

Obesity

● Improve uptake to lifestyle advice across the borough

● Increase the proportion of people taking regular daily exercise in Halton

Drugs

● Improve education and awareness of the impacts of cannabis use, especially preventing young people from starting to use cannabis.

Housing

● Increase access to grants and equipment to increase energy efficiency in

People's homes

● Continue to work across the private rented sector to improve housing standards

Environment

● Continue the implementation of the Halton Council Transport Plan to improve traffic flow, reduce emissions and encourage active transport

● Identify opportunities to further improve air quality across Halton

ii. Earlier detection of respiratory diseases

In Halton:

43.1% of lung cancers are detected at early stage 1 and 2.

One and five year survival from lung cancer is higher than regionally and nationally.

2.6% of the population have COPD, but there is a possible 0.79% we don't know about.

Failing to treat the estimated 1328 people in Halton who have Sleep Apnoea could increase NHS costs, social care costs and accidents locally.

Early diagnosis of lung disease delivers significant benefits, particularly in such conditions as asthma, COPD, and lung cancer. There is a need for greater public awareness of the symptoms of such lung diseases, of the risks posed by smoking and by any delay in diagnosing smoking-related lung conditions such as lung cancer and COPD to encourage people to recognise early indications that there may be a problem and to seek medical attention early. In addition, there is a requirement to ensure that primary care are fully aware of the early symptoms of specific conditions and explore appropriate diagnostic tests, and referrals early.

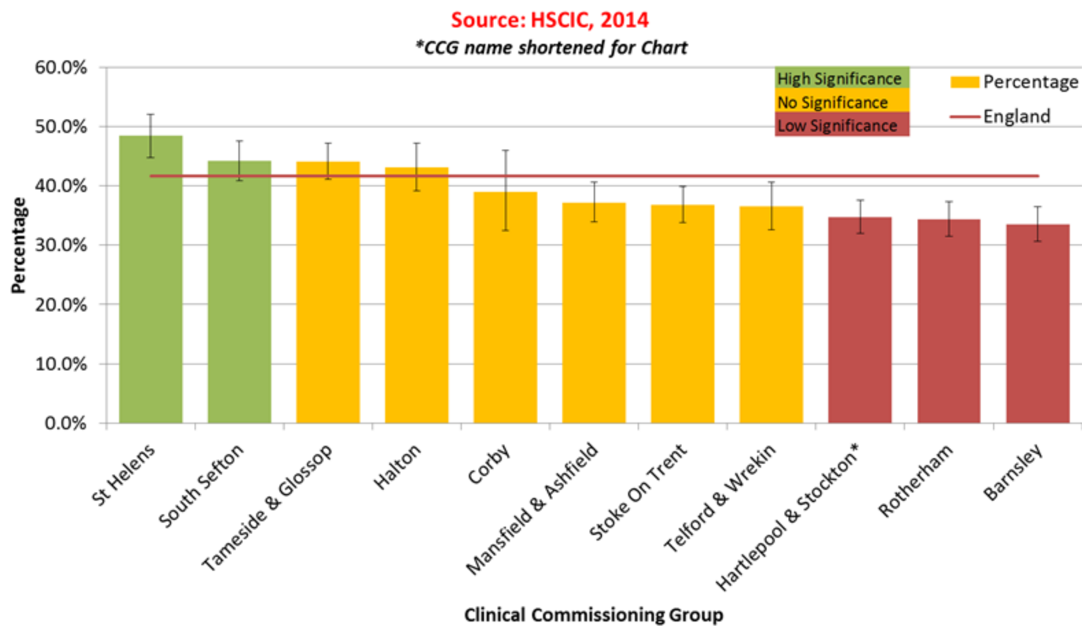
Whilst prevention of ill health remains the primary long term focus to safeguard respiratory health in to the future, significant improvements in health outcomes and mortality can only be made by earlier diagnosis and interventions for respiratory illnesses. There are a number of respiratory conditions that have early signs and symptoms, that can be diagnosed early, or that are more frequently diagnosed late and opportunities may exist for earlier diagnosis. Such conditions include

Lung cancer

In Halton, 43.1% of lung cancers were detected at an early stage (stage 1 and 2), where the cancer is much more treatable, has generally had less opportunity to spread and leads to much better outcomes for the patient. This is slightly higher than the England average early diagnosis and is significantly higher than many of comparable Clinical Commissioning Group (CCG) areas as seen on **Figure 2**.

People with lung cancer normally present with common respiratory symptoms (cough, coughing blood and breathlessness). These patients are nearly always seen by a respiratory physician for diagnosis before referral to oncologists and many are admitted as an emergency because the correct diagnosis is not made. This means that we should put emphasis on early and accurate diagnosis of any unusual respiratory symptoms.

Figure 2: Percentage of lung cancers diagnosed at stage 1 and 2 for Halton and Statistically similar CCGs



Halton has been running a Get Checked public awareness campaign since 2008 which raises awareness about the early symptoms of cancer to the public. From 2008 to date, 'Get checked', in combination with other national awareness initiatives such as Be Clear on Cancer have increased the volume of fast track GP referrals year on year for suspicious breast, bowel and lung cancer symptoms by 24% with an associated increase of cancer diagnosis of 19%. The continuation of the Halton Get Checked campaign and further innovations in delivery are required to further increase awareness of signs and symptoms of lung cancer. These approaches should be backed up with a system approach to ensure that 2 week wait referrals are made appropriately, that system capacity is able to meet any increase in demand in terms of urgent referrals, diagnostics, and treatment and rehabilitation pathways.

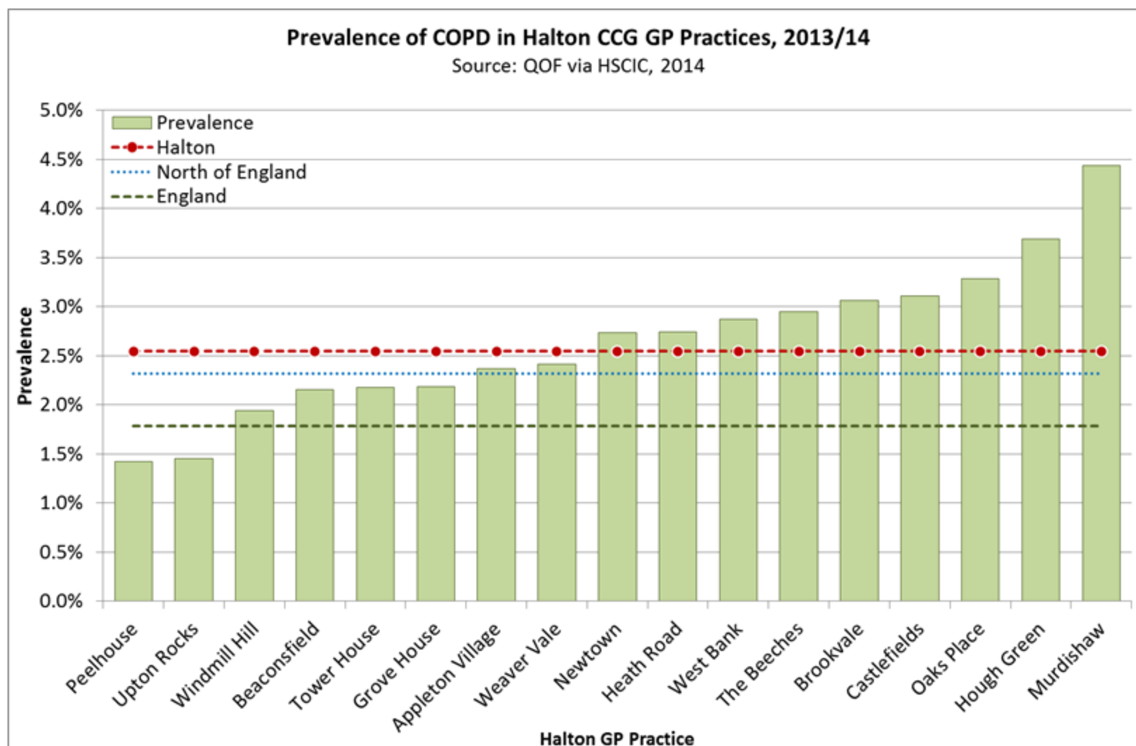
COPD

In Halton it is estimated that 3,916 residents over the age of 16 had COPD as of 2010, which is predicted to rise to 4,420 by 2020. The biggest increase is predicted to be in the 65 plus age group.

It is a requirement of the GP contract that practices hold a register of all patients with COPD, data for 2012/13 indicates that 3,210 patients who are registered with practices in Halton have COPD. This represents 2.6% of the registered population.

The prevalence of COPD varies considerably by practice, with some practices experiencing higher than average rates of COPD, and other considerably lower. **Figure 3** below shows the practice variation in COPD prevalence ranging from 1.4% to 4.4% prevalence across the practices.

Figure 3: Prevalence of COPD in Halton CCG GP practices 203/14



Estimates have been made of the number of people that would be expected to have COPD, based on the demographics within the Borough, and these suggest that 3207 people (3.39% of the population)[17] would have COPD. The difference between expected and actual registered cases of COPD suggests that there is a proportion of the population who have undiagnosed COPD. There have been improvements in case finding since 2009/10 closing the gap between the modelled estimated number of people with COPD and those of GP disease registers. But it is important that we continue to actively identify those with undiagnosed COPD. Early diagnosis and treatment initiation for COPD can markedly slow down decline in lung function provide patients with an opportunity to enjoy an active life for longer. Improving public awareness of COPD, including what good respiratory health looks like and signs and symptoms of possible COPD, in addition to wider community, high quality spirometry to assess lung function will help to identify possible COPD patients to enable more rapid diagnosis and earlier treatment plans.

Interstitial lung diseases

Interstitial Lung Diseases (ILD) comprises a large number (over 150) of diverse conditions which primarily affect the lung's smallest airways and alveolar air sacs. Whilst the cause of some ILDs is unknown, there is an overlap with occupational and

[17] COPD Prevalence Estimates Dec 2011, East of England Public Health Observatory http://www.apho.org.uk/resource/item.aspx?RID=111122

environmental lung diseases such as Coal and Slate workers' pneumoconiosis, asbestosis and Farmer's lung.

Due to the variety of the illness that comprise ILD, there is no single early diagnosis tool or single set of signs and symptoms, although shortness of breath especially with relatively minor exertion is one common feature. A number of the most common ILD can be related to occupational or environmental factors, and therefore, it is important that a full personal and work history is taken within primary care when a patient presents with breathing problems. In addition, it is also important to ensure that the population are aware of the potential risks so that those who may be in higher risk groups, coal workers, farmers etc. are aware of possible signs and symptoms and encouraged to present early to health services.

Obstructive Sleep Apnoea (OSA)

Due to the risk factors and profile of those who develop OSA, it is possible to predict the likely proportion of a local population who are likely to have OSA. Based on the British Lung Foundation OSA calculator, 1328 people (1.06% of the population) will have OSA. By assessing predicted rates within a population, against known rates, it would possible to identify how many people are likely to have the condition, but remain undiagnosed. However, there are no accurate data on the actual local prevalence of OSA. Locally we need to ensure that we are aware of the population rates of OSA.

The British Lung Foundation estimates that cost of not treating all those with moderate to severe OSA will cost the local health and social care economy will be over £109,000 more per year than the cost of actually treating all people with moderate to severe OSA. In addition, identifying and treating all those with moderate to severe OSA could prevent 157 road traffic accidents every year.

People with symptoms, abnormal tests or screening results should have these addressed locally and/or where appropriate, should be referred for further assessment and management when lung disease is suspected or confirmed.

Spirometry, oxygen saturation measurement and chest radiology are important investigations widely available in both primary and secondary care practice. They can be used to identify at risk groups within case finding strategies which can be most effectively undertaken in local community settings and we must ensure that local spirometry services are robust and accessible.

People with Learning Disability

The Confidential Inquiry into the Premature Death of People with Learning Disability found the most prevalent immediate cause of death in people with learning disabilities was respiratory disorders, followed by heart and circulatory disorders. The report highlights that these deaths are most likely to be amenable to health care interventions. The most common

respiratory illness associated with premature death in people with Learning Disability was usually pneumonia.[18]

15.5% of the general population develop respiratory disease and 17% of those die from it. By comparison, 19.8% of people with a learning disability develop the disease but about 50% of these die from it.

Actions for early detection

Cancer

- Ensure that increase the number of appropriate 2 week wait referrers to increase early diagnosis and enable early treatment of lung cancer
- Expand the Get Checked campaign to further increase awareness of signs, symptoms and encourage early presentation for lung cancer.

COPD

- Encourage improved and early case finding to facilitate better management and treatment access
- Develop and implement a Borough wide, inclusive community spirometry service

ILD

- Ensure risk markers are identified on patient records, known risk occupations etc

OSA

- Improve mechanisms for case finding, including access to spirometry and diagnostic tools to ensure rapid access to treatment and management

People with Learning Disability

- Adults with learning disability should be considered a high risk group for deaths from respiratory problems, screening and risk assessment should be included as part of the annual health check for patients with a learning disability.
- People with learning disability should be regarded as a high risk group for the purpose of seasonal flu and pneumonia vaccination programmes even if they do not live in a residential care setting.

[18] Confidential Inquiry into premature deaths of people wioth Learning Disability (CIPOLD) 2013 http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf

I. Primary Care and Community based support

In Halton

- GP practices perform slightly better than the England average for all but 1 clinical indicator for asthma
- GP practices perform slightly better than the England average for all but 1 clinical indicator for COPD
- There is a higher rate of emergency admissions for bronchiolitis than the England average.

Conditions affecting respiratory health are numerous, varied and often complex, requiring a multidisciplinary approach to identification and management offered by many different providers. The route of these approaches invariably lies within primary care. Ensuring that primary care, and the community health approaches are robust and effective will improve outcomes for patients and minimise the health system burden resulting from respiratory ill health.

There are a number of lung conditions where improvements in the delivery of effective primary care and community support care can result in high impact changes to the respiratory health of people in Halton.

Asthma

Asthma is a condition that can affect people of any age. It is an important factor in repeated respiratory infections in children and causes breathlessness in adults. If undiagnosed or inadequately treated it can in the short-term lead to potentially life-threatening exacerbations and in the long-term to irreversible damage to the lungs.

To ensure high quality diagnosis and treatment, it is key that appropriate services are commissioned that enable all practitioners and services to meet the NICE Quality Standards 25 for asthma. The 10 quality statements which will improve care and treatment for people with asthma are:

Statement 1	People with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance.
Statement 2	Adults with new onset asthma are assessed for occupational causes.
Statement 3	People with asthma receive a written personalised action plan.
Statement 4	People with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment.
Statement 5	People with asthma receive a structured review at least annually.

Statement 6	People with asthma who present with respiratory symptoms receive an assessment of their asthma control.
Statement 7	People with asthma who present with an exacerbation of their symptoms receive an objective measurement of severity at the time of presentation.
Statement 8	People aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within 1 hour of presentation.
Statement 9	People admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge.
Statement 10	People who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma are followed up by their own GP practice within 2 working days of treatment.
Statement 11	People with difficult asthma are offered an assessment by a multidisciplinary difficult asthma service.

Most people with asthma are managed within primary care. However, some people will require hospital admission. In some instances, increased hospital admissions may result for poor management of the condition which can result in inadequate response and management of exacerbations.

The GP contract requires that practices closely monitor diagnosis, assessment of control and smoking status in young people. For 2012/13, **figure 4** shows that Halton Practices performed better than the England average for asthma diagnosis and assessments of control, but below the national average for recording of smoking status.

Figure 4: Achievement against asthma clinical indicators, 2012/13

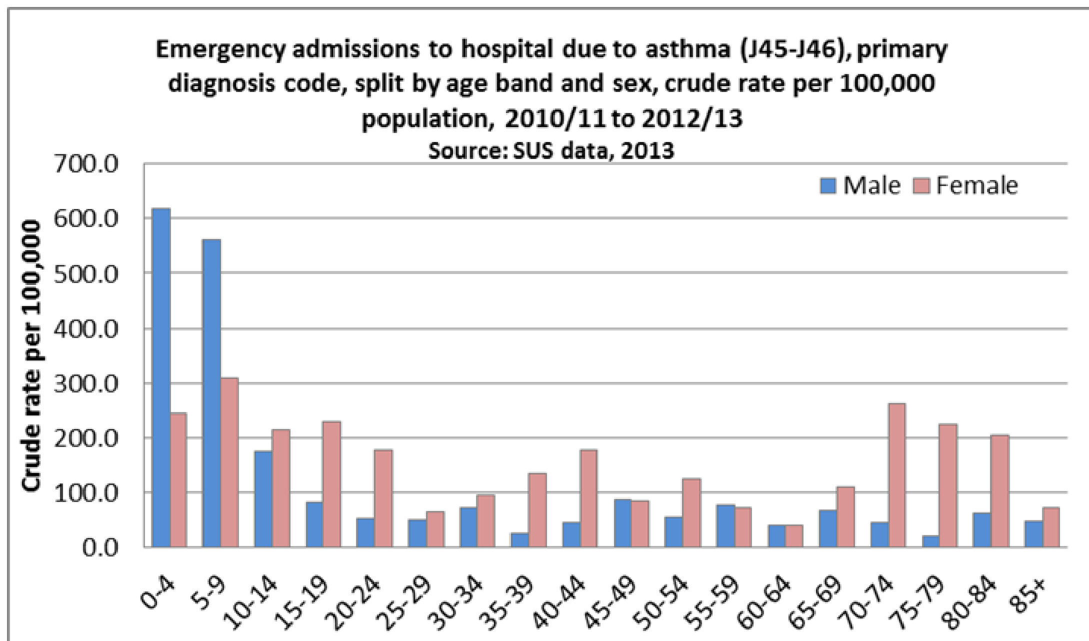
Practice Code	Practice Name	ASTHMA08	ASTHMA09	ASTHMA10
N81011	Beaconsfield	82.6%	79.3%	85.1%
N81019	Castlefields	95.9%	73.4%	87.5%
N81035	Appleton Village	83.1%	71.1%	100.0%
N81037	Beeches	85.5%	62.3%	75.6%
N81045	Peelhouse	89.0%	78.9%	89.4%
N81054	Weaver Vale	94.9%	81.9%	86.8%
N81057	Tower House	97.5%	90.7%	95.7%

N81064	Newtown	82.2%	78.0%	88.5%
N81066	Grove House	95.6%	74.5%	85.5%
N81072	Murdishaw	94.4%	77.2%	87.5%
N81096	Brookvale	81.9%	76.7%	87.5%
N81119	Hough Green	98.1%	74.2%	100.0%
N81618	Heath Road	91.9%	62.1%	100.0%
N81619	Oaks Place	94.0%	75.0%	90.0%
N81625	West Bank	91.4%	89.4%	84.6%
N81651	Upton Rocks	82.8%	78.3%	100.0%
Y02512	Windmill Hill	87.5%	77.9%	83.3%
Halton CCG		**90.5%**	**76.1%**	**88.9%**
Merseyside Area Team		**87.4%**	**76.4%**	**90.6%**
North of England		**87.8%**	**75.4%**	**89.6%**
England		**87.6%**	**74.8%**	**89.3%**

ASTHMA08: The percentage of patients aged 8 years and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility
ASTHMA09: The percentage of patients with asthma who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions
ASTHMA10: The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months

Effective primary care and case management is key to preventing exacerbations and preventing hospital admissions. **Figure 5** shows that the highest rate of admissions is for the 0-9 age groups, this could be admissions as a result of first diagnosis or where management systems are not yet in place, however, for older age group, effective management is more likely to be in place and close monitoring and engagement with primary care and community could potentially reduce emergency admissions.

Figure 5: shows the emergency admissions by age group for Asthma from 2010/11 to 2012/13.



Smoking cessation is an important part of ensuring good respiratory health, for people with asthma (and COPD) it is even more vital that they receive high level support to quit smoking to improve treatment out comes and limit potential serious exacerbations. All people who are on the asthma (and COPD) registers in practice should also have smoking status recorded, and regular (repeated as necessary) offers to engage with smoking cessation services. Encouraging practices to benchmark smoking status and set reduction targets for smoking in these practice populations can have a significant effect on ongoing symptom management.

COPD

COPD is a chronic progressive disease of the airways associated with high morbidity and mortality. It is largely managed in primary care but exacerbations of symptoms often result in acute admission to hospital. Patient and community support groups can improve quality of life for patients living with COPD. Secondary care is involved with providing increasingly more complex interventions such as domiciliary ventilation and assessment for referral to thoracic surgery. As the disease progresses, accessing palliative care services can improve the quality of life of patients with advanced disease.

Adherence to evidence-based guidelines, regular review in primary care, self-management initiatives, long-term oxygen therapy and pulmonary rehabilitation programmes (PRP) can all improve quality of life and reduce hospital admission.

Non-invasive ventilation is cost effective and improves outcomes for selected patients. Optimisation and full integration of COPD care following discharge from hospital improves life for the patient and reduces re-admission rates.

NICE COPD Quality Standards 10 identifies 13 key statements that will improve care and management for patients with COPD, that we must endure appropriate services are commissioned locally and that clinicians are able to meet these standards to maximise care and treatment for COPD patients in Halton. The statements are:

Statement 1	People with COPD have one or more indicative symptoms recorded, and have the diagnosis confirmed by post-bronchodilator spirometry carried out on calibrated equipment by healthcare professionals competent in its performance and interpretation.
Statement 2	People with COPD have a current individualised comprehensive management plan, which includes high-quality information and educational material about the condition and its management, relevant to the stage of disease.
Statement 3	People with COPD are offered inhaled and oral therapies, in accordance with NICE guidance, as part of an individualised comprehensive management plan.
Statement 4	People with COPD have a comprehensive clinical and psychosocial assessment, at least once a year or more frequently if indicated, which includes degree of breathlessness, frequency of exacerbations, validated measures of health status and prognosis, presence of hypoxaemia and comorbidities.
Statement 5	People with COPD who smoke are regularly encouraged to stop and are offered the full range of evidence-based smoking cessation support.
Statement 6	People with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme.
Statement 7	People who have had an exacerbation of COPD are provided with individualised written advice on early recognition of future exacerbations, management strategies (including appropriate provision of antibiotics and corticosteroids for self-treatment at home) and a named contact.
Statement 8	People with COPD potentially requiring long-term oxygen therapy are assessed in accordance with NICE guidance by a specialist oxygen service.
Statement 9	People with COPD receiving long-term oxygen therapy are reviewed in accordance with NICE guidance, at least annually, by a specialist oxygen service as part of the integrated clinical management of their COPD.

Statement 10	People admitted to hospital with an exacerbation of COPD are cared for by a respiratory team, and have access to a specialist early supported-discharge scheme with appropriate community support.
Statement 11	People admitted to hospital with an exacerbation of COPD and with persistent acidotic ventilatory failure are promptly assessed for, and receive, non-invasive ventilation delivered by appropriately trained staff in a dedicated setting.
Statement 12	People admitted to hospital with an exacerbation of COPD are reviewed within 2 weeks of discharge.
Statement 13	People with advanced COPD, and their carers, are identified and offered palliative care that addresses physical, social and emotional needs.

The GP contract requires practices to manage patients in line with best practice. For COPD this relates to diagnosis, recording of FEV1 (maximal amount of air you can forcefully exhale in one second), influenza vaccination and an assessment of the level of breathlessness a patient is experiencing. For 2012/13, Halton practices showed better than the national average performance on all but one factor. The percentage of COPD patients who received a flu vaccination was below the England average (**Figure 6**).

Figure 6: Achievement against COPD clinical indicators, 2012/13

Practice Code	Practice Name	COPD08	COPD10	COPD13	COPD15
N81011	Beaconsfield	96.9%	89.4%	92.1%	100.0%
N81019	Castlefields	96.6%	87.6%	96.4%	97.2%
N81035	Appleton Village	88.9%	80.5%	97.0%	97.2%
N81037	Beeches	97.1%	85.0%	90.8%	90.0%
N81045	Peelhouse	93.0%	90.0%	91.3%	86.2%
N81054	Weaver Vale	87.4%	95.1%	93.3%	90.0%
N81057	Tower House	97.4%	98.4%	98.6%	100.0%
N81064	Newtown	31.9%	88.1%	96.0%	91.7%
N81066	Grove House	90.6%	93.2%	91.1%	87.5%
N81072	Murdishaw	94.0%	89.1%	97.4%	98.8%
N81096	Brookvale	96.3%	80.9%	90.1%	90.9%

N81119	Hough Green	81.5%	93.9%	94.6%	88.9%
N81618	Heath Road	92.7%	95.1%	95.0%	88.9%
N81619	Oaks Place	94.9%	94.0%	92.0%	85.7%
N81625	West Bank	94.5%	95.6%	97.1%	85.7%
N81651	Upton Rocks	97.6%	92.7%	93.0%	83.3%
Y02512	Windmill Hill	85.7%	87.5%	92.5%	100.0%
Halton CCG		**89.8%**	**89.4%**	**94.2%**	**93.6%**
Merseyside Area Team		**92.4%**	**82.8%**	**91.0%**	**92.0%**
North of England		**92.7%**	**87.9%**	**91.1%**	**91.3%**
England		**92.7%**	**88.4%**	**91.1%**	**91.3%**

COPD08: The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March
COPD10: The percentage of patients with COPD with a record of FEV1 in the preceding 15 months
COPD13: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months
COPD15: The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry

COPD is a rare condition before the age of 40. Most people who develop the condition are managed within primary care. However, some people will develop exacerbations of the condition or they may be undiagnosed, which can result in an emergency (unplanned) admission to hospital. **Figure 7** shows the data for 2010/11 to 2012/13 which show that admissions rise from the age 45 onwards for both males and females but that the rate of admissions is generally higher for men than for women.

A number of people with COPD are admitted on more than one occasion during a single year. Research suggests that there are nearly half a million ‘frequent flyers’ in the United Kingdom and that they cost the health service approximately £2.3 billion a year (2003-4 figures). Assessing the numbers of re-admissions or frequent flyers, does not indicate that the hospital admissions are unnecessary, but we need to understand the data to ensure that primary care and patient management are maximised to prevent these repeated admissions.

Figure 7: Emergency admissions due to COPD for 2010/2011 to 2012/13

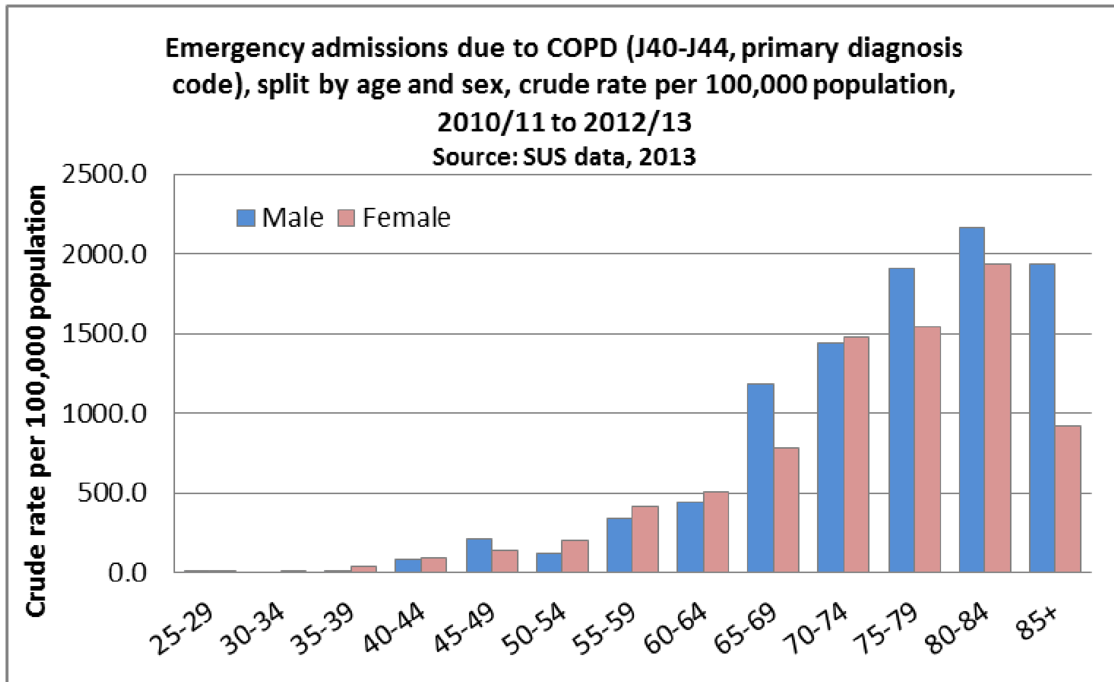
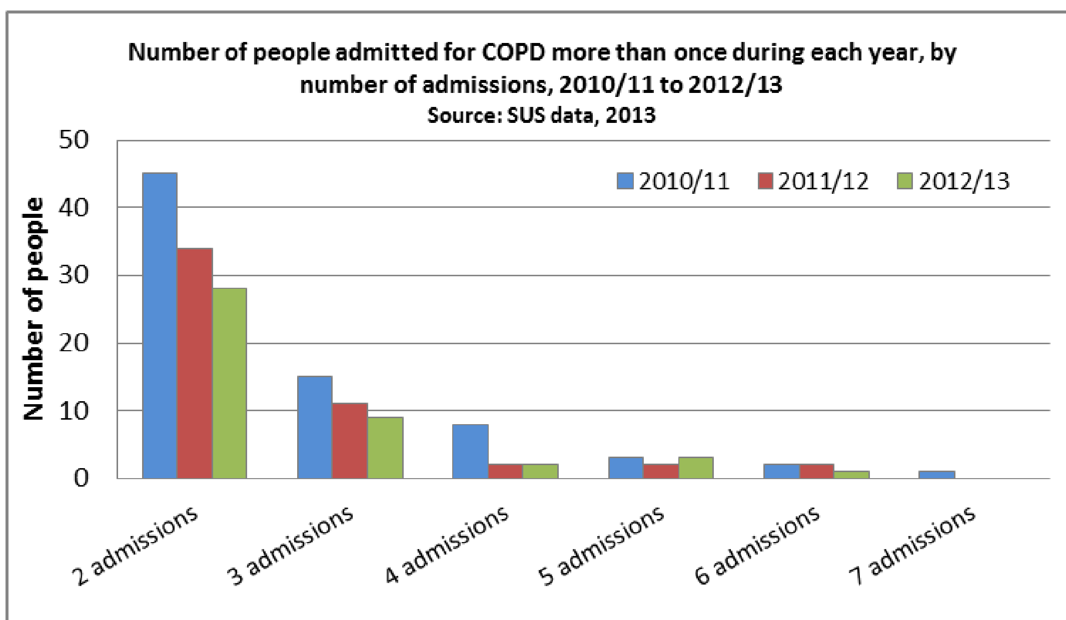


Figure 8 shows the number of patients admitted more than once during a year from 2010/11 to 2012/13. In Halton, most people who were admitted more than once were admitted either 2 or 3 times, with very few people being admitted more than this.

Figure 8: Number of people admitted for COPD more than once in a year



During 2012/13 there were over 100 readmissions due to COPD, however, the number, and percentage of total COPD admissions, has decreased from 2010/11.

	2010/11	2011/12	2012/13
Total number of admissions	452	331	358
Number of readmissions	201	131	112
Percent	44.5%	39.6%	31.3%

Halton Rapid Response Respiratory Team provide services for patients with respiratory illness in the Halton area, assessing conditions such as COPD, asthma, pneumonia, bronchiectasis, interstitial lung disease and lung cancer. The team also has expertise in non-invasive ventilation (NIV) to help support patients with neuromuscular disease, chest wall deformity and OSA. It provides an accessible and responsive service that strives to deliver the highest standards of care possible, to patients with respiratory illness.

Halton Rapid Response Respiratory Team

About this service

The Team offer an award winning service for patients with respiratory illness in the Halton area, assessing conditions such as COPD, asthma, pneumonia, bronchiectasis, interstitial lung disease and lung cancer. The team also has expertise in non-invasive ventilation (NIV) to help support patients with neuromuscular disease, chest wall deformity and obstructive sleep apnoea.

The Team aim is to provide an accessible and responsive service that strives to deliver the highest standards of care possible, to patients with respiratory illness.

The team can be accessed by referral from the GP or hospital and will undertake an assessment to of what you need. Available services and information include:

- Respiratory assessment in your own home
- Pulmonary Rehabilitation
- Long-term Oxygen Therapy
- Ambulatory Oxygen clinics
- Nurse Led Clinics
- Physiotherapy led clinics

Patients are referred to the team either by the GP or the hospital with an aim to seeing each patient the same day or within 24 hours for advice, assessment, support, intervention and supported discharge.

British Lung Foundation's COPD Patient Passport, available through practices and Breathe Easy Groups, helps patients with COPD identify if they are getting the right care and support.

Bronchiectasis

Bronchiectasis is a condition characterised by chronic sputum production and a increased likelihood of developing frequent lung infections, often requiring hospital admission.

There is often pre-existing COPD. People with a suspected diagnosis of bronchiectasis should have the diagnosis confirmed by chest CT (computed tomography).

There has been a steady rise in the number of emergency admissions involving bronchiectasis over the last few years, from 62 in 2011/12, 92 in 2012/13 to 121 in 2013/14. The causes of this are unknown. Primary care management of patients and early identification and treatment of infections could prevent admissions. Physiotherapy has a major role in the management of bronchiectasis and self-help to enable patients to manage signs and symptoms better, helping to reduce infections and hospital admissions.

Halton Oxygen Assessment Service for Long Term Oxygen Therapy

Halton oxygen assessment service was formed in January 2009, following the introduction of the NICE COPD guidelines which recommended that all oxygen assessments should be completed in secondary care.

The service is run by **Senior Respiratory Nurse Specialists**. Our service is based with the Respiratory team at Halton General Hospital in block 4. Our working hours are **Monday-Friday 8.30am to 6.30pm,** our direct telephone number during these hours is **01928 753165.** We are also available on **Bank Holidays** and **weekends** from **8.30am to 6.30pm** on **01928 714567** - please ask for on call staff.

Our initial aim is to provide an up to date assessment for the people who are already on oxygen therapy so that they know what their oxygen needs are. As the service becomes more established and more funding becomes available we are hoping to expand the service and take open referrals. At this time we are limited to completing assessments on individuals with respiratory diseases, unfortunately there is no capacity for the assessment of cardiac related breathlessness at this time.

Referral criteria: Individuals should be considered for oxygen assessment if their oxygen saturations are <92% at rest on room air. To complete the oxygen assessment the individual needs to be stable (i.e. 6 weeks post exacerbation/chest infection).

Interstitial Lung Disease

Interstitial Lung Diseases (ILD) comprises a large number (over 150) of diverse conditions which primarily affect the lung's smallest airways and alveolar air sacs. Whilst the cause of some ILDs is unknown, there is an overlap with occupational and environmental lung diseases such as Coal and Slate workers' pneumoconiosis, asbestosis and Farmer's lung. It is known that some ILDs are caused by cigarette smoke and others may occur as a reaction to medication and yet others occur in association with diseases such as rheumatoid arthritis. Finally, ILDs need to be distinguished from other lung conditions which they sometimes mimic.

Idiopathic pulmonary fibrosis (IPF), the commonest ILD, has shown a greatly increased prevalence over the past 20 years although local prevalence data is not easy to determine as a result of the range of conditions that could be included under the ILD definition.

NICE Quality Standard 79 identifies the set of 5 key statements which will improve the quality and standard for care for people with ILD, these should be adopted locally to ensure best quality of care for patients in Halton.

Statement 1	People are diagnosed with idiopathic pulmonary fibrosis only with the consensus of a multidisciplinary team with expertise in interstitial lung disease.
Statement 2	People with idiopathic pulmonary fibrosis have an interstitial lung disease specialist nurse available to them.
Statement 3	People with idiopathic pulmonary fibrosis have an assessment for home and ambulatory oxygen therapy at each follow up appointment and before they leave hospital following an exacerbation of the disease.
Statement 4	Pulmonary rehabilitation programmes provide services that are designed specifically for idiopathic pulmonary fibrosis.
Statement 5	People with idiopathic pulmonary fibrosis and their families and carers have access to services that meet their palliative care needs.

Hospital admissions for ILD increase with age. **Figure 9** shows the admissions per 5 year age group for the period 2011/12 to 2013/14. The higher rates of admission amongst men are likely to reflect the work related nature of some forms of ILD, but the crude rates represent a significant burden on secondary care capacity.

The number of emergency admissions per year for ILD (**Figure 10**) has increased in the last few years. An assessment is needed to identify if this increase is as a result of increasing prevalence. There is also a need to assess if community and primary care management and services achieve quality standards locally to prevent emergency admissions.

Figure 9: Admissions by 5 year age band and sex, 2011/12 to 2013/14

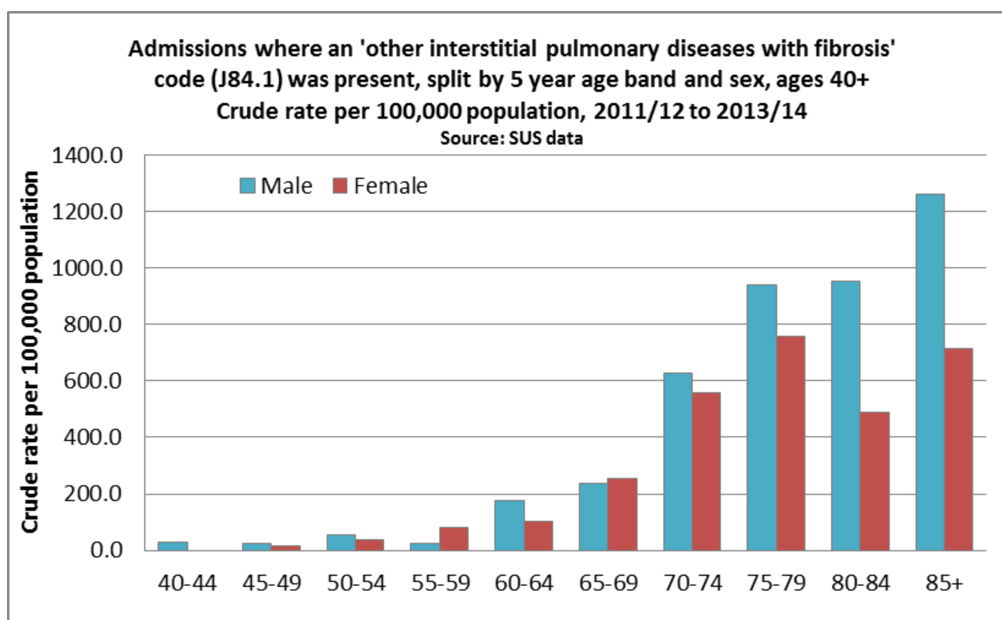


Figure 10: Number of admissions by year

Year	Elective	Emergency
2011/12	31	68
2012/13	33	95
2013/14	21	150

The median survival for IPF is just three years – a prognosis that is worse than many cancers. Lung transplantation is the only treatment proven to improve survival in some forms of ILD.

Ambulatory oxygen therapy (AOT) assessment

AOT allows the patient to leave the home and improves daily activities and quality of life.

The purpose of a formal **AOT assessment** is to:

1. Determine if the patient has evidence of exercise desaturation, which is defined as a 4% drop in SaO_2 below 90%.
2. To determine the appropriate flow rate to correct exercise desaturation.
3. To see if an oxygen conserving device is appropriate for that particular patient

Who qualifies for AOT?

Ambulatory Oxygen only indicated in a number of conditions. There are 3 grades of patients who qualify for AOT.

- **Group 1**. On Long Term Oxygen Therapy with low activity level. This group **do not** usually require a **formal** AOT assessment. There flow rate is usually set to their Long Term Oxygen Therapy flow rate.

- **Group 2**. On Long Term Oxygen Therapy but are active.

- **Group 3**. Not on Long Term Oxygen Therapy but demonstrate exercise oxygen desaturation. In this group AOT should be considered only if there is evidence of improvement in exercise tolerance and dyspnoea and the Patient is motivated to use it.

Sleep-Disordered Breathing

Identification and diagnosis of Obstructive Sleep Apnoea is a key challenge. Once diagnoses has been made promotion and provision of lifestyle advice including

assessment of weight and measures of obesity, with primary care support and access to community weight management service, smoking cessation and exercise provides a primary approach to reduction in symptoms. Halton Health Improvement Team are able to provide a wide range of lifestyle interventions which would improve outcomes for people with OSA, from diet and exercise based weight management to smoking cessation services and can receive referrals directly from primary care.

Bronchiolitis

Bronchiolitis usually presents with cough with increased work of breathing and it often affects a child's ability to feed. Symptoms are usually mild and might only last for a few days, but in some cases the disease can cause severe illness. There are several individual and environmental risk factors that can put children with bronchiolitis at increased risk of severe illness.

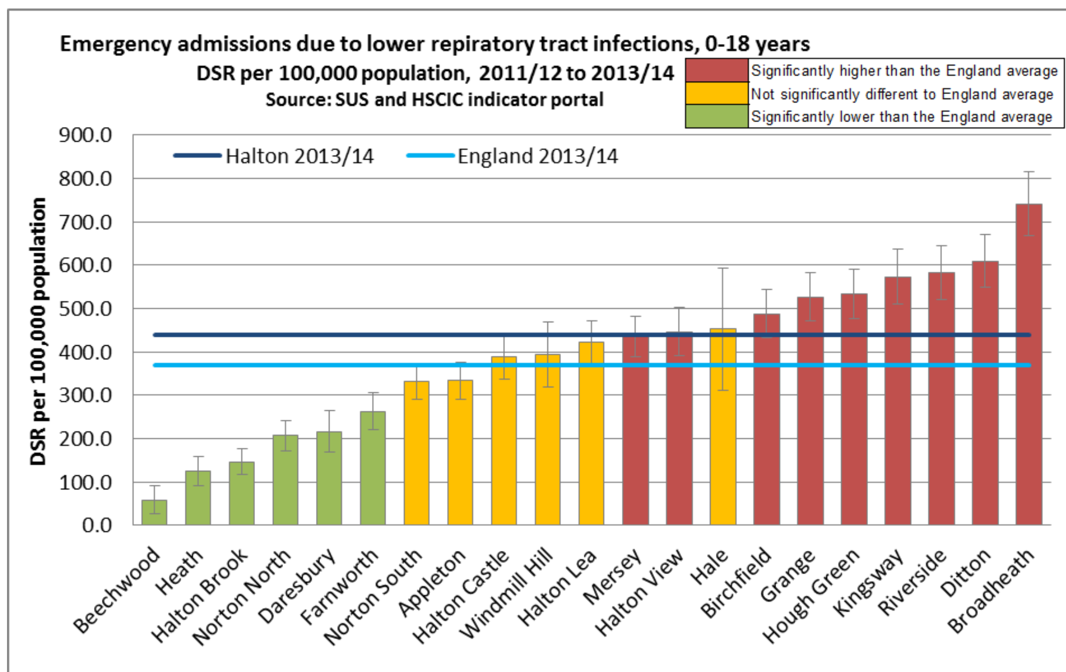
Most children with bronchiolitis present in primary care to a GP. The diagnosis of bronchiolitis is based on clinical assessment showing the presence of various characteristic symptoms and signs. Although bronchiolitis can usually be managed at home, approximately 3% of affected children are admitted to hospital. In 2011/2012 in England there were 30,451 secondary care admissions for the management of bronchiolitis.

The management of bronchiolitis depends on the severity of the illness. In most children bronchiolitis can be managed at home by parents or carers. In mild or moderate cases treatments that improve feeding and reduce the work of breathing could be beneficial. A range of treatments have been trialled, including: inhaled bronchodilators; inhaled corticosteroids; systemic corticosteroids; antibiotics.

Children in Halton are admitted as an emergency admission for lower respiratory tract infections (of which bronchiolitis is the most common) at a higher rate than the England average, and there is significant variation in the rate of admission across different wards within the Borough, which suggests that there could potentially be variations in the primary care management for children with respiratory infections. **Figure 11** shows the variation in emergency admission rate for lower respiratory tract infections for 0-18 year olds between 2011/12 to 2013/14 by ward across Halton. There is little correlation between the variations and the levels of local deprivation, or known lifestyle factors to explain the pattern in variation, which could suggest a potential primary care link (although the data is not presented by practice)

There are 6 wards with significantly higher admission rate for lower respiratory tract infections than the Halton average, and 9 wards are significantly higher than the England average emergency admission rate. During 2011/12 to 2013/14, 81.5% of all emergency admissions in Halton for lower respiratory tract infections were for children under 1 year of age, 79% of these were for acute bronchiolitis; for the rest of England this was 70%.

Figure 11: Emergency Admission due to lower respiratory tract infection in children 2011/12 to 2013/14



NICE are due to publish Guidance for the Diagnosis and Management of Bronchiolitis in Children in May 2015. This guidance needs to be assessed against local services provision and pathways to ensure that local case management and care follow the best practice guidance.

Actions for Primary Care and community based support

General

- Ensure the NICE Guidance and Quality Standards compliance in the recognition, diagnosis and management of respiratory illness and ensure best practice service commissioning.
- Pro Active Care programme Local Enhanced Service (2014/15)
- Review provision of pulmonary rehabilitation across Halton
- Establish integrated delivery of respiratory services across Halton
- Improve prescribing of respiratory medication across primary care

Asthma and COPD

- Implement standardised COPD and Asthma template across primary and secondary case

● Practices to benchmark recording of smoking status for patients on the COPD and asthma registers and set local reduction targets.

● Every patient diagnosed with asthma to receive a personalised action plan and annual review.

ILD

● Recording of occupation, particularly for risk occupations, on primary care records and identify those at possible risk of ILD to red flag early warning signs and symptoms.

OSA

● Maximise case finding against OSA predictor calculator and ensure rapid access to diagnostics.

● Review the pathway for people with OSA

Bronchiolitis

● Rapid review (and application) of NICE Guidance when it is released in May 2015

● Review cause for practice variations in admissions for bronchiolitis across Halton practices

iii. High Quality Hospital Services

Conditions that affect respiratory health are numerous. They are often varied and often complex and need a multidisciplinary approach to treatment and management. In terms of ensuring appropriate high quality hospital services are available, this document will identify were improvements in the delivery can result in high impact changes for respiratory health conditions.

Nurse Led Clinic

The **respiratory nurses** at Halton and Warrington Hospitals run nurse led clinics. These are done in conjunction with **Respiratory Consultants** and are in parallel to their clinics. If the nurse feels the patient is not responding to treatment or needs further advice, they can discuss the patient with the consultant.

Types of patients seen in the clinics are;

- Medication review and optimisation of medication
- Trial of nebuliser
- Post discharge
- To review pulmonary function tests
- To review post discharge
- Review medication change
- To assist in diagnosis, such as asthma
- General monitoring of patients
- Prior to pulmonary rehabilitation
- Following pulmonary rehabilitation
- Following rapid response respiratory team input
- Request from consultant
- GP requests

The clinics run on **Tuesday mornings**, in the Delemere Centre, Halton and **Thursday afternoons**, clinic A, Halton. **Monday afternoon**, OPD clinic Warrington.

Patients can be referred to the clinic by letter to the respiratory nurse, Block 4, Halton General Hospital or respiratory support team, A7/A8 corridor, Warrington Hospital.

Patients cannot self-refer to the clinic, this must be done by a health professional.

Asthma

Asthma is a condition that can affect people of any age. It is an important factor in repeated respiratory infections in children and causes breathlessness in adults. If undiagnosed or inadequately treated it can worsen and in the short-term lead to potentially life threatening symptoms, but in the longer term can lead to irreversible damage to the lungs

Once a diagnosis of asthma has been achieved, information about asthma which is relevant, easy to understand and in an accessible format should be provided to the patient and their family. Those diagnosed should all be provided with an individual asthma management plan including relevant contacts and what to do in the event that their asthma becomes uncontrolled, including training in inhaler technique to support effective self-management strategies for the condition. All patients with asthma will receive treatment appropriate to the severity of their Illness.

With regard to children there is a multidisciplinary asthma pathway in place at St Helens & Knowsley Acute Hospital Trust for children who present at A&E, which incorporates issuing of self-management plans. Follow ups take place with the GP. At Warrington & Halton Hospitals Foundation Trust there is a similar A&E Pathway, which incorporates issuing of an Asthma/Wheeze Management Plan. Follow ups take place in an asthma clinic at Springfield Medical. Asthma UK self-management plans have also been made available to all GP practices for use in annual reviews to ensure those children who do not attend secondary care services also have the choice for robust self- management.

COPD

COPD is largely managed in primary care but exacerbations of symptoms often result in acute admission to hospital. Patient support groups can improve quality of life for patients living with COPD. Secondary care is involved with providing increasingly more complex interventions such as domiciliary ventilation and assessment for referral to thoracic surgery.

As the disease progresses, accessing palliative care services can improve the quality of life of patients with advanced disease. Adherence to evidence-based guidelines, regular review in primary care, self-management initiatives, long-term oxygen therapy and pulmonary rehabilitation programmes (PRP) can all improve quality of life and reduce hospital admission. Optimisation and full integration of COPD care following discharge from hospital improves life for the patient and reduces re-admission rates.

Lung Cancer

Liverpool Heart and Chest Hospital is the local specialist unit for Lung Cancer. It is essential that decisions are made efficiently as a patient identified in primary care, or

via a local hospital will often need to be referred to a different provider for specialist treatment.

Timeliness of referrals between trusts for cancer treatments is monitored on a regular basis in line with national cancer waiting time targets. This process allows the identification of any recurrent issues in relation to cancer pathways and allows multidisciplinary discussion to take place to work towards improving them.

From April 2013, diagnostic imaging has been unbundled from the Outpatient tariff (PbR Guidance 13/14), which includes; Magnetic resonance imaging (MRI) scans, Computerised tomography scans (CT), Dexa scans, Contrast fluoroscopy procedures, Non-obstetric ultrasounds, Nuclear medicine and simple echocardiograms. There is local commitment (from the CCG) to working with healthcare providers to explore options for direct access, in particularly direct GP access to diagnostics that will aid with the diagnosis of lung cancer including MRI, ultrasound and chest X-Ray.

Acute respiratory illness

Acute respiratory illnesses are common and include community-acquired pneumonia, acute exacerbations of COPD, asthma attacks and a number of less common conditions. Together these represent a major demand on primary and particularly hospital care.

We need to ensure that we have adequate primary and community provision in place so that we can maximise admission avoidance wherever possible and ensure people can be treated successfully in the community and at home. From secondary care, we need to ensure that early assessment and discharge schemes can be effectively utilised to reduce delays in effective treatment and subsequently the length of hospital stay, thus optimising the use of hospital beds and reducing the considerable costs of such conditions.

Actions for High Quality Hospital Services

General

- Review Warrington & Halton NHS Foundation Trust Rapid Response Respiratory Team
- Review current arrangements regarding Halton adult residents admitted to Whiston Hospital with respiratory health problems
- Review current arrangements regarding Halton children & young people admitted to Halton and Warrington Hospitals and ST Helens and Knowlsey Hospitals with respiratory health problems

● Ensure the NICE Guidance and Quality Standards compliance in the treatment and secondary care management of respiratory illness and ensure best practice service commissioning.

iv. Promoting Self Care and Independence

Improving health outcomes for people with respiratory disease not only requires appropriate medical interventions but also enhanced communication, knowledge, skills, and the development of a therapeutic alliance between the patients and the healthcare professional. All patients with respiratory disease and/or their carers should strive to become better informed. Every effort should be made to equip patients, carers and families with the necessary knowledge and skills to improve decision making and thereby improve outcomes.

Education is key to improving awareness of respiratory disorders and associated symptoms, helping achieve an earlier diagnosis and improved self-management.

Having confident and informed respiratory patients at the centre of the decision-making processes will allow them to take ownership of their conditions leading to fewer unplanned primary care consultations, reductions in visits to outpatient departments, reduced hospital admissions and reduced length of stays in hospital.

Individuals with chronic lung disease benefit greatly from a multidisciplinary approach to care and gain the most benefit from this care if delivered in the community, closer to home. This ensures that individuals have two key elements of care: physical and psychological support. These are important, when living with such chronic disease, to help the individual cope with distressing symptoms such as breathlessness, as well as ensuring that respiratory infections are treated earlier to prevent worsening structural damage to the lungs. Professionals involved in supporting individuals with respiratory conditions should be trained in techniques which build self-sufficiency in their clients and address health related behaviours such as smoking and obesity. Pulmonary rehabilitation provides many aspects of this care and should be available locally for all patients with chronic lung disease.

Pulmonary Rehabilitation

Pulmonary rehabilitation is a programme of exercise and education for people with long-term chest problems designed to help patients manage breathlessness due to respiratory conditions. Pulmonary rehabilitation aims to improve patients' exercise tolerance, quality of life, and reduce breathlessness. The service in Halton is provided by Warrington and Halton NHS Foundation Trust’s Rapid Respiratory Team. The programme runs twice weekly for 6 weeks. Each session comprises of 1 hour of individualised exercise and 1 hour of education. Each person receives a resource pack on completion with all aspects of education topics included and encouragement for people to continue with exercises at home after they have completed the course in order to maintain the benefits it produces. There are a number of ongoing exercise classes arranged for pulmonary rehabilitation patients the Halton Health Improvement Team.

- Between March 2012 and December 2013, 420 patients attended Pulmonary Rehabilitation in Halton. 69% at Halton Hospital and 31% at Ditton Community Centre.
- The largest referrers were GPs, Respiratory Consultant (Halton) and respiratory physiotherapists. Of the GPs, Castlefields, Weavervale and Grove House referred the most patients.
- Of those that attended; 171 patients completed at least 9 of the 12 sessions, 64 patients partially completed (<9 sessions), 49 did not attend and 101 were unable to attend due to illness.
- As of June 2015 there were 22 people waiting for an appointment for assessment with a waiting time to assessment of 10 weeks. The service currently sees around 17% of people with respiratory illnesses.

Pulmonary rehabilitation

The programme

Pulmonary rehabilitation is an exercise and educational programme designed to help patients manage breathlessness due to respiratory conditions such as COPD. Pulmonary rehabilitation aims to improve patients' exercise tolerance, quality of life, and reduce breathlessness. For more detailed information about pulmonary rehabilitation there are links to the NHS Choices and British Lung Foundation Websites below.

We run a six-week programme which patients attend twice weekly for two hours. Classes will run every Monday and Friday in Runcorn and Tuesday and Thursday in Widnes.

Pulmonary rehabilitation is available both in Widnes and Runcorn; all sessions are in the afternoon.

Who should be referred?

Patients with a diagnosed respiratory condition with symptomatic breathlessness do well on this course.

Expert Patient programme

The Expert Patients Programme (EPP) is a self-management programme for people living with a chronic (long-term) condition. The aim is to support people by:

- increasing their confidence

- improving their quality of life
- helping them manage their condition more effectively

Local Authority Public Health have just commissioned an extension of the Expert patient programme which will encourage people to live healthy active lives, better manager their own conditions and be able to be more involved in decision making around their care.

Asthma

The children's multidisciplinary asthma pathway at St Helens and Knowsley Acute Trust and Warrington & Halton Hospitals Foundation Trust for children presenting at A&E incorporates self-management plans and guidance on self-care. School nurses also signpost parents/carers to access their GP/Practice nurse for appropriate asthma management as necessary.

Lung cancer

The Runcorn and Widnes Cancer Support Group has been providing numerous support services for a number of years ranging from basic information, to caravan breaks, it offers support and information on the whole range of cancers including lung cancer. Funding for the service has been agreed collaboratively between the CCG, Halton Borough Council and Public Health going forward and the service will continue to receive referrals from a variety of health professionals across the locality including GP's and social services and explore ways to raise awareness of the service across Halton.

Widnes & Runcorn
CANCER SUPPORT
Centre

0151 423 5730 / 0151 424 8989

Widnes & Runcorn Cancer Support Centre 21-23 Alforde Street, Widnes, Cheshire WA8 7TR

Call in anytime Monday to Friday 10am to 3pm

Integrated Breathe Easy Project

The British Lung Foundation’s Nesta-funded ‘Integrated Breathe Easy project’ aims to increase self-care opportunities for people affected by respiratory illness. Halton Clinical Commissioning Group is working in partnership with BLF to support the development of two new groups (Widnes and Runcorn). The groups provide peer support and access to a wide range of information that enhances and supports wellbeing. The groups are part of a national project seeking to establish the value of group-delivered self-care due to report in June 2016.

Breathe Easy Widnes	**Breathe Easy Runcorn**
Where: Ditton Community Centre, Dundalk Road, Widnes, WA8 8DF **Date:** First Tuesday of each month **Time:** 12.30pm to 2pm	**Where:** Palacefields Community Centre, The Uplands, Runcorn, WA7 2UA **Date:** Second Wednesday of each month **Time:** 12.00pm to 1.30pm

Patients, Friends, family or carers are welcome to just turn up
There is usually a respiratory healthcare professional in attendance

Breathe Easy groups provide support and information for people living with a lung condition, and for those who look after them.

Groups hold regular meetings, usually monthly, where people can meet and talk to others, share their experiences and learn from each other. Regular speakers can also share information about living with their condition and coping with the emotional aspects of having a lung condition.

They also raise awareness locally about lung conditions, their group and the BLF.

Breathe Easy Case study

"When I returned from Australia I found that I was unable to walk my dogs, walk up slopes or even bend down without getting out of breath. I then caught flu which also affected my chest quite badly. I visited my practice nurse who gave me spirometry and informed me my lung age was 80. I was prescribed an inhaler and told to come back in 4 weeks. My flu got worse. Two weeks later I collapsed and ended up in hospital. I was prescribed antibiotics. I felt down as I used to be so active. Four weeks later when I saw my nurse again she gave me the BLF COPD leaflet and told me that I had COPD. I went home and cried and felt really down again. I read the leaflet which really helped but I still felt panicky. I then went on to the BLF website and found out that there was a Breathe Easy group in Runcorn and the next meeting was imminent. I went along to the Breathe Easy group meeting and haven't looked back. I found BLF information including the BLF COPD passport available and it was so good to meet and chat to other members who have the same condition as me. They gave me advice and tips at that meeting. I took a copy of the COPD passport away and went with my daughter to see my GP who went through each step and explained what it meant. At the next Breathe Easy meeting the community respiratory nurse talked to us about inhalers and inhaler technique. I realised that I had been using mine incorrectly and the nurse showed me how to use it properly. When I visit the chemist they sometimes call me in to ask me about my medications and I had been prescribed a new inhaler. We tried to work out how to use it but I realised that I had been using it incorrectly until the nurse showed me at the Breathe Easy meeting. Next time I am at the chemist I am going to tell them the correct way. I am also waiting to go on a course of pulmonary rehabilitation which I am looking forward to. Sometimes I still feel down but I can honestly say that since joining the Breathe Easy group I have felt so much better and it has changed my life; I know that it is not the end. I have also joined other local groups and realise that I can lead a full life."

Actions for Promoting Self-care and Independence

- Develop a range of interventions to support self-management
- Improve the feedback of patients and carers on their experiences of respiratory services
- Further develop and expand the Expert Patients Programme

Recommendations

There are key actions to be considered in order to achieve each individual aim of the strategy and ultimately improve respiratory health and respiratory health outcomes for people in Halton that are highlighted at the end of each chapter. These actions form the key recommendations of this strategy and are summarised below:

VI. Prevent respiratory ill health

Smoking
- Increase the number of people attending Smoking Cessation Services in Halton
- Reduce the proportion of people smoking in Halton

Vaccination
- Increase the uptake of flu vaccination amongst at risk groups, to achieve national target
- Increase uptake of childhood vaccinations in lowest uptake practices.

Obesity
- Improve access and uptake to lifestyle advice across the borough
- Increase the proportion of people taking regular daily exercise in Halton

Drugs
- Improve education and awareness of the impacts of cannabis use especially preventing young people from starting to use cannabis.

Housing
- Increase access to grants and equipment to increase energy efficiency in People's homes
- Continue to work across the private rented sector to improve housing standards

Environment
- Continue the implementation of the Halton Council Transport Plan to improve traffic flow, reduce emissions and encourage active transport
- Identify opportunities to further improve air quality across Halton

VII. Earlier detection of respiratory diseases

Cancer
- Ensure that increase the number of appropriate 2 week wait referrers to increase early diagnosis and enable early treatment of lung cancer
- Expand the Get Checked campaign to further increase awareness of signs, symptoms and encourage early presentation for lung cancer.

Chronic Obstructive Pulmonary Disease
- Encourage improved and early case finding to facilitate better management and treatment access

● Develop and implement a Borough wide, inclusive community spirometry service

Interstitial Lung Disease
● Ensure risk markers are identified on patient records, known risk occupations etc

Obstructive Sleep Apnoea
● Improve mechanisms for case finding, including access to spirometry and diagnostic tools to ensure rapid access to treatment and management

People with Learning Disability
● Adults with learning disability should be considered a high risk group for deaths from respiratory problems, screening and risk assessment should be included as part of the annual health check for patients with a learning disability.
● People with learning disability should be regarded as a high risk group for the purpose of seasonal flu and pneumonia vaccination programmes even if they do not live in a residential care setting.

VIII. Primary Care and Community based support

General
● Ensure the NICE Guidance and Quality Standards compliance in the recognition, diagnosis and management of respiratory illness and ensure best practice service commissioning.
● Pro Active Care programme Local Enhanced Service (2014/15)
● Review provision of pulmonary rehabilitation across Halton
● Establish integrated delivery of respiratory services across Halton
● Improve prescribing, in line with guidance[19], of respiratory medication across primary care

Asthma and COPD
● Implement standardised COPD and Asthma template across primary and secondary case
● Practices to benchmark recording of smoking status for patients on the COPD and asthma registers and set local reduction targets.
● Every patient diagnosed with asthma to receive a personalised action plan and annual review.

ILD
● Recording of occupation, particularly for risk occupations, on primary care records and identify those at possible risk of ILD to red flag early warning signs and symptoms.

OSA
● Maximise case finding against OSA predictor calculator and ensure rapid access to diagnostics.

[19] Pan Mersey Area Prescribing Committee Guidelines http://www.panmerseyapc.nhs.uk/guidelines.html

● Review the pathway for people with OSA

Bronchiolitis
● Rapid review (and application) of NICE Guidance when it is released in May 2015
● Review cause for practice variations in admissions for bronchiolitis across Halton practices

IX. High Quality Hospital Services

General
● Review Warrington & Halton NHS Foundation Trust Rapid Response Respiratory Team
● Review current arrangements regarding Halton adult residents admitted to Whiston Hospital with respiratory health problems
● Review current arrangements regarding Halton children & young people admitted to Halton and Warrington Hospitals and ST Helens and Knowlsey Hospitals with respiratory health problems
● Ensure the NICE Guidance and Quality Standards compliance in the treatment and secondary care management of respiratory illness and ensure best practice service commissioning.

X. Promoting Self Care and Independence

General
● Develop a range of interventions to support self-management
● Improve the feedback of patients and carers on their experiences of respiratory services
● Further develop and expand the Expert Patients Programme

The recommendations will be translated in to the Respiratory Action Plan and progressed assessed against these, and current actions by the Respiratory Health Group

How Will We Know Strategy Is Successful?

By 2020 this strategy will have;

I. Embedded respiratory health into a range of preventive programmes and be seeing a decline in prevalence of a number of key preventable respiratory illnesses.
II. Improvements in smoking quit rates and increase number of people referred to smoking cessation services.
III. Increased uptake of flu vaccination amongst those with existing respiratory conditions and amongst those with other on term health conditions, including those with learning disability, to mitigate the effects of flu on general respiratory health.

IV. Improved awareness within the general population of factors that prevent and protect against respiratory ill health, enable earlier identification of problems and health seeking behaviours.
V. Improved the recognition, diagnosis and management of a variety of respiratory illnesses (including COPD, asthma, lung cancer) within primary care.
VI. Developed a range of interventions and support to enable individuals and their carers to better 'self–manage' their respiratory condition.
VII. Involved more individuals and their carers in the planning and quality assurance of respiratory health services.
VIII. Improved the pathways between primary, acute, residential, nursing and social care for individuals and their carers.

Contributors

Many thanks to the Halton Respiratory Strategy Group, and other colleagues who have contributed to the development of the strategy.

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Document Summary

Title
Respiratory Strategy for Halton 2015 – 2020,

Date
Produced July 2015

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REPORT TO:	Executive Board
DATE:	19 November 2015
REPORTING OFFICER:	Strategic Director, People and Economy
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Formation of a Merseyside Regional Sensory Service
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To outline proposals for a collaborative procurement process to establish a regional sensory service, this will include delivery of statutory assessment of need. The report also sets out Transfer of Undertakings Protection of Employment (TUPE) implications and seeks Executive Board approval to transfer four Council employees to this service.

2.0 **RECOMMENDATION: That**

1) **Executive Board note the report and;**

2) **In accordance with the Transfer of Undertakings Protection of Employment (TUPE) Regulations 2006 Executive Board approve the transfer of two full time Vision Rehabilitation Officer Posts and two part time Support Worker Posts to the proposed Merseyside Regional Sensory Service.**

SUPPORTING INFORMATION

3.1 At its 20th November 2014 meeting Executive Board agreed (Minute 90) to recommend to Council, budget savings for 2015/16 which included £50,000 from the restructure of vision rehabilitation services both in-house and within the voluntary sector

3.2 Rather than looking at vision rehabilitation in isolation a more pragmatic approach is to consider all provision to meet the needs of those with sensory impairment. Sensory services are provided across all age groups though highest and growing demand arises from the needs of the ageing population. Dual sensory loss, that is both visual and hearing impairment, is now widespread amongst older people and the impact can severely restrict a person's daily living.

3.3 Statutory assessments of need relating to sensory loss and prevention and early intervention support are offered by the Council through in-house services and contracts held with voluntary sector providers.

3.4 Commissioners across Merseyside are proposing to establish a regional sensory service for both statutory and non-statutory services. Combining resources across the region will achieve efficiencies by maximising capacity to meet increasing demand for statutory assessments of need and maintain a focus on preventative support whilst maintaining service quality.

3.5 Halton is participating in this regional procurement process and engagement with providers, service users and other stakeholders is underway. It is also proposed to externalise the in-house vision rehabilitation service through a transfer to the regional service.

3.6 Currently two full time vision rehabilitation officers are employed by the Council. In addition one officer is supported by two 18.5 hours per week, support worker posts under access to work. Transfer of Undertakings Protection of Employment (TUPE) regulations apply to all four posts.

3.7 The transfer will be managed as part of the procurement process and relevant employment information including current terms and conditions will be shared with bidders. Bidders must sign a declaration that they are satisfied that the Transfer of Undertakings (Protection of Employment) Regulations 2006 apply to the contract for the regional service.

3.8 Executive Board are asked to approve the transfer of the two vision rehabilitation officer posts and the two associated access to work support posts to the proposed Merseyside Regional Sensory Service.

3.9 Work is underway to identify needs for those living with sensory loss and services will be co-designed through service user/provider engagement at both regional and local level. Rehabilitation will remain a focal point of the service with innovative solutions including use of assistive technology and digital inclusion to support daily living being championed.

3.10 One service provider will be contracted to lead the regional service and will collaborate with other agencies to ensure comprehensive support for sight and hearing loss is available. A core specification will be established to ensure compliance with legal duties. Each Authority will determine its financial contribution to this and the additional services required to meet local priorities.

4.0 **POLICY IMPLICATIONS**

4.1 As part of the UK Vision Strategy a number of priorities have been set for England and include:

'*Habilitation and rehabilitation available on a free and timely basis for as long as needed to learn or relearn key life skills including mobility'*

This priority will continue to be met through vision rehabilitation services within the proposed Merseyside Regional Sensory Service.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The redesign of sensory services, transfer of posts to a regional service and the setting of a financial envelope for the procurement of future services will achieve the required savings identified by Council.

5.2 The Council's HR section will work with the service to ensure compliance with all prevailing employment legislation relating to the TUPE transfer outlined. This will include informing and consulting with staff in scope of the transfer and providing the required Employment Liability Information to a new provider, as the new employer. Section 8.0 of the Council's Staffing Protocol will apply; this assures that staff terms and conditions are protected upon transfer in their current job role to a new employer.

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

6.1 **Children & Young People in Halton**
Sensory service provision is across all ages and the needs of children, young people and their families will be considered in developing the regional service.

6.2 **Employment, Learning & Skills in Halton**
None identified

6.3 **A Healthy Halton**
None identified

6.4 **A Safer Halton**
None identified

7.0 **RISK ANALYSIS**

7.1 Demand for statutory assessments relating to sensory impairment is increasing and this will be managed as a priority within the redesigned regional service.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Equality and Diversity issues will be considered within the service specification for the regional service.

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

None under the meaning of the Act.

REPORT TO:	Executive Board
DATE:	19 November 2015
REPORTING OFFICER:	Strategic Director, People and Economy
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Additional Payments (for Accommodation) - Policy
WARD(S)	Borough-wide

1.0 PURPOSE OF REPORT

1.1 To outline the circumstances around 'Additional Payments' (sometimes known as Top-Ups) made by people who choose to pay extra for an enhancement to their home accommodation. Such additional payments can be made by individuals whose care home costs are partially or totally supported by the Council, or who are self-funders with Halton arranging their social care.

2.0 RECOMMENDED: That the Board agrees the current 'Additional Payments' Policy.

3.0 SUPPORTING INFORMATION

3.1 Under the Care Act 2014 an individual can choose care home accommodation best suited to their needs. This may be more expensive than the 'going rate' for the type of accommodation that Halton has negotiated with the provider for a person with such needs. In such cases, a 3rd party, usually a nominated family member, will agree to pay the additional amount the provider is asking. Dealing with these 'additional payments', monitoring them and agreeing liability when the 3rd party can no longer continue to make such payments is what the policy sets out.

3.2 Prior to the Care Act, those who had the financial resources to pay for their own social care (self-funders) typically communicated entirely with their provider of choice. If they opted for an improvement on their current accommodation which was more expensive than initially arranged, then a 3rd party would agree to pay any additional amount required. This would be a private agreement between the 3rd person and the provider, Halton was not involved.

3.3 For those who were part-funded or wholly funded by Halton, the person or their family would choose an appropriate care home from a number of affordable options. The provider would enter into a contract with Halton to provide care at the rate specified and on Halton's terms

and conditions.

3.4 However, if the person or their family selected a provider that was more expensive than their funding entitlement from HBC allowed, or perhaps selected an upgrade to a slightly bigger room, then they would arrange to pay the extra separately to the provider as an additional payment. This would be a separate agreement between the 3rd party who was paying the extra amount and the provider. Halton was not involved, as this was viewed as part of the person's independence and freedom to choose his/her own living accommodation.

3.5 Because responsibility for top-ups has historically been between the 3rd party and the provider, Halton has never previously required an Additional Payments policy. However, in the light of the changes stemming from the Care Act and advice from Halton's legal department, this approach is no longer regarded as best practice. It could result in a greater risk of litigation in situations where the 3rd party is no longer able to maintain payments. Legal felt that a policy would be beneficial. The Act recommends that each LA should have a level of oversight of the Top-Up payments between 3rd party and provider.

3.6 Halton's legal department have recommended that most appropriate way to achieve this is to have a policy and a tripartite agreement which clearly states that liability lies with the 3rd party if Top-Up payments can no longer be met. Failure to do so could result in prolonged and expensive legal cases involving not only the provider, but also the 3rd party or the person in need of care.

3.7 This report strongly recommends the second option and a draft contract is provided in Appendix 1 of the policy. Having both a policy and a contract is viewed by the Department of Health as best practice. In addition, clearly identifying the 3rd party as being solely liable for any additional payments will indemnify the Council against unnecessary legal costs.

3.8 Advantages:

- If the agreement was between the 3rd party and the provider and the 3rd party failed to maintain payments for whatever reason, then depending upon the provider's accounting system it could be weeks before the deficit was noticed. In the absence of a contract clearly stating that liability lies with the 3rd party, the provider could make a claim for the shortfall off the Council and this could have accumulated to a considerable sum. Having a tri-partite agreement (HBC, 3rd party and Provider) which clearly states that the 3rd party is liable for all

Additional payments would be a better approach;

- Further, if the 3rd party notify the Council at an early stage that they are experiencing difficulty making the extra payment then HBC could then take appropriate steps to investigate the problem and offer financial advice. Adopting this approach gives Halton a level of oversight that would enable any 3rd party financial difficulties to be spotted early and acted upon;

- The Care Act Guidance recommends that although not a duty, it is nonetheless best practice for a LA to monitor and assist where possible by offering such financial information and advice;

3.9 According to estimates, of the number of self-funders in Halton 207 receive care and support at home and 300 are in residential or nursing homes. It is possible there could be a significant increase in the number of individuals choosing accommodation where an additional payment is required. Research carried out by Age UK in 2013 found that around 30% of care home residents in England were expected to supplement the cost of their stay by making additional payments (often as much as an extra £140 per week) through a 3rd party.

3.10 This policy recommends that as best practice, a 3-way agreement be drawn between the 3rd party, the provider and HBC. This agreement stresses that liability for payment of the additional amount lies with the 3rd party. The Council will be responsible for paying agreed standard fee that it has negotiated with the provider and the 3rd party is responsible for making extra payments direct to the Provider. In the event of the 3rd party having financial difficulty making such payments, they must inform HBC as soon as possible, so that advice and assistance can be provided.

4.0 POLICY IMPLICATIONS

4.1 This is a new policy.

5.0 SAFEGUARDING IMPLICATIONS

5.1 There are no implications for this priority.

6.0 FINANCIAL IMPLICATIONS

6.1 In 2013 Age UK estimated that around 30% of Care Home residents in England were making 'Additional Payments' (often as much as £140 per week through a 3rd party, to their care home provider (an annual increase of 5%). They suggested this was likely to continue as more providers viewed such payments as a means of supplementing their income, by claiming that Council funding for placements was not enough.

6.2 According to the Performance Team, Halton currently has 620 people in care homes in and out of the Borough. This figure includes those whose full cost is arranged by Halton CASSR. In addition, there are 300 self-funders making a total of 920 in residential care in the Borough. Using the Age UK estimate of 30% this suggests that 276 of these are paying additional fees to providers in 2015 through 3rd parties. If we assume a 5% increase each year then this will suggest 305 by 2017 and 353 by 2020. These figures represent a rate of 5 per week (2015) to 7 per week (2020). What is the financial implication of these figures?

6.3 However, according to the Area Manager (Revenues & Benefits) this impact is likely to be minimal and can be absorbed within current practice, with few changes, without the need for extra staff and without extra cost.

6.4 The Social Work assessment team will need to flag up the issue of 'Additional Payments' during the assessment process which can be weeks before the financial assessment. Again, this can be included in the current assessment procedure, with present staffing, using current procedures and at no extra cost.

6.5 The Care Arranging team currently create a service agreement for each individual entering residential care at basic cost. The cost of producing additional service agreements can be absorbed by the extra Care Arranger posts that were created as part of Halton's implementation process for the Care Act. These allow the Council considerable flexibility in coping with any potential increases in the volume of service agreements.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 Children & Young People in Halton

There are no implications for this priority.

7.2 Employment, Learning & Skills in Halton

There are no implications for this priority.

7.3 A Healthy Halton

There are no implications for this priority.

7.4 A Safer Halton

There are no implications for this priority.

7.5 Halton's Urban Renewal

There are no implications for this priority.

8.0 RISK ANALYSIS

8.1 This is covered in section 16 of the policy

9.0 EQUALITY & DIVERSITY ISSUES

9.1 There are no Equality and Diversity implications arising as a result of the proposed action.

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

None.

People & Economy Directorate

The Care Act

Additional Payments for Accommodation In Residential Care

(Top-Up Fees)

Policy, Procedure and Practice

2015 - 2017

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INFORMATION SHEET

Service area	Financial Assessment and Social Care Commissioning
Date effective from	June 2015
Responsible officer(s)	Area Manager Revenues & Benefits Quality Assurance Manager Complex Care and Commissioning Policy Officer (Communities)
Date of review(s)	May 2017
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)** •	Mandatory
Target audience	Financial assessment and commissioning teams
Date of SMT decision	02/06/15
Related document(s)	Guardianship, November 2013 Nearest relative, November 2013 Section 135, November 2013 AMHP Management Responsibilities, November 2013 Mental Health Act, Section 117 Policy, HBC 2015
Superseded document(s)	None
File reference	GGCTUPJUNE15

	POLICY	Practice
	Scope This policy is intended to assist officers of Halton Borough Council involved in carrying out social care need assessments and financial assessments. It also includes officers carrying out reassessments, reviews, support planning, direct payment audits or who are otherwise involved in the arrangement and administration of services for people with assessed eligible care needs. It provides a clear framework to the Council's position on Care Top Up payments.	
1	**Background**	
1.1	Under the Care Act 2014, Local authorities (LAs) have a duty to arrange care and support for those with eligible needs and a power to meet both eligible and non-eligible needs. Where it decides to charge it **must** follow the Care and Support (Charging and Assessment of Resources) regulations and have regard to the guidance.	
1.2	The LA **must** not charge more than the cost it incurs meeting the assessed needs of the person. In addition, it cannot recover any administration fee related to arranging that care and support, with the exception of an individual who is self-funding their own care whose assets are above the upper capital limit.	Because of the postponement of Phase 2 of the Care Act, LAs no longer have a duty to arrange care for self-funders. It may do so however as 'good practice,' if the number of self-funders is small.
1.3	Prior to charging the individual, the LA must first carry out a financial assessment of what the person can afford to pay. It must explain how the assessment is carried out, what the charge will be and how often it will be made. It must be communicated to the person in a way that can easily be understood, in line with the LA's duty to provide Information and Advice under the Care Act 2014. If after the financial assessment a person has to make a contribution to the cost of their care, they must not be asked to pay more than the assessment says they can afford to pay.	
1.4	Where a local authority is meeting needs by commissioning a care home, it is responsible for contracting with the provider.	
2	**Choice of Accommodation**	
2.1	If the LA has determined that the person's needs are best met in a care home, it must provide for the person's preferred choice of accommodation, subject to certain conditions. Determining the appropriate type of accommodation will be made with the adult as part of the care and support planning process.	This being the case choice applies only between providers of the same type: nursing, residential…etc.

2.2	The LA **must** ensure that the person has a genuine choice and **must** also ensure that at least one option is affordable and within the person's personal budget. Provided choice of accommodation is: • Suitable and available; • Will not cost more than the amount specified in the adult's personal budget for accommodation of that type; and • The provider is willing to enter into a contract with the LA to provide the care at the rate specified in the personal budget **on the LA's terms and conditions**.	It **should** also ensure than one such option is always available. Choice is not limited to providers or settings with which Halton already contracts with or operates, or even those within Halton. It must be a genuine choice that can be outside the Halton area. (but see Care Act Guidance on Ordinary Residence).
2.3	However, a person must also be able to choose alternative options, including a more expensive setting where a third party or in certain circumstances the resident is willing and able to pay the additional cost. This is known as a Top-Up. This additional payment **must** always be optional and never as the result of market inadequacies or commissioning failures leading to a lack of choice.	Halton **must not** ask for the payment of a Top-Up fee. Such a payment can only be sought **when the person has chosen** a more expensive accommodation.
2.4	The LA must take steps to ensure the person understands the full implications of this choice, by providing sufficient information and advice around the terms and conditions. For example, it must be clearly established that suitable funding can be arranged by the person their family or friends and that this additional amount will be available long-term to fund Top-Up payments over a number of years (see sections 6 - 8).	This is a crucial part of the financial assessment and it is important that it is communicated to the person along with the consequences of failure to maintain Top-Up payments.
2.5	If no preference has been expressed and no suitable accommodation is available at the amount specified in the personal budget, then the LA must arrange care in a more expensive setting and adjust the budget accordingly to ensure needs are met. This however, would be treated as a temporary arrangement only, subject to review that would seek to secure care and support at the agreed council rates. Such temporary arrangements would be contracted at the best affordable price, closest to the Council's current rate. In such circumstances, the council cannot ask for the payment of a Top-Up fee.	The social worker who has completed the assessment, makes it clear that this would be a temporary arrangement only, until more suitable accommodation that meets needs, is found.
3	**Choice that Cannot be Met and Refusal of Arrangements**	
3.1	Inevitably there will be occasions when a person's choice cannot be met, for example if the provider hasn't the capacity to accommodate the person. In such situations the LA must set out in writing why it cannot meet the individual's choice and offer similar alternatives. It should present details of the LA's complaints procedure and if and when the decision may be reviewed.	
3.2	Where a person unreasonably refuses the arrangements the LA is entitled to consider that it has fulfilled its statutory duty to meet needs and may then inform the person in writing that	

	they need to make their own arrangements.	
3.3	However, this should be a step of last resort and the risks posed by such a step would need to be considered for both the authority and the person concerned.	
3.4	Should the person contact the LA again at a later date, then the LA should reassess the person's needs and re-open the care and support planning process.	
	PROCEDURE	
4	**Charging for Care and Support in a Care Home**	Where a person contributes to the cost of their care following a financial assessment, they must not be asked to pay more than their assessment shows they can afford.
4.1	As a consequence of the financial assessment, the LA must assure itself that even if the person remains responsible for paying for their own care, they must have sufficient assets for the arrangements that are put in place to be both affordable and sustainable.	
4.2	Where a person is receiving more expensive care and support solely because the LA has been unable to make arrangements at the LA budget cost, the personal budget must be adjusted to reflect this additional cost.	
4.3	In the case of a self-funder who approaches Halton for an assessment and asks the LA to arrange their care home placement. If Halton decides to help the person chose a care home, then the LA will charge the self-funder for the administrative costs in doing so.	
5	**Availability**	
5.1	The LA has a duty to shape and facilitate the local market of care and support services to ensure there is sufficient supply. As a result the person should not have a prolonged delay before their needs are met. However, in some cases a short wait may be unavoidable, especially when the person has chosen a particular setting that is not immediately available. Putting in place a temporary arrangement may be necessary, however as such arrangements can be unsettling for the person, they should be avoided where possible.	It is important to keep in touch with the person during the temporary arrangement. To do so the person's needs would ordinarily be reassessed after 6 weeks. This would ensure that any interim and assessed options still meet their needs and that their choice is unchanged.
5.2	In establishing temporary arrangements the LA must provide the person with clear information in writing as part of their care and support plan.	
5.3	A person may decide to remain in their interim setting, even if their original preferred choice becomes available. If the setting of their temporary residence is able to accommodate the arrangement on a permanent basis, then this should be arranged and the person removed from their preferred waiting list. However before doing so, Halton must make clear the	

	consequences of their choice, especially the long-term financial implications.	
6	**Additional Payments or Top-Up Fees**	
6.1	If a **person chooses** a setting that is more expensive than the amount identified for the provision of accommodation in their personal budget then an arrangement has to be made to meet the additional cost (Top-Up).	
6.2	In such cases the LA must arrange for the person to be placed there, provided a 'third party' or in certain circumstances, the person in need of 'care and support,' (first party) is willing and able to meet the additional cost. *First Party Top-Ups*	
6.3	A person can pay their own top-up fee if: • they have entered into either a 12 week Property Disregard; • They have a Deferred Payment Agreement in place; • They are receiving accommodation that is provided under Section 117 for mental health aftercare.	
6.4	If however, the LA has placed the person in the more expensive setting because it has not been possible to make arrangements at the anticipated cost, the personal budget must reflect this and the LA would not be able to ask the person to reimburse the Top-Up element. <u>A Top-Up Example</u>:	
6.5	If the LA had a standard rate of £450 a week and there are two care homes available, both of which have a place and are equally able to meet the person's assessed needs. The first is quite basic as far as décor is concerned and costs £450 a week. The second is more luxurious and costs £490 a week. If as is the case both are equivalent in terms of meeting needs, then the LA will only fund the standard rate. If the person chooses the second more expensive option, then the LA would ask for a Top-Up to cover the additional £40 a week.	The more expensive option is not a necessity. If the person chooses it, they must pay the extra amount.
6.6	If however, the only available care home to **meet all of the person's needs** was the second one, then the council would have to increase its standard rate to £490. This would be because the more expensive care home was supporting some additional needs. In this case the LA could not ask for a Top-Up.	The person has no choice in this case. So neither they nor a third person would have to pay the extra.
6.7	Such additional needs could be as follows: ➢ The person has to locate to a more expensive part of England to be nearer family;	

	➢ The person's first language is not English and it may be reasonable for the LA to pay more for a care home where there are staff and other residents who can speak the person's language; ➢ The person may have additional cultural or spiritual needs which can only be met in a specific type of care home which can cater for these or which is closer to the individual's pace of worship; ➢ The person requires special dietary requirements or requires specialist care, which can only be met in a home designed to meet such requirements; ➢ The person has very specific needs such as a hearing visual or physical impairment and the care home is specifically designed to meet such needs.	
7	**Third party Top-Ups**	
7.1	Any individual (self-funding or otherwise) who has decided to choose more expensive care and support can make use of a third party to help pay for the services which are more expensive than the LA would normally pay to meet their assessed eligible needs. This is called a third party Top-Up.	Any fees charged by the provider are likely to increase in line with inflation. Once a 3rd Party Top-Up agreement has been signed, the Provider would not be able to increase fees for a year.
7.2	The third party is usually a family member or a friend, but it can be anyone. This option allows people to choose the care and support they wish.	
7.3	Only one person can be named as the third party. However, this does not prevent other family members getting together and agreeing the payment between them. It does mean that only one individual (member of the family) is responsible for making the payments and can be liable for any default, if payments are not made.	It is important that both the provider and the person are made fully aware of the consequences (legal and financial) of the contract they have signed (see 8.3).
7.4	The third party must be both willing and able to continue making the Top-Up payments from their own account, for the duration of the person's stay at the care home. They cannot use the cared for person's assets or their income to cover the Top-Up payments.	
7.5	For an individual who lacks mental capacity (i.e. who has failed a capacity test), then any choice made on their behalf with the assistance of an advocate or other person (often a close family member or friend), would have to be shown to be in the person's 'best interests.'	See Mental Capacity Act 2005, Policy Procedure and Guidance, HBC, December 2013.
8	**Agreeing to a Top-Up Fee**	
8.1	Having chosen a more expensive setting it is important that the social worker responsible for conducting the care assessment makes the person aware of the full implications of this choice. This involves making the person more aware of the consequences of their choice which can lead to future crisis if payments can no longer be made. If the additional cost cannot be met then it is	This would be explained during the discussions that are an important part of support planning and financial assessment.

	important to explain that the care provided may have to be moved to an alternative setting.	
8.2	According to the Care Act best practice suggests that a written agreement between the person paying the Top-Up (third party), the provider and the LA must be drawn up (Appendix 1 is a draft agreement). The third party will agree the amount and will pay this themselves from their own financial resources directly to the Provider for the duration of the person's stay at the care home.	This 3-way agreement ensures that Top-Ups are a matter of choice and not a necessity. Guidance suggests relatives, residents, the Council and the provider to develop the third party Top-Up agreement together.
8.3	Prior to entering into the agreement, the Council must provide the person paying the Top-Up with sufficient information and advice to ensure that they fully understand the terms and conditions, including actively considering the provision of independent financial information and advice (see appendix 2 and the list of independent financial advice services available on the Council website (Appendix 3).	
8.4	The CareFirst 6 process for recording Top-Ups is as follows: • Social care and Financial care assessments carried out as closely to each other as possible, given time constraints; • Care Manager identifies Top-Up agreements on the person's Support Plan Summary (SPS); • Review date arranged; • A trigger is sent from the SPS to the Care Arranger for the standard agreed amount payable to the Provider (not the Top-Up); • Care Arranger records a service agreement for the amount in CF6 using the current Residential Service types.	
9	**Failure to Continue To-Up Payments**	
9.1	For a variety of reasons the Top-Up arrangement may fail with the result that Top-Up payments are no longer made and a Top-Up debt accumulates. The tripartite agreement between the LA, the 3rd Party and the Provider must make it clear that the LA will not under any circumstances accept liability for any arrears owed in relation to the top up element, which the service user or third party is liable for and has subsequently failed to pay.	The SW must be confident that the consequences of failure to pay are thoroughly explained to the person and / or the 3rd Party and fully understood by them and the provider. Only when this has been established can the agreement be signed.
9.2	The 3rd party must inform HBC as soon as possible if they are having financial difficulty in meeting the Top-Up payment. This gives the council a level of overview and an opportunity to offer financial advice and guidance where necessary. Ultimately however, the legal responsibility for making the additional payment to the Provider lies with the 3rd party and not HBC. This will have been explained in the signed agreement between the 3rd party, the provider and HBC.	This is in keeping with best practice under the Care Act 2014. This should be communicated to the **Revenues and Benefits Team.**
9.3	Providers must share information regarding any Top-Up agreements with HBC before the placement commences. This is to ensure the arrangement is in line with government guidance.	
9.4	Top-Ups will only be applied for costs and services over and above the standard assessed care needs of the person	
9.5	Such arrangements can be agreed both with new residents and those who were previously self-funding in the home, but can no	Halton may move the person to another provider if such needs

	longer continue with the self-funding arrangement and have been assessed by Halton as requiring residential care.	are not being met. Such changes must be communicated to the LA in a timely manner.
9.6	On commencement of the placement (or its continuation if the resident was self-funding), providers must satisfy themselves and record that the person and / or their representative, can afford to pay the third party contribution. Any increase resulting in a Top-Up must be appropriate and proportionate. The intention to apply an increase must be communicated to both the person and Halton at least 30 days before the date on which the increase commences.	
9.7	If the person fails to maintain Top-Up payments then a full assessment will be conducted to see if the current service is the only one that can meet the person's current assessed needs.	
9.8	The provider must inform the Quality Assurance Team if the person fails to maintain their Top-Ups or if their circumstances change and they can no longer pay.	
9.9	The Provider must also advise Halton, service users and/ or their representatives of all financial aspects of the ''Third-Party Arrangement. Typically this would include: • Thresholds, processes, current legislation and guidance for Top-Ups. • How much the charges are • Who is responsible for them • What services do they cover	
10	**The Amount to be Paid and Frequency of Payments**	
10.1	The amount of the Top-Up will be the difference between the actual costs of the preferred provider and the amount that has been set in the individual's personal budget or local Mental Health after-care amount, as a means of meeting eligible needs through the provision of accommodation of the same type.	It is important that the financial assessor considers the personal budget set at the time care and support is needed, rather than defaulting to a cheaper rate or to any other arbitrary figure.
10.2	Typically a range of costs will be identified, offering choice and which apply to different circumstances and settings. In agreeing to any Top-Up arrangement, it must be clearly set-out and explained how often such payments are to be made (whether weekly or monthly).	
11	**Responsibility for Costs and to Whom Payments are Made**	
11.1	The LA can enter into a contract to provide care that is more expensive than the amount identified in the personal budget. For example, a more expensive setting may be required because other more appropriate settings that matched the person's needs were unavailable at the time.	This is quite a different situation to one where the person receiving care chooses a more expensive option. In the case of 11.1 and 11.2 no choice is involved as there are no other options available which match the person's eligible
11.2	Also, a more expensive option may be required because of the complex nature of the person's needs. Hence, if there is a breakdown in the Top-Up arrangement (the person making the Top-Up ceases to make their agreed payments), then the	

11.3	LA would not be liable for the Top-Up element alone. The authority could however agree to meet cost of the top-up to the provider until it managed to recover the additional costs incurred from the 3rd party or made alternative arrangements to meet the cared for person's needs. This is the Care Act's and Halton's preferred approach and requires a tri-partite contract signed by the 3rd person, the LA and the Provider. This approach requires greater transparency between all parties to the agreement. This makes it clear from the outset that liability is with the 3rd party and the process that must be adopted in the event of failure to make payments. This process will necessarily require a further assessment and it may be necessary as a last resort, to move the cared for person to another provider.	needs. The only exception is where funding is by a deferred payment agreement, when it would be added to the amount owed.
12 12.1 12.2 12.3 12.4 12.5	**Reviewing the Agreement and Price Increases** The Act states that local; authorities should review Top-Ups 'from time to time' and the Guidance has clarified this to mean at least an annual review. The reason being that it is important to check that the Top-Up payments are still affordable and the 3rd party remains able and willing to pay. The review would necessarily look at changes in circumstances of the cared for person, the person making the Top-Up payments (if different from the cared for person), the LA's commissioning arrangements or a change in provider costs. Such changes are unlikely to occur together and the LA must set out in writing how they will be dealt with. The contract will include details of how agreement will be reached on the sharing of any price increases. This should also point out that there is no guarantee such increases will be shared evenly, should the provider's costs rise more quickly than the amount the LA would have increased the personal budget or local mental health after-care. One way of assuring the Top-Up remains affordable is to negotiate in advance any future price rises with the provider at the time of entering into the contract. The LA would expect a care home placement to be sustainable for at least 3 years, paid from the individual's own capital, assets or savings. Where this is not possible, the council would look to the nominated third party to commit to pay any Top-Up costs. Otherwise, the person would have to move to a care home which accepted the LA's contract rate with a lower Top-Up or no Top-Up at all.	This review would nominally be annual. However if a payment was missed a review would be triggered. Also, if the person's circumstances change, this would require a support plan review. This detail around such changes should be included in the contract.
13 13.1	**Consequences of Changes in Circumstances** An unexpected change in a person's financial circumstances can	

	have a significant impact on their ability to pay the Top-Up. Halton has the power to make alternative arrangements to meet a person's needs subject to a needs assessment and can seek to recover any outstanding debt.	
13.2	The LA must set out in writing (as part of the contract) how it will respond to such a change and what the responsibilities of the person making the Top-Up payment are, in terms of informing Halton what their change in circumstances are.	Appendix 1.
14	**Self-Funders who Ask Halton to Arrange Their Care**	
14.1	Under the Care Act 2014, a person who can afford to pay for their own care and support in full can ask their local authority to arrange care on their behalf. This was to have been implemented in Phase 2 (April 2016) of the Act. This has now been deferred until 2020. Hence a local authority no longer has a duty to provide such an arrangement. However, it still may do so by way of providing information and advice.	
14.2	If the individual already has a contract with a provider then it must be made clear to them that although they are entitled under the Care Act to have their LA assess and commission their care with the same or a new provider, they must first see out the terms of their contract with their current provider. Usually they will have to give notice of termination to their provider 4-6 weeks in advance. In addition, they would have to meet all of their financial commitments to their provider prior to ending their contract. The person may also decide, having ended the contract and brought all payments up-to date, to move to another Care Home.	It is important that the Social Worker carrying out the social care assessment, discusses this issue and makes it clear where liability lies.
14.3	In supporting self-funders to arrange care, the LA can choose to enter into a contract with the provider, or may broker a contract on behalf of the person. Where the LA is arranging and managing the contract with the provider, it should ensure there are clear arrangements in place around how costs will be met, including any Top-Up element. These contractual arrangements must clearly set-out where the responsibilities for all costs lie and that the self-funder understands those arrangements.	
14.4	Self-funders will have to pay for the costs of their care and support. This includes situations where they choose a setting that is more expensive than the amount identified in their personal budget and the Top-Up element for the new cost for that setting.	The Care Act recommends this approach as 'best practice.' It enables the LA to monitor payments being made and any financial difficulties spotted at an early stage.
14.5	The Care Act recommends that LAs should enter into a tri-partite agreement with self-funders and care home providers. The self-funder would pay the full amount to the Council who would then pay the provider. This would enable the Council to monitor all payments from the self-funder and identify problems with payment at an early stage, before a large debt	

	was accumulated and the situation became critical.	
15 15.1	**People Who are Unable to Make Their Own Choice** If a person lacks capacity to express a choice for themselves then the LA will act on choices made by the person's advocate, carer or legal guardian in the same way they would on the person's own wishes.	This is provided the representatives are acting in the best interests of the person. Hence a Best Interests Assessment would be necessary.
16 16.1 16.2 16.3	**Choice of Accommodation and Mental Health After-care** Under Section 117A of the Mental Health Act 1983 those who qualify for after-care may express a preference for particular accommodation, provided such accommodation is specified in the regulations as part of that after-care. After-care is provided free of charge and for the purposes of S117 after-care, references to a 3rd party should be read as 'the adult receiving the after-care.' This is because an adult can also meet the additional cost when a local authority is providing or arranging the provision of accommodation in discharge of the after-care duty. As a means of securing funds to meet the additional cost to the LA the person or 3rd party will pay the Top-Up amount to the LA and the LA then pays the full amount to the provider.	For details of how S117 of the mental Health Act 1983 (amended 2007) overlap with the Care Act see HBC policy: Section 117, Mental Health Provision of Aftercare Services, April 2015. Top-Ups are discussed in 1.9.4. The SW (Mental Health) is responsible for developing a care plan with the person.
17 17.1 17.2	**Risk If 3rd Party Defaults on Payments** Where the agreement has been solely between the 3rd party and the provider then should payments fail to be made, it is quite possible that the provider depending upon their accounting system may not notice the default for some weeks or months. In the absence of a tripartite agreement they could make claim off the LA under the assumption the LA was liable for payments. This could be a sizeable accumulated amount and demonstrates the potential financial risk the LA could be faced with in the absence of an agreement. Conversely, an agreement which clearly states that liability will lie with the 3rd party in the event of failure to maintain payments would significantly reduce the likelihood of legal action against the LA by other signatories to the contract. This would also enable the LA to take action to retrieve payment and if necessary use the legal system to force the 3rd party to pay.	
18.0 18.1	**Agreeing Top-Ups and what happens next** The amount of the Top-Up must be agreed at the time the person starts receiving care and support or when they enter the care home. The care provider can review the Top-Up as long as they give suitable notice to the third party and it is	

	agreed between all three parties. The Care provider must notify the council of any intention they may have to alter the agreement.	
18.2	Once the council has received a copy of the Top-Up agreement from the third-Party and the financial assessment results, it will complete discussions with the provider and then inform the care manager to arrange a moving date for the person. However, this will only happen when the council is satisfied the third-party has the funds to make the agreed payments.	The social Worker is responsible for explaining the consequences, if the 3rd party should fail to make their Top-Up payments.

Draft

Appendix 1

HALTON BOROUGH COUNCIL

THIRD PARTY TOP-UP AGREEMENT FOR RESIDENTIAL CARE

This agreement is in respect of (“the service user”)…………………………………………
It concerns a placement in ………………………………………………………………..
Residential Care Home (“name of the *Care Home*”)…………………………………………
The cost of this requires a Third-Party Top-Up.

Following a full social care assessment of the Service User’s needs, we the Local Authority (LA) have established that residential care is necessary to meet their needs, and the Service User or their representative (where appropriate) has chosen to move to/ remain in “the Care Home” above, in which they will be/ are currently self-funding.

The Care Home’s weekly fee is greater than the “usual cost” Halton Borough Council has negotiated with care homes in its area or (where the Care Home is outside Halton) the “usual cost” agreed by the local authority within which the care home is located.

I agree to pay the Top-Up fee in respect of
(service user’s name)………………………………………………………………..………
Resident at………………………………………………………………………………………
…………………………………………………………………………………………………

The cost of the Top-Up fee is £…………………Per week as of (dd/mm/yy)

As third party, I agree to make the payments from the date of admission. The consequences of failing to maintain payment of Top-Up fees has been fully explained to me. I understand payment is an ongoing commitment for which I am financially liable until the service is no longer required.

I understand that the Top-Up cannot be paid from any monies that I hold, manage or receive for the resident other than as laid down in accordance with the provisions of the Care Act 2014, its accompanying statutory guidance and the Care and Support and After-care (Choice of Accommodation) Regulations 2014.

I understand that should I fail to pay the Top-Up fee for a period of more than 6 weeks, Halton Borough Council has the right to arrange for alternative residential accommodation to be provided for (**service user's name**), subject to a needs assessment.

The Top-Up is agreed at the rate and at the time of the person requiring care and support. The current weekly cost of the Care Home, Halton Borough Council's "usual cost" and the amount of Third Party Top-Up are as follows:-

	£
Care Home Weekly Fee	_____________
The Council's "Usual Cost" (per week)	_____________
Third Party Top-Up required (per week)	_____________

The third party Top-Up is the difference between the agreed contract rate paid by Halton Borough Council and the charge made by the above care provider. The Top-Up payment excludes the individual's personal allowance and the assessed contribution the person is required to make towards the costs of the home. It also excludes any NHS nursing fees.

Name of third party…………………………………………………………………………

Signature of third party……………………………………………………………………..

Name of Provider Manager…………………………………………………………………..

Signature of Provider Manager………………………………………………………………

Name of HBC Area Manager ………………………………………………………………
(Revenues and Benefits)

Signature of HBC Area Manager……………………………………………………………
(Revenues and Benefits)

Those considering paying third party Top-Ups for a Service User should seek independent legal advice, if they have any concerns regarding matters set out in this agreement, or generally.

Declaration

- I understand that Halton Borough Council (HBC) will fund the Care Home placement at the level of its “usual cost”, less the Service User’s assessed weekly contribution (if applicable).
- I agree to pay the Third Party Top-Up set out above, and any subsequent increases, for the duration of the placement directly to the Provider. I agree to provide HBC with details of my financial circumstances and accept that the placement will not be agreed until this information has been provided. (In line with Guidelines from the Department of Health, HBC has the right not to agree to a Third Party Top-Up until they have received enough information about my financial circumstances and is reassured that I can continue to pay the difference.)
- I understand that, as a private enterprise, the Care Home may revise the overall cost of care and the level of Third Party Top-Up needed will always be the difference between the Care Home’s fee and HBC’s “usual cost”.
- I understand that I will be given suitable notice (at least 4 weeks) by the Provider of any such increase in the overall cost of my Top-Up payment.
- I understand that the Third Party Top-Up will be paid direct to the Provider. I understand that failure to continue Third Party Top-Up payments may result in the need for the Service User to move to another room within the Care Home or to an alternative care home, but only after a full Community Care and risk assessment. The Service User may be moved, unless it is identified during the assessment that the current Care Home is the only home which can meet their assessed needs.
- In the event of financial difficulty in paying the Top-Up amount, I must inform HBC as soon as possible and HBC will provide me with advice on how I may receive further financial information from local or national Independent Financial Advisors.
- Should HBC be required to make payments in lieu of any unpaid Third Party Top-Up payments in order to safeguard the Service User’s placement, I agree to indemnify HBC for such payments (provided that I have been given written notice of the amount and duration of such payments).

Signed ____

PRINT NAME ____

Relationship to Service User _____________________________

Date ____

Appendix 2

Choice of residential accommodation and third party "Top Ups"

This information tells you about your right to choose the accommodation in which you will receive care and support, whether it is in a care home, supported living or shared lives, once the care planning process has identified that one of these types of accommodation is the most appropriate way of meeting your needs. It also explains what you will have to do if you wish to choose accommodation that costs more than the amount that has been specified in your personal budget for the provision of accommodation of that type.

For choice to apply the council could be proposing that you live in, a care home that also provides nursing care, a shared lives setting or supported living and social work staff will have advised you which will meet your care needs most appropriately.

A personal budget is the cost to the council of meeting those of your needs which it is required to or has decided to meet and has identified in your care and support plan.

Your Right to Choose

The care planning process will have identified how your needs are to be met. Where this involves a particular type of accommodation, you have the right to choose between different providers and/or locations of that type of accommodation in England and your social worker or care coordinator will be able to give you a list of all of the relevant settings for you to choose from. You may wish to choose to live near to where you are living now or move to a different area to be closer to your family, or in a specialist home such as one run by a religious organisation. There are special cross-border arrangements if you wish your local council to arrange for you to live in accommodation in Wales, Scotland or Northern Ireland. You should seek advice from social work staff if you would like the council to arrange this.

There are 6 conditions which need to be met for you to have your choice of setting. These are:

1. **Care and support needs**
   That your care and support plan specifies that your need a are going to be met by arranging care in a care home, shared lives or a supported living accommodation.

2. **Type of Accommodation**
   That the accommodation you choose is of the type specified in your care and support plan.

3. **Suitability of Accommodation**
   That the accommodation you choose is suitable to meet your eligible care needs. Social work staff will advise you which types of accommodation are suitable to meet the needs that are set out in your care and support plan.

4. **Cost**
   Your council will have undertaken a care planning process and prepared a personal budget for you that will cover the cost of meeting your eligible care and support needs. The amount in your personal budget must be sufficient to meet your

assessed eligible needs and ensure that you have at least one choice of setting that is affordable within that amount and the council should try to ensure there is more than one affordable setting. However, you might wish to choose a setting that costs more than the amount in your personal budget. If you do, a payment will need to be made to meet the difference between the weekly charge for accommodation and the amount in your personal budget. This extra amount is called a Top-Up payment and these are explained later in this leaflet.

If you choose a setting outside of your local area the local authority will still pay the amount identified in your personal budget.

5. **Availability**
   The accommodation that you choose may not have space available. If you do not want to choose different accommodation it may be necessary for you to go on a waiting list until a place becomes available and go into alternative accommodation or receive care at home while you are waiting. This is called an Interim Care arrangement.

   Your social worker will explain how long you are likely to wait, but this will only be an estimate and not a guarantee.

   If the temporary accommodation charges more than the amount in your personal budget the council will pay the difference. If this happens and you decide to stay in that accommodation permanently you will only be able to stay there if a Top-Up is made – Top Up payments are explained later in this leaflet.

6. **Terms and Conditions**
   The provider of the accommodation you choose must agree to contract with the council to provide you with accommodation subject to the council's usual terms and conditions.

If you are in Hospital

You have all of the rights set out in this leaflet if you are going to move from hospital to accommodation of your choice, but there are some special rules for this.

As soon as medical staff have agreed that you can be discharged from hospital the law requires that the council must arrange your move within a very short period. If the accommodation that you choose does not have a place available, the hospital will not be able to allow you to stay in hospital until a place becomes available. Instead, you may need to have an Interim Care arrangement, as set out above.

Your Right to Choose More Expensive Accommodation and Top Up Payments

When making your choice, you may choose a setting that costs more than the amount identified in your personal budget. There are many reasons why a setting may cost more. It could be due to commercial business reasons or because the provider considers that the accommodation is of a superior standard - a bigger room or other additional services.

The amount identified in your personal budget must be sufficient to meet your needs and the council must ensure that at least one option is available that is affordable within your personal budget and should ensure that there is more than one. However, you can choose to live somewhere that costs more if you wish. If you do, your family, a friend or someone

else such as a charity, or in some circumstances you, must be willing and able to make a top up payment to cover the difference between the care homes fees and the amount in your personal budget for the likely duration of your stay. Your council must never force you into having to pay a top up fee because no suitable accommodation is available within the amount in your personal budget. In these circumstances, the personal budget must be adjusted to meet the costs of the accommodation needed to meet your assessed eligible needs.

It is very important that you are aware of the following:-

- The amount set in your personal budget will be reviewed regularly and may increase to ensure the amount is still sufficient to meet your eligible needs. However, the council cannot guarantee that the accommodation will increase its costs at the same rate and this may affect the level of the top up payment.

- The Top-Up will always be the difference between the care home's fees and your personal budget.

- Whoever is paying the top-up (you or the third party) will need to sign a written agreement that they are willing, able and financially liable to meet the difference in cost and will continue to do so throughout your stay. Prior to signing the agreement, the person paying the top-up will have to satisfy the Council that they can afford the weekly top up amount. If the person paying the top-up cannot satisfy the Council that they will be able to afford the top up for the likely duration of your stay, the Council will not agree to arrange care and support in the preferred accommodation.

- The person paying the top-up should be aware that the top-up amount may vary as providers review their fee levels usually on an annual basis in line with inflation.

- If the person paying the top-up is unable to continue to pay the difference you may have to move to another room within the accommodation or to another accommodation that charges fees that are within the amount set in your personal budget.

- Any move to other accommodation will only happen after a community care and risk assessment of your needs to make sure that the other accommodation is right for you.

I am a considering paying a Top-Up fee, what does this mean for me?
The council providing care and support will want to know that you are willing and financially able to make the additional payment for the cared for person, for the likely duration of the contract. They will therefore want to assure themselves that you can afford this and will ask you to fill out a financial questionnaire and to sign a written agreement confirming you are willing and able to make the payments. Should you fail to make the necessary payments you will be liable for the cost of all Top-Up arrears. In addition, the cared-for person may have to be moved to alternative accommodation.

What will be in the written agreement?
The written agreement must include the following:

- The amount of the top up payment
- The amount of the Council will fund (Usual Cost)
- How often payments must be paid
- To whom the payments must be paid – this should normally be the council as they must have oversight of all top up arrangements.
- Signatures of: Third party, care provider and Area Manager (Revenues and Benefits).
- How and when the Top-Up arrangement is to be reviewed
- The consequences should you be unable to continue to make a payment. This could include moving the person receiving care.
- The effect of any increases in charges made by the provider
- The effect of changes in the finances of the person paying the Top-Up.

Other Information
If you or your family have any other questions about your rights to choose accommodation, please talk to your social worker.

Information on payments for the accommodation is given in a separate leaflet which your social worker can provide for you.

I confirm I have received and understand this factsheet: Choice of residential accommodation and third party contributions “top ups”

Service User Name: …………………………………………………

Signed: ………………………………. Date: …………………..

Appendix 3

Independent Financial Advice - Local and National

Financial advisors fall into two broad groups:

1. Those who are regulated by the Financial Conduct Authority (FCA) and have to charge for any advice they give;
2. Those which are not regulated by the FCA and who can offer free advice.

1. Since 2013 FCA **regulated advisors** cannot be paid a commission if they provide advice about: pensions, investments or retirement income products such as annuities. They must instead charge a fee. However, if they are giving advice on equity release, mortgages and general insurance (life insurance), they can charge a commission.

   Typical FCA regulated Independent Financial Advisor's fees vary from £75 to £350 per hour and the UK average is £150/ hour. Depending upon the nature of the advice there are alternative ways of paying:
   - A set fee for a particular type of work. Depending upon the size of the work this could be hundreds or thousands of pounds;
   - A monthly fee which can be either a flat rate or a percentage of what the person wishes to invest;
   - An ongoing fee if they are providing an ongoing service.

   To find a local financial advisor that is FCA regulated there are a number of websites which simply require your postal code to generate a list. Examples are:
   - Find Financial Advisors;
   - Local Financial Advisors.

We cannot recommend any particular adviser or advice service and it's important that you find out if an adviser is qualified to give advice. Below are list of organisations that may be able to help you find a suitable independent financial organisation:

Society of Later Life Advisers (SOLLA) (**http://societyoflaterlifeadvisers.co.uk**)

SOLLA helps people to find independent financial advisers who specialise in the financial needs of older people. All advisers on the database have to prove that they meet appropriate criteria and have the right qualifications before they are accredited by SOLLA.

See the adviser search on the SOLLA website to find a local, fully accredited adviser quickly and easily.

Paying for care (**http://www.payingforcare.org/**) Paying for Care is a website that offers advice on care costs and planning for care. They also help you to search for local care fees advisers.

The Money Advice Service (**https://www.moneyadviceservice.org.uk/en**) The Money Advice Service was set up by the Government, and offers impartial and unbiased money advice and information to help you make the most of your money, whatever your circumstances.

My Care, My Home (**http://www.mycaremyhome.co.uk/**) My Care, My Home is an organisation that provides support and guidance to people who fund their own care. The initial assessment, information and advice is free. They can offer telephone advice or do home visits.

2. Free Financial Advice – **non-regulated**. This means they are not liable for any product they are likely to recommend to you which later turns out to be unsuitable with the result that you have fewer rights in law. Examples of good general free financial advice are:
   - Which magazine;
   - Citizens Advice Bureau (local);
   - MoneySaving Expert.com is free to use;
   - Media – newspapers, magazines and the BBC (Moneybox) or their related websites;
   - Government-led or Government-backed services;
   - Commercial organisations such as comparison websites.

   In addition, there are specific services which are aimed at those who are over 50 or who offer free debt or free tax advice…etc. Examples are:

   Advice for those who are aged 50+
   - Age UK;
   - Tax help for older people

   Free Debt Advice:
   - Christians against poverty;
   - CAB local;
   - StepChange debt charity;
   - Debt Advice Foundation;
   - National Debtline.

   Free Tax Advice:
   - Low Income Tax Reform Group – provide advice to anyone on a low income such as students and pensioners;
   - Tax help for older people – independent free advice;
   - Taxaid (a charity).

REPORT TO:	Executive Board
DATE:	19 November 2015
REPORTING OFFICER:	Strategic Director, People and Economy
PORTFOLIOS:	Economic Development
SUBJECT:	Inward Investment Scrutiny Review Report and Recommendations
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Board with the recommendations from the Employment, Learning, Skills and Community Policy and Performance Board Inward Investment Scrutiny Topic Group.

2.0 RECOMMENDATION: That Executive Board consider the Inward Investment Scrutiny Topic report and recommendations, attached in Appendix 1.

3.0 **SUPPORTING INFORMATION**

3.1 A scrutiny review topic group was established with four Members from the Employment, Learning, Skills and Community Policy and Performance Board, with support from Operational Director for Economy, Enterprise and Property, Tim Leather, Principal Business Development Officer and Principal Policy Officer for Children and Economy, along with additional support from partner organisations, as set out below.

Members	Officers and partners
Cllr Sue Edge – Chair Cllr Peter Lloyd Jones Cllr Andrew McManus Cllr Stan Parker	Wesley Rourke – Operational Director for Economy, Enterprise and Property Tim Leather - Principal Business Development Officer Paul Corner – Business Development Officer Debbie Houghton – Principal Policy Officer Paula Cain - Chief Executive Halton Chamber of Commerce & Enterprise Mark Basnett – Liverpool LEP

The report was commissioned as the Liverpool City Region together with the local authorities are looking at the current approach to inward investment and considering how a collaborative approach may make better use of limited resources going forward.

The scrutiny review was conducted through a number of means between March 2015 and August 2015, as follows:

- Meetings of the scrutiny review topic group;
- Presentations by various key members of staff from the Council and partners;
- Business site visit

The full report is attached in Appendix 1.

3.2 The report makes a number of recommendations, which are set out below:-

Recommendations

Local Authority role - Recommendations

- A significant role for the local authority is to support the promotion of the LCR City Region with attracting investors from overseas.

- Implement the client management system (Evolutive) to ensure high quality and up-to-date CRM producing management information to drive continuous improvement.

- Develop and implements an investment social media strategy to link Halton with export agencies from around the world.

- Pursue relationships and links with the top 50 employers in Halton to ensure retention and growth of the businesses. This will include skills development and working with planning to help enable businesses to physically expand and grow.

- Focus on employability and other skills required in Halton to support key sector business needs and their growth in Halton, focusing on meeting the skills needs of local businesses in target high-value-adding sectors

- Greater connectivity between schools/ curriculum and the needs of businesses. This will help ensure that young people in Halton are best placed to access local jobs.

- Work together with planning to help ensure where appropriate that businesses in Halton can expand and grow.

- Continue to develop Business Cluster Group working, to assist businesses to become more competitive and productive.

LEP/LCR Role- Recommendations

- Chanel foreign Investment enquiries.

- With limited resources there is a need to focus on collaborative working.

- Focus on the strengths that Halton and the wider LCR has to offer.

- There is an opportunity to demonstrate a collective approach and the Liverpool brand to potential investors, particularly of benefit to Halton.

3.3 Each of the recommendations has been assessed in terms of what this means for Halton, key actions, how the impacts will be measured and any associated resource implications. This is attached within the report as **Annex 4.**

3.4 In summary, all of the recommendations and associated actions can be delivered within existing resources and are at no additional cost to the Council. The actions set out in the table summarise the forward thinking and pro-active approach to inward investment that Halton has developed.

4.0 POLICY IMPLICATIONS

4.1 Inward investment plays a crucial part in delivering economic growth and employment opportunities within Halton and the wider Liverpool City Region.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 All of the Halton recommendations will be delivered within existing resources of Halton Borough Council and are at no extra cost.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People and Families**
Delivering inward investment will create new job opportunities which will benefit Halton families.

6.2 **Economic Development**
Inward investment plays a significant role in driving economic development, supporting Halton businesses to grow and encouraging new businesses to locate here.

6.3 **A Healthy Halton**
There are no direct implications on Healthy Halton from this report, although employment opportunities may help to improve the health and wellbeing of residents that are employed and their families.

6.4 **A Safer Halton**
There are no direct implications on Safer Halton from this report, although a vibrant economy where there are employment opportunities for residents may help to reduce crime.

6.5 **Halton's Environment and Regeneration**
Inward investment has a role to play in helping to regenerate the borough's employment areas enabling them to grow and businesses to invest in the Borough.

7.0 RISK ANALYSIS

7.1 Inward investment plays a significant role in driving the borough's economy, supporting business growth and encouraging new business to locate here. Not doing this is likely to impact on the borough's employment offer going forward.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 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

Inward Investment Scrutiny Review

DRAFT

Report

November 2015

CONTENTS

Contents	Page	Paragraph
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Structure of the report	3	2.0
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Overall Conclusion	12	6.0
Way Forward - Delivering the recommendations from the Inward Investment Scrutiny topic group	15	7.0

Annexes	Number
Topic brief	1
Methodology	2
Presentations considered as part of the review	3
Implementing the Recommendations	4

1.0 PURPOSE OF THE REPORT

The purpose of the report is to present an overview of the ELS&C PPB Inward Investment Scrutiny Topic Group.

2.0 STRUCTURE OF THE REPORT

This report is structured with an introduction, a brief summary of the methodology followed by evidence, analysis with findings/conclusions and recommendations. The annexes include the topic brief, methodology detail and an action plan to capture the recommendations from the scrutiny review.

3.0 INTRODUCTION

3.1 Reason the scrutiny review was commissioned

Halton Borough Council's Business Improvement and Growth (BIG) Team deliver Halton's inward investment service, which includes:-

- Managing inward investment enquiries from both inward investors and local companies wishing to expand and grow
- Managing the commercial property database and servicing enquiries for commercial property
- Engaging with the key companies in the Borough

The Liverpool City Region Local Enterprise Partnership has proposed the creation of a stand-alone inward investment agency for the City Region called 'Invest Liverpool'. However, any such agency would have to be resourced by the six Local Authorities, primarily through the provision of secondees.

The LEP have issued a tender for a private sector consultancy to work with the Local Authorities to identify the 'Liverpool City Region Offer' for inward investment. Following this work an analysis will need to be undertaken to determine how city region collaboration would lead to a more effective service to investors and what this would mean in practice.

However, in order to contribute to this analysis, it is important to understand the current arrangements for managing Inward Investment enquiries locally, including the source of these enquiries and the resources allocated to delivering the service. This will then help Members to determine whether there is synergy between a local and city-region wide inward investment service and where added value can be obtained.

To inform the Scrutiny Topic Group Members identified key lines of enquiry as follows:

1) How does Halton's inward investment service currently operate;
2) The Liverpool City Region Perspective;
3) Halton Business and Chamber of Commerce Perspective.

3.2 Policy and Performance Boards

This report was commissioned as a scrutiny working group for the Employment, Learning, Skills and Community Policy and Performance Board.

3.3 Membership of the Scrutiny Working Group

Membership of the Scrutiny Working Group included:

Members	Officers
Cllr Sue Edge – Chair Cllr Peter Lloyd Jones Cllr Andrew McManus Cllr Stan Parker	Wesley Rourke – Operational Director for Economy, Enterprise and Property Tim Leather - Principal Business Development Officer Paul Corner – Inward Investment Officer Debbie Houghton – Principal Policy Officer

4.0 Methodology Summary

This scrutiny review was conducted through a number of means:

- Meetings of the scrutiny review topic group;
- Presentations by various key members of staff and partners (detail of the presentations can be found in *Annex 2*);
- Provision of information.
- Business site visits.

5.0 Evidence (summary of evidence gathered) and Analysis with findings/conclusions

5.1 How does Halton's inward investment service currently operate?

Tim Leather delivered a presentation to members on inward investment in Halton, starting with the role of the team, which is to:-

- Manage commercial property database.
- Deliver Halton part of LCR funding streams.
- Also proactive inward investment – limited due to lack of resources what we can do.

Direction of travel for inward investment in Halton and the wider LCR is towards an 'Invest Liverpool' joint approach which would be tasked with supporting inward investment across LCR. This approach would have to be resourced from each LA through secondments. Compromise solution each LA

auditing what they do and then hopefully can be used to draw down European match to resource 'Invest Liverpool'.

Foreign company investment in our economy
Halton has the greatest concentration of foreign owned companies in LCR, behind Liverpool, which accounts for 5% gross number of companies but have 20% employee posts, which is significant.

In 2013 26.5 billion dollars came in to UK as Foreign Direct Investment (FDI). Most FDI comes from US, but UK second i.e. UK companies investing abroad.

In terms of emerging market growth for FDI– significant growth is expected from South America and parts of Africa.

State owned enterprises have a lot of buying power. So need to be mindful of these significant businesses alongside private businesses.

Mergers and acquisitions of businesses have experienced a significant jump however one deal can alter figures, so need to bear that in mind.

Investor development
Working with businesses already here in Halton so they remain here longer term and can grow and prosper. For example we have worked with Thermofisher Scientific, the outcome being that they have stayed in Halton.

Inward investment enquiries – we are now getting to pre-recession levels of about 300 per yr. Conversions also increasing and exceeding our targets currently about 10% conversions.

The geographical origin of direct investment enquiries to Halton are 94% made directly to the council, 4% from the North West and the remaining 2% from outside of that area.

Source of enquiries to inward investment service – 3% referred from UKTI, 94% made an enquiry over the telephone..

Halton Approach

- Travel distance important for business growth so Halton people can access new jobs.
- Team currently have a graduate working with businesses to identify what businesses want.
- Looking to engage with the 50 most significant employers
- Inward Investment post - Now recruited to this post, who will work with these 50 companies.

- Sector focused network group has been established to facilitate closer working between related businesses, which has been well received. Plan to extend these to other business sectors where possible.

Full presentation is attached in Annex 3

5.1.1 Conclusions

- The majority of inward investment enquiries are from local businesses based in Halton at 94%. A further 4% come from the NW.
- Foreign Investment enquiries are very low at less than 2%.
- Halton focus on the 50 most significant employers.
- Inward investment enquiries close to pre-recession levels of about 300 per year.
- Halton has the greatest concentration of foreign owned companies in LCR, behind Liverpool, which accounts for 5% gross number of companies but have 20% employee posts, which is significant.

5.1.2 Recommendations

- Implement rigorously the client management system (Evolutive) to iron out a number of inconsistencies with the information that we log.

- Develop and implement an investment social media strategy to link Halton with export agencies from around the world.

- Pursue relationships and links with the top 50 businesses in Halton to ensure retention and growth of the businesses.

5.2 The Liverpool City Region Perspective

Mark Basnett from the Liverpool City Region Local Enterprise Partnership (LEP) provided an overview on Inward Investment challenges in the Liverpool City Region and drivers for growth and the need to have the right Inward Investment product e.g. skills, talent, infrastructure, cost effectiveness.

Mark stated that the things we need to focus on are working smarter together with limited resources and pooling capabilities.

The LEP and partners were looking at options which focus on:

1) Creating an investment hub and a virtual team.

2) Spending time with sector specialists, developing a LCR investment strategy that we all agree to.

Mark remarked that looking at Halton's strengths; logistics, accessibility and buildings are key strengths.

We have promoted Halton sites at national exhibitions e.g. 3MG at the NEC Multi-Modal Hub.

Mark reported on an area by area analysis and consideration of opportunities through a City Region Inward Investment Asset Matrix and working jointly can create economies of scale.

The LCR has some sector strengths i.e. automotive and relationship with the sector supply chain.

Just in time supply is critical in this sector and we can offer a broader package to businesses and reasons and a product to offer.

A third area focus on world class facilities including Big Data, for example, Si-Tech Daresbury.

LEP will work with local teams to promote and market opportunities in the area.

One team, operating on a Common Customer system as the key function of the LCR Inward Investment Framework would be a desired long-term position.

An Investment Strategy will focus on key sectors and would establish a set of performance measures and be accountable to City Region Leaders, and Chief Executives.

Also emphasis on engaging with business leaders.

Future proposals would not be about taking away existing lines of enquiry.

LA Leaders have signed up to these principles.

£1m had been allocated to Inward Investment. activity in LCR, of which 20% is a contribution from Local Authority partners.

The intention is to create a continual dialogue to refine a better product to attract investment to Halton and beyond.

Mark shared a paper that had been presented to Regeneration Directors identifying potential options and level of funding required.

There is an opportunity to demonstrate a collective approach to the “outside world”.

Full presentation is attached in Annex 3

5.2.1 Conclusion

- With limited resources there is a need to focus on working smarter together and pooling capabilities.

- Need to focus on the strengths that Halton has to offer e.g. Logistics and science.
- Also need to focus on the wider strengths of the LCR such as the automotive industry and the sector supply chain.

- There is an opportunity to demonstrate a collective approach to the “outside world”.

5.2.2 Recommendations

- Chanel foreign Investment enquiries through the LCR/LEP where appropriate.

- With limited resources there is a need to focus on collaborative working across local authorities and the LCR.

- Focus on the strengths that Halton and the wider LCR has to offer.

- There is an opportunity to demonstrate a collective approach and the Liverpool brand to potential investors, particularly of benefit to Halton.

5.3 Halton Business and Chamber of Commerce Perspective.

Paula Cain gave some background on the borough from a business perspective, including strengths such as location and opportunities from the new Mersey Gateway etc.

Paula talked about the challenges such as diminishing council resources and the bridge tolls and the advantages of Halton’s BIG Team approach which provides a focus, builds loyalty and provides better use of scant resources. The disadvantages of the current approach were identified as a risk in terms of available resources in the future ? Paula also identified opportunities of a LCR approach including, pooling of resources and using Liverpool as an international recognised brand.

Should the LCR proposal go ahead then the Chamber highlighted some key issues that need clarification. These include Governance arrangements, clarity of roles and clarification of the offers available. Also what will be the impact on Halton’s brand?

Paula then identified four things that we could do:-
- Image/Brand (Runcorn and Widnes vs Halton)
- Local marketing initiatives
- Business at the forefront
- Business Champions

There was a discussion around Merseyside Business Support Programme (MBSP) which provides support for SMEs that have been in business for over 12 months. They provide an in depth diagnostic to help them develop and grow. There is no financial support and this ends in September 2015. The Chamber delivers specialist modules of support to businesses.

There was comment about the significant differences between small and medium business, many small businesses have only 1-2 people where medium businesses are perhaps in a better position to grow more quickly. MBSP hasn't provided cash but helps enable business leaders to step back and look objectively at their business.

The Topic Group asked Paula about links between the Halton CoC and that of Liverpool. Paula responded that the Chambers do collaborate but there are two powerhouses Liverpool and St Helens. However there have been discussions around combining to provide one LCR Chamber of Commerce. Businesses are not enthusiastic for this to happen currently and perhaps there may be a different model with more collaborative working that can be developed?

Businesses are perhaps more concerned about the Offer rather than who provides it. Going forward we need to be clear about what the LCR offer is and how Halton contributes to that. Halton for example could be the lead in the LCR around investment in Science and any science enquiries to the LCR directed to us? Signposting to funding providers is also key as is a quick response. Perhaps the 'Smart City' model is a good one where access, skills, IT etc. are all linked together.

Devolution and the role of each LA may present some issues as well as collaboration, there will be potentially competition amongst LAs. We need to market Halton as well as the LCR and focus on what we can offer. Concern was expressed that a LCR approach may result in a Liverpool bias

Full presentation is attached in Annex 3

5.3.1 Conclusion

- Diminishing resources and bridge tolls are challenges for support for inward investment going forward.
- Halton's BIG Team approach is an advantage for Halton providing a clear focus, building loyalty and presents good use of scant resources.
- Opportunities of a LCR approach include pooling of resources and using Liverpool as an international recognised brand.

5.3.2 Recommendations

- With limited resources there is a need to focus on collaborative working across Halton and the LCR.

- Focus on the strengths that Halton and the wider LCR has to offer.

5.4 Business Tour

ELS&C PPB members were invited on a tour of selected businesses in Halton, which was attended by:-

Cllr Sue Edge
Cllr Andrew McManus
Cllr Peter Lloyd-Jones
Cllr Geoffrey Logan
Tim Leather
Paul Corner
Debbie Houghton

<u>Site Visit 1</u>

Sigmatex Group, Manor Park Runcorn

Sigmatex are converters of carbon fibre, manufacturing a high tech range of reinforcements for a wide variety of applications, including the aerospace industry. They also have premises in Shanghai, California and Rochdale. They are an independent fibre provider and they develop fibres in a number of different formats, ranging from materials to form vehicle upholstery to vehicle carbon components. They started out in Whitehouse industrial state in Halton. 10% of the workforce works in R and D. As well as this plant in UK there is a centre in Rochdale.

Overall group turnover is £250m. A very interesting fact is that 95% of space fibres are developed in Runcorn.

Main clients are in automotive, aerospace and marine transport and they worked on the Bloodhound supersonic car. Also supply upholstery to the prestige motor vehicle brands and Supercars.

They operate an apprenticeship scheme and they invest a large amount of resource in helping young people with the transition from education to work. A willingness to work is more important with young people than purely job specific skills as you can build these skills.

Key issues facing Sigmatex

1. Skills
2. Recruitment

Address: Manor Farm Rd, Runcorn, Cheshire WA7 1TE

<u>Site Visit 2</u>

Whitford Group, Manor Park Runcorn

Whitford Group is the manufacturer of the largest range of fluoropolymer coatings in the world with applications including the chemical, petrochemical and automotive industries. Research & Development also takes place at the Runcorn site. Most notable Fluoropolymer to domestic user is Teflon.

The main product produced at this plant is car fluropolymer solutions. For example paints to regulate the temperature of a timing belt in extremes of heat and cold. So, in effect they service the majority of automotive businesses in Europe. The other smaller line produced here is a coating for bakeware.

Their sister plant in Italy produces coating for pans etc.

Key issues facing Whitford Group

1. Training and Employability
2. Planning and extension

Address: 11 Stuart Road, Manor Park, Runcorn, Cheshire WA7 1TH

Site Visit 3

Fresenius-Kabi, Manor Park Runcorn

Fresenius Kabi is a global health care company specialising in lifesaving medicines and technologies for infusion, transfusion and clinical nutrition. The company's products and services are used to help care for critically and chronically ill patients. On these premises the business services the nutrition market. There are 400 people working on site.

Key issues facing Fresenius:

1. Business continuity
2. Recruitment issues at all levels of employment
3. The possibility of developing bespoke programmes was raised and this could be achieved with the SFA, College and Halton Employment Partnership.

Address: Cestrian Court, Eastgate Rd, Manor Park WA7 1NT

5.4.1 Conclusion

1. Skills development is a major issue affecting all of the businesses visited.
2. Attitude and approach to work is a key attribute recruiters look for with existing and potential new staff.
3. All employers support apprenticeships
4. The mix, status and impact of local companies on the international supply chains of aerospace, automotive and bio-tech sectors is stunning.

5.4.2 Recommendations:

- Focus on skills required in Halton to support key sector business needs and their growth in Halton.

- Work together with planning to help ensure where appropriate that businesses in Halton can expand and grow.

6.0 Overall Conclusions from the Scrutiny Review

6.1 This scrutiny review has been both a successful and a worthwhile exercise in terms of covering all the outputs and outcomes from the initial topic brief and gaining a sound knowledge and understanding of the issues affecting inward investment in Halton and the wider Liverpool City Region.

6.2 It is recognised that there is much good practice happening in Halton and excellent working relationships between the council and the Liverpool City Region.

6.3 The key ingredients of inward investment broken down into:

- Foreign Direct Investment
- Indigenous Development

The emphasis on the two elements underscores the importance of both in attracting new foreign investors as well as retaining existing investors and supporting them to grow and expand. Both are a vital source of local employment in Halton.

6.4 The current position in relation to inward investment is set out in the diagram below and the context of both the local and LCR position is explained in the bullet points that follow.

6.5 Local Position

- The vast majority of investment enquiries handled by the BIG Team are both relatively local in origin (94%) and follow direct enquires to the Local Authority (94%).
- Halton Borough Council receive relatively few investment enquires from either UKTI\LEP (3%) or from intermediaries (3%).
- Foreign Investment enquiries are low at less than 2%.
- Inward investment enquiries close to pre-recession levels of about 300 per year.
- Halton has the greatest concentration of foreign owned companies in LCR, behind Liverpool, which accounts for 5% gross number of companies but have 20% employee posts, which is significant.

6.6 LCR Position

- Currently deal with UKTI Investment inquiries as appropriate.
- With limited resources there is a need to focus on working smarter together and pooling capabilities.
- Need to focus on the strengths that Halton has to offer e.g. Logistics and science.
- Also need to focus on the wider strengths of the LCR such as the automotive industry and the sector supply chain.

- There is an opportunity to demonstrate a collective approach to the potential investors and export agencies.

- Marketing Liverpool currently market the LCR through the Liverpool brand both inside and outside of the UK.

6.7 Overall Recommendations from the Scrutiny Review

Local Authority role - recommendations

- A significant role for the local authority is to support the promotion of the LCR City Region with attracting investors from overseas.

- Implement the client management system (Evolutive) to ensure high quality and up-to-date CRM producing management information to drive continuous improvement.

- Develop and implements an investment social media strategy to link Halton with export agencies from around the world.

- Pursue relationships and links with the top 50 employers in Halton to ensure retention and growth of the businesses. This will include skills development and working with planning to help enable businesses to physically expand and grow.

- Focus on employability and other skills required in Halton to support key sector business needs and their growth in Halton, focusing on meeting the skills needs of local businesses in target high-value-adding sectors

- Greater connectivity between schools/ curriculum and the needs of businesses. This will help ensure that young people in Halton are best placed to access local jobs.

- Work together with planning to help ensure where appropriate that businesses in Halton can expand and grow.

- Continue to develop Business Cluster Group working, to assist businesses to become more competitive and productive.

LEP/LCR Role- Recommendations

- Chanel foreign Investment enquiries.

- With limited resources there is a need to focus on collaborative working.

- Focus on the strengths that Halton and the wider LCR has to offer.

- There is an opportunity to demonstrate a collective approach and the Liverpool brand to potential investors, particularly of benefit to Halton.

7.0 Way Forward - Delivering the recommendations from the Inward Investment Scrutiny topic group

7.1 Each of the recommendations has been assessed in terms of what this means for Halton, key actions, how the impacts will be measures and any associated resource implications. This is attached as **Annex 4**

7.2 In summary, all of the recommendations and associated actions can be delivered within existing resources and are at no additional cost to the council. The actions set out in the table summarise the forward thinking and pro-active approach to inward investment that Halton has.

<table>
<tr><th colspan="2">Employment, Learning, Skills and Community Scrutiny Panel</th></tr>
<tr><th colspan="2">Review of Inward Investment 2015</th></tr>
<tr><th colspan="2">Aims and Objectives</th></tr>
<tr><td>Aim and Objectives</td><td>The aim of the review is to support the Employment, Learning, Skills and Community PPB to determine if:

(a) the inward investment service provided in Halton is fit for purpose;

(b) there is synergy between a local and city-region wide inward investment service and where added value can be obtained.</td></tr>
<tr><td>Context/Background</td><td>Halton Borough Council's Business Improvement and Growth (BIG) Team deliver Halton's inward investment service, which includes:-

▪ Managing inward investment enquiries from both inward investors and local companies wishing to expand and grow
▪ Managing the commercial property database and service enquiries for commercial property
▪ Engaging with the key companies in the Borough</td></tr>
</table>

	The Liverpool City Region Local Enterprise Partnership has proposed the creation of a stand-alone inward investment agency for the City Region called 'Invest Liverpool'. However, any such agency would have to be resourced by the six Local Authorities, primarily through the provision of secondees. The LEP have issued a tender for a private sector consultancy to work with the Local Authorities to identify the 'Liverpool City Region Offer' for inward investment. Following this work an analysis will need to be undertaken to determine how city region collaboration would lead to a more effective service to investors and what this would mean in practice. However, in order to contribute to this analysis, it is important to understand the current arrangements for managing Inward Investment enquiries locally, including the source of these enquiries and the resources allocated to delivering the service. This will then help to determine whether there is synergy between a local and city-region wide inward investment service and where added value can be obtained.
Methodology	
Timescale	It is proposed that this review will be conducted during the period February to June 2015 with a view to submitting a report/ recommendations to the ELS&C PPB meeting in June 2015. It is proposed that the review will comprise 4 meetings, covering topics set out below, followed up by a final session to consider the content of Scrutiny topic Group report and recommendations. 4) How does Halton's inward investment service currently operate; 5) The Liverpool City Region Perspective; 6) Halton Business and Chamber of Commerce Perspective; 7) Final session to consider the content of Scrutiny topic Group report and recommendations.

	Following endorsement by the ELS&C PPB, it is anticipated that the final Inward Investment Scrutiny Topic Group report and recommendations will be submitted to a meeting of the Executive Board .
Scrutiny Topic Group Session 1	**Date of meeting**: 12th March 2015 **Purpose of the session**: To provide a clear understanding of inward investment in Halton **Expert witnesses**: Wesley Rourke - Operational Director, Economy Enterprise & Property Tim Leather - Lead Officer – Business Improvement & Growth
Scrutiny Topic Group Session 2	**Date of meeting:** 30th April 2015 **Purpose of the session:** To consider the inward investment proposals being considered by the Liverpool city Region. **Expert witnesses:** Mark Basnett (Local Enterprise Partnership
Scrutiny Topic Group Session 3	**Date of meeting:** 24th June 2015 **Purpose of the session:** To consider the business perspective of Halton's inward investment offer **Expert witnesses:** Paula Cain (Chamber of Commerce)

Scrutiny Topic Group Session 4	**Date of meeting:** ELS&C PPB 21st September **Purpose of the session:** To consider and agree the review's final report and recommendations.
Potential outcomes	
Expected outcomes	It is expected that this review will support the ELS&C PPB in: (a) Providing a clear understanding of inward investment in Halton; (b) Providing a steer as to whether Halton's approach to inward investment is fit for purpose; (c) Deciding if the approach to inward investment is meeting the needs of Halton businesses; (d) Identify activities that we could undertake to better meet the needs of Halton businesses (e) Inform future inward investment activity in Halton to complement the emerging model proposed within the Liverpool City Region (LCR)
Measuring success	Any recommendations arising out of the review will be considered by the Employment, Learning, Skills and Community PPB and once agreed presented to the council's Executive Board. Subject to Executive Board approval, recommendations will be implemented and

	monitored.
Officer/Member involvement	
Members	All Members of the ELS&C PPB were given the opportunity to be involved in the Scrutiny Topic Group review. The following members took part in the Scrutiny Topic Group. Chair of the scrutiny topic group – Cllr Sue Edge Cllr Peter Lloyd Jones Cllr Andrew McManus Cllr Stan Parker The Scrutiny topic Group was supported by the following council officers:- Wesley Rourke - Operational Director, Economy Enterprise & Property Tim Leather - Lead Officer – Business Improvement & Growth Paul Corner – inward Investment Officer Debbie Houghton – Principal Policy Officer Other officers and guest speakers will be invited to participate in the Scrutiny Topic Group as appropriate.

Annex 2

METHODOLOGY DETAIL

a) Presentations

The following officers gave presentations as part of this scrutiny review:

Name of officer	Title of Presentation
Tim Leather	Halton's approach to Inward Investment
Mark Basnett	Inward Investment proposals being considered by the Liverpool city Region.
Paula Cain	A Business Perspective of Halton's inward investment offer

b) Site Visit

A site visit was arranged for members of the ELS&C PPB to the following businesses.

- **Sigmatex Group, Manor Park Runcorn**
- **Whitford Group, Manor Park Runcorn**
- **Fresenius-Kabi, Manor Park Runcorn**

Annex 3

Presentations delivered as part of the review

- **Employment, Learning, Skills & Community Scrutiny Panel Inward Investment in Halton - A Halton Perspective**

- **Employment, Learning, Skills & Community Scrutiny Panel Inward Investment in Halton - A LCR Perspective**

- **Employment, Learning, Skills & Community Scrutiny Panel Inward Investment in Halton – A Business Perspective**

Implementing the Recommendations

Annex 4

Local Authority Recommendations				
Recommendations	**What this means**	**What are the associated actions**	**How will we measure the impact**	**Resource implications**
Support the promotion of the Liverpool City Region with attracting investors from overseas.	Collaborative working with LEP and other partners	Site and premises portfolio management including Mersey Gateway	Attracting more businesses	Met within existing resources, no further cost implications
Implement the client management system (Evolutive)	Formalise a client relationship management system	Whole council approach to client management	Survey returns on effectiveness of the council	Met within existing resources, no further cost implications
Develop and implements an investment social media strategy	Formalised social media strategy and actions in place	Diary of social media and calculating the reach of the service through social media	Assessing the impact we have on twitter, internet, facebook etc Assess the impact of the Halton Brief Newsletter	Met within existing resources, no further cost implications
Pursue relationships and links with the top 50 employers in Halton to ensure retention and growth of the businesses.	Systematic approach to engaging with and performing diagnostics (where appropriate) with Halton's most significant employers	Prioritising engagement with 50 most significant employers	Satisfaction with the service offered Retention of existing jobs within Halton	Met within existing resources, no further cost implications
Focus on employability	More dynamic role for	Representing business	Reduced unemployment	Met within existing

and other skills required in Halton to support key sector business needs and their growth in Halton	the BIG Team in the Halton Employment Partnership	needs on the HEP		resources, no further cost implications
Greater connectivity between schools/ curriculum and the needs of businesses. This will help ensure that young people in Halton are best placed to access local jobs.	Working with Employment Business Partnership to improve connectivity	Innovative tools to develop young people's skills eg. Enterprise game for specific industries	Reduction in NEET	Met within existing resources, no further cost implications
Work together with planning to help ensure where appropriate that businesses in Halton can expand and grow.	Close liaison with planning advocating the business	Internal representation of the business community	Successful planning applications	Met within existing resources, no further cost implications
Continue to develop Business Cluster Group working, to assist businesses to become more competitive and productive.	More sector specific working	Follow model developed for the advanced manufacturing network	Perception of strong industry specific working with Halton leading the way for the LCR	Met within existing resources, no further cost implications

Liverpool City Region Recommendations				
Recommendations	**What this means**	**What are the associated actions**	**How will we measure the impact**	**Resource implications**
Chanel foreign Investment enquiries.	Continuing to provide an inward investment service for Halton	Property search Diagnostics Skills brokerage	Number of new investments into Halton	Met within existing resources, no further cost implications
With limited resources there is a need to focus on collaborative working.	Working with local partners to secure national funding for local projects	Expansion of projects that are already collaborative eg. Advanced Engineering/Manufacturing Network (AEM)	More investment in Halton and better local employee skills	Met within existing resources, no further cost implications
Focus on the strengths that Halton and the wider LCR has to offer.	Build on sector strengths in Halton and the wider LCR eg. Science, logistics, automotive, aerospace and their supply chains	Expansion of projects that are already collaborative eg. Advanced Engineering/Manufacturing Network (AEM)	More investment in the priority sectors	Met within existing resources, no further cost implications
There is an opportunity to demonstrate a collective approach and the Liverpool brand to potential investors, particularly of benefit to Halton.	Playing a leadership and supportive role in the work of the LEP and the LCR	Taking a pro-active role in the work of the LCR	More investment and jobs in Halton and the wider LCR	Met within existing resources, no further cost implications

Agenda Item 6a

REPORT TO:	Executive Board
DATE:	19 November 2015
REPORTING OFFICER:	Operational Director – Finance
PORTFOLIO:	Resources
SUBJECT:	Determination of Council Tax Base 2016-17
WARD(S):	Borough-wide

1.0 PURPOSE OF REPORT

1.1 The Council is required to determine annually the Council Tax Base for its area and also the Council Tax Base for each of the Parishes.

1.2 The Council is required to notify the Council Tax Base figure to the Cheshire Fire Authority, the Cheshire Police & Crime Commissioner and the Environment Agency by 31st January 2016. The Council is also required to calculate and advise if requested, the Parish Councils of their relevant Council Tax Bases.

2.0 RECOMMENDED: That

(1) Council set the 2016/17 Council Tax Base at 32,948 for the Borough, and that the Cheshire Fire Authority, the Cheshire Police & Crime Commissioner, and the Environment Agency be so notified; and

(2) Council set the 2016/17 Council Tax Base for each of the Parishes as follows:

Parish	Tax Base
Hale	659
Halebank	499
Daresbury	159
Moore	326
Preston Brook	336
Sandymoor	966

3.0 SUPPORTING INFORMATION

3.1 The Council Tax Base is the measure used for calculating the council tax and is used by both the billing authority (the Council) and the major precepting authorities (Cheshire Fire Authority and the Cheshire Police & Crime Commissioner), in the calculation of their council tax requirements.

3.2 The Council Tax Base figure is arrived at in accordance with a prescribed formula, and represents the estimated full year number of chargeable dwellings in the Borough, expressed in terms of the equivalent of Band 'D' dwellings.

3.3 The Council Tax Base is calculated using the number of dwellings included in the Valuation List, as provided by the Listing Officer, as at 19th October 2015. Adjustments are then made to take into account the estimated number of discounts, voids, additions and demolitions during the period 19th October 2015 to 31st March 2016.

3.4 From 2013/14 onwards, the tax base calculation has included an element for the Council Tax Reduction Scheme (the replacement for Council Tax Benefit). The estimated amount of Council Tax Support payable for 2016/17, is converted into the equivalent number of whole properties which are deducted from the total. The reduced tax base will not result in an increase in Council Tax as the Council's budget requirement will be reduced by payment of a grant in lieu of Council Tax Support.

3.5 An estimated percentage collection rate is then applied to the product of the above calculation, to arrive at the Council Tax Base for the year.

3.6 Taking account of all the relevant information and applying a 97.0% collection rate, the calculation for 2016/17 provides a tax base figure of **32,948** for the Borough as a whole.

3.7 Taking account of all the relevant information and applying a 97.0% collection rate, the appropriate Council Tax Base for each of the Parishes is as follows;

Parish	Tax Base
Hale	**659**
Halebank	**499**
Daresbury	**159**
Moore	**326**
Preston Brook	**336**
Sandymoor	**966**

4.0 POLICY IMPLICATIONS

4.1 None.

5.0 FINANCIAL IMPLICATIONS

5.1 The Council Tax Base will enable the Council to set the level of council tax to be charged for 2016/17.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

None.

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

7.1 There would be significant loss of income to the Council if the Council Tax Base were not agreed, as it would not be possible to set the level of council tax to be charged for 2016/17.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None.

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

Document	Place of Inspection	Contact Officer
Working Papers	Kingsway House	P. McCann

Agenda Item 6b

REPORT TO:	Executive Board
DATE:	19 November 2015
REPORTING OFFICER:	Operational Director – Finance
PORTFOLIO:	Resources
SUBJECT:	2015/16 Quarter 2 Spending
WARD(S):	Borough-wide

1.0 PURPOSE OF REPORT

1.1 To report the Council's overall revenue and capital spending position as at 30 September 2015.

2.0 RECOMMENDED: That

(i) All spending continues to be limited to the absolutely essential;

(ii) Strategic Directors ensure overall spending at year-end is within their total operational budget;

(iii) The transfer of £0.5m from the 2015/16 contingency budget to the Children & Families Department as outlined in paragraph 3.7, be approved;

(iv) Council approve the revised capital programme as set out in Appendix 3.

3.0 SUPPORTING INFORMATION

Revenue Spending

3.1 Appendix 1 presents a summary of spending against the revenue budget up to 30 September 2015, along with individual statements for each Department. In overall terms revenue expenditure is £0.168m below the budget profile. However the budget profile is only a guide to eventual spending and experience shows that spending is usually lower in the first half of the financial year and is likely to accelerate towards the end of the year. Directorates should continue to limit all spending to the absolutely essential to ensure that each Directorate's spending at year-end is within its total operational budget.

3.2 Total spending on employees is £0.642m below budget profile at the end of the quarter. Vacant posts exist within a number of Departments which has helped generate the favourable variance to date. A number of these

posts are intended to be offered as savings for 2016/17, whilst others will need to be filled and thereby the variance will reduce.

3.3 Included within the employees budget is a staff turnover savings target of 2.6% which reflects the saving made between a member of staff leaving a post and the post being filled. The target for the quarter has been achieved for all departments with the exception of the Economy, Enterprise & Property Department and the Community & Environment Department. This was due to low staff turnover, particularly within the first quarter of the financial year.

3.4 Expenditure on general supplies and services is £0.262m below budget as at 30 September 2015, although these budgets were cut by 8% for 2015/16, being one of the measures approved in balancing the budget. Supplies & Services expenditure has been restricted in a number of Departments to offset against other budget pressures.

3.5 The Children and Families Department is continuing to experience budget pressures and is significantly over the profiled budget to date. There is high demand for a number of services within the Department including residential placements, direct payments, out-of-Borough fostering, special guardianship orders and in-house foster carer placements.

3.6 Spending on employees within the Department is £0.094m over the profiled budget to date. This variance can largely be attributed to the use of agency staff, although this has reduced from previous periods as a recent staffing restructure is now taking effect and other steps are being taken to reduce the need for use of agency staff.

3.7 Given the continued high demand for services within the Children & Families Department it is proposed to allocate £0.5m of the contingency budget to the Department, to help mitigate the budget and service pressures. After allowing for this contingency allocation, it is estimated the Department budget will be approximately £2.5m over the budget allocation at year-end. Work is on-going to identify underspending areas elsewhere across the Directorate, which can be used to help offset this spending pressure.

3.8 Net expenditure within the Economy, Enterprise & Property Department is currently £0.304m over the profiled budget to date. A savings target of £1.0m was set against surplus property assets for the current year and it is not expected this will be achieved in the current year. Whilst an action plan has been implemented, the time period required to rationalise property assets and thereby realise budget savings, means the full amount of the target will not be achieved until 2016/17 at the earliest. It is therefore estimated that the Department will be over budget by around £0.6m at year-end.

3.9 The Complex Care Pool budget has performed well over the first half of the financial year and at 30 September 2015, net spend is £0.058m below the budget to date. The number of clients receiving care was slightly lower than at the start of the financial year, although this was

offset by a slight increase in the average cost per client. Appendix 2 provides a summary of spending against the budget.

3.10 The Community & Environment Department is currently £0.122m over the budget to date. This is largely due to shortfalls in various income areas and not yet fully achieving the staff turnover target.

3.11 The collection rate for council tax for the quarter is 56.1%, slightly lower (0.06%) than at this stage last year. Whilst the collection rate for business rates of 54.76% is down by 1.18% from this point last year. The forecast retained element of business rates is in line with the estimate used when setting the 2015/16 budget. However, it remains very difficult to forecast retained business rates to the end of the financial year, due to the high number of valuation appeals lodged by businesses with the Valuation Office Agency prior to 31 March 2015.

3.12 The Council's overall net spending is marginally below the budget profile at 30 September 2015. Given a number of budget pressures being felt across all Departments it is important that budget managers continue to closely monitor and control spending and income. In the current financial climate budget underspends will be required to keep the Council's overall spending within budget, therefore spending should continue to be limited to the absolutely essential.

Capital Spending

3.13 The capital programme has been revised to reflect a number of changes in spending profiles and funding as schemes have developed. These are reflected in the capital programme presented in Appendix 3. The schemes which have been revised within the programme are as follows;

1. Fairfield Primary School
2. Halebank School
3. Hale Primary School
4. Street Lighting
5. Travellers' Site Warrington Road
6. Norton Priory
7. Widnes Waterfront
8. Crow Wood Play Area
9. Signage – The Hive
10. Advertising Screen – The Hive
11. Lowerhouse Lane Depot – Upgrade
12. Police Station Site
13. STEPS Programme
14. S106 Schemes
15. Ashley School
16. Mersey Gateway Land Acquisition and Development Costs
17. Local Pinch Point – Daresbury Expressway
18. Brookvale Biomass Boiler

3.14 Capital spending at 30 September 2015 totalled £10.944m, which is slightly ahead of the planned spending of £10.788m at this stage. This

represents 26% of the total Capital Programme of £41.767m (which assumes a 20% slippage between years).

3.15 Capital spending on the project for Runcorn Hill Park is £0.310m over the budget allocation for the year. This is due to the contractor tasked with phase 1 of the building works going into liquidation once work had commenced. As a result there have been increased costs. Consideration is being given as to whether the costs of subsequent phases of the work can be reduced to offset the phase 1 overspend.

Balance Sheet

3.16 The Council's Balance Sheet is monitored regularly in accordance with the Reserves and Balances Strategy which forms part of the Medium Term Financial Strategy. The key reserves and balances have been reviewed and are considered prudent and appropriate at this stage in the financial year and within the current financial climate.

4.0 POLICY IMPLICATIONS

4.1 None.

5.0 FINANCIAL IMPLICATIONS

5.1 The financial implications are as set out within the report and appendices.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**

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

6.3 **A Healthy Halton**

6.4 **A Safer Halton**

6.5 **Halton's Urban Renewal**

There are no direct implications, however, the revenue budget and capital programme support the delivery and achievement of all the Council's priorities.

7.0 RISK ANALYSIS

7.1 There are a number of financial risks within the budget. However, the Council has internal controls and processes in place to ensure that spending remains in line with budget.

7.2 In preparing the 2015/16 budget, a register of significant financial risks was prepared which has been updated as at 30 September 2015.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1072

9.1 There are no background papers under the meaning of the Act.

APPENDIX 1

Summary of Revenue Spending to 30 September 2015

Directorate / Department	Annual Budget £'000	Budget to Date £'000	Expenditure to Date £'000	Variance to Date (overspend) £'000
Children and Families Services	19,233	10,052	11,128	(1,076)
Education, Inclusion and Provision	15,149	6,384	6,112	272
Economy, Enterprise & Property	3,226	-72	232	(304)
Commissioning & Complex Needs	12,659	6,928	6,864	64
Prevention & Assessment	26,036	10,304	10,219	85
People & Economy	**76,303**	**33,596**	**34,555**	**(959)**
Policy, People, Performance & Efficiency	-370	-403	-427	24
Planning & Transportation	16,408	4,404	4,348	56
Legal & Democratic Services	525	210	103	107
Finance	4,778	-1,442	-1,782	340
ICT & Support Services	0	-653	-760	107
Public Health & Public Protection	1,018	1,313	1,217	96
Community & Environment	24,273	7,176	7,298	(122)
Community & Resources	**46,632**	**10,605**	**9,997**	**608**
Corporate & Democracy	**-21,522**	**1,861**	**1,342**	**519**
Mersey Gateway	**39**	**281**	**281**	**0**
Net Total	**101,452**	**46,343**	**46,175**	**168**

PEOPLE & ECONOMY DIRECTORATE

Children & Families Services Department

	Annual Budget £'000	Budget to Date £'000	Expenditure to Date £'000	Variance to Date (overspend) £'000
Expenditure				
Employees	8,635	4,445	4,539	(94)
Premises	339	201	203	(2)
Supplies & Services	962	363	373	(10)
Transport	8	4	6	(2)
Direct Payments / Individual Budgets	252	76	217	(141)
Commissioned Services	342	104	121	(17)
Residential Placements	3,273	2,074	2,290	(216)
Out of Borough Adoption	80	0	0	0
Out of Borough Fostering	435	327	387	(60)
In house Adoption	195	130	182	(52)
Special Guardianship	527	286	615	(329)
In House Foster Carer Placements	1,753	879	1,009	(130)
Care Leavers	125	56	59	(3)
Family Support	117	26	48	(22)
Capital Financing	6	0	0	0
Total Expenditure	**17,049**	**8,971**	**10,049**	**(1,078)**
Income				
Adoption Placements	-43	0	0	0
Fees & Charges	-114	-81	-85	4
Dedicated Schools Grant	-75	0	0	0
Reimbursements & Other Income	-354	-146	-144	(2)
Transfer from Reserves	-80	-80	-80	0
Total Income	**-666**	**-307**	**-309**	**2**
Net Operational Expenditure	**16,383**	**8,664**	**9,740**	**(1,076)**
Recharges				
Premises Support Costs	288	144	144	0
Transport Support Costs	72	30	30	0
Central Support Service Costs	2,446	1,214	1,214	0
Asset Rental Support Costs	44	0	0	0
Total Recharges	**2,850**	**1,388**	**1,388**	**0**
Net Expenditure	**19,233**	**10,052**	**11,128**	**(1,076)**

Education, Inclusion and Provision Department

	Annual Budget £'000	Budget to Date £'000	Expenditure to Date £'000	Variance to Date (overspend) £'000
Expenditure				
Employees	6,889	3,201	2,998	203
Premises	444	60	43	17
Supplies & Services	3,548	1,285	1,238	47
Transport	5	3	3	0
School Transport	919	303	371	(68)
Commissioned Services	2,157	675	633	42
Agency Related Expenditure	52	31	15	16
Independent School Fees	1,541	1,258	1,258	0
Inter Authority Special Needs	252	0	0	0
Nursery Education Payments	2,949	2,062	2,062	0
Schools Contingency	517	233	233	0
Special Education Needs Contingency	1,036	453	453	0
Capital Finance	3	0	0	0
Early Years Contingency	191	0	0	0
Total Expenditure	**20,503**	**9,564**	**9,307**	**257**
Income				
Fees & Charges	(425)	(74)	(74)	0
Rent	(100)	(7)	(10)	3
HBC Support Costs	(79)	0	0	0
Transfer to / from Reserves	(782)	(782)	(782)	0
Dedicated Schools Grant	(9,551)	(2,708)	(2,708)	0
Government Grant Income	(245)	(147)	(147)	0
Reimbursements & Other Income	(671)	(253)	(255)	2
Sales Income	(46)	0	0	0
Inter Authority Income	(578)	0	0	0
Schools SLA Income	(246)	(224)	(234)	10
Total Income	**(12,723)**	**(4,195)**	**(4,210)**	**15**
Net Operational Expenditure	**7,780**	**5,369**	**5,097**	**272**
Recharges				
Premises Support Costs	205	104	104	0
Transport Support Costs	296	54	54	0
Central Support Service Costs	1,851	857	857	0
Asset Rental Support Costs	5,017	0	0	0
Total Recharges	**7,368**	**1,015**	**1,015**	**0**
Net Expenditure	**15,149**	**6,384**	**6,112**	**272**

Economy, Enterprise & Property Department

	Annual Budget £'000	Budget to Date £'000	Expenditure to Date £'000	Variance to Date (overspend) £'000
Expenditure				
Employees	4,359	2,074	2,098	(24)
Repairs & Maintenance	2,731	1,201	1,202	(1)
Premises	40	37	37	0
Energy & Water Costs	625	258	247	11
NNDR	542	518	516	2
Rents	456	307	304	3
Marketing Programme	22	3	3	0
Promotions	8	3	3	0
Supplies & Services	1,634	654	647	7
Agency Related Expenditure	42	6	3	3
Grants to Non Voluntary Organisations	323	311	311	0
Surplus Property Assets	-685	-342	0	(342)
Revenue Contrib'n to / from Reserves	35	35	35	0
Total Expenditure	**10,132**	**5,065**	**5,406**	**(341)**
Income				
Fees & Charges	-574	-413	-422	9
Rent - Markets	-766	-375	-383	8
Rent - Industrial Estates	-639	-333	-342	9
Rent – Investment Properties	-656	-307	-310	3
Transfer to / from Reserves	-591	-591	-591	0
Government Grant - Income	-1,876	-924	-924	0
Reimbursements & Other Income	-257	-39	-42	3
Recharges to Capital	-227	-26	-26	0
Schools SLA Income	-486	-475	-480	5
Total Income	**-6,072**	**-3,483**	**-3,520**	**37**
Net Operational Expenditure	**4,060**	**1,582**	**1,886**	**(304)**
Premises Support Costs	1,924	980	980	0
Transport Support Costs	32	13	13	0
Central Support Service Costs	1,824	932	932	0
Asset Rental Support Costs	2,543	0	0	0
Repairs & Maint. Rech. Income	-2,558	-1,279	-1,279	0
Accommodation Rech. Income	-2,763	-1,382	-1,382	0
Central Supp. Service Rech. Income	-1,836	-918	-918	0
Total Recharges	**-834**	**-1,654**	**-1,654**	**0**
Net Expenditure	**3,226**	**-72**	**232**	**(304)**

Commissioning & Complex Needs Department

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	7,533	3,514	3,414	100
Premises	243	130	136	(6)
Supplies & Services	2,102	1,051	1,053	(2)
Carers Breaks	427	289	288	1
Transport	187	94	86	8
Contracts & SLAs	90	45	41	4
Payments To Providers	3,531	1,440	1,440	0
Emergency Duty Team	93	23	14	9
Other Agency Costs	640	296	289	7
Total Expenditure	**14,846**	**6,882**	**6,761**	**121**
Income				
Sales & Rents Income	-218	-149	-142	(7)
Fees & Charges	-176	-88	-62	(26)
CCG Contribution To Service	-360	-155	-133	(22)
Reimbursements & Grant Income	-536	-230	-228	(2)
Transfer From Reserves	-620	0	0	0
Total Income	**-1,910**	**-622**	**-565**	**(57)**
Net Operational Expenditure	**12,936**	**6,260**	**6,196**	**64**
Recharges				
Premises Support	174	96	96	0
Transport	450	222	222	0
Central Support Services	1,516	747	747	0
Asset Charges	62	0	0	0
Internal Recharge Income	-2,479	-397	-397	0
Total Recharges	**-277**	**668**	**668**	**0**
Net Expenditure	**12,659**	**6,928**	**6,864**	**64**

Prevention & Assessment Department

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	6,818	3,212	3157	55
Other Premises	113	36	41	(5)
Supplies & Services	399	197	201	(4)
Aids & Adaptations	113	56	79	(23)
Transport	17	5	5	0
Food Provision	28	8	10	(2)
Other Agency	22	9	9	0
Transfer to Reserves	1,874	0	0	0
Contribution to Complex Care Pool	17,330	6,836	6,778	58
Total Expenditure	**26,714**	**10,359**	**10,280**	**79**
Income				
Fees & Charges	-292	-131	-136	5
Reimbursements & Grant Income	-149	-80	-81	1
Transfer from Reserves	-1,001	0	0	0
Capital Salaries	-121	0	0	0
Government Grant Income	-300	-300	-300	0
Other Income	-3	-3	-3	0
Total Income	**-1,866**	**-514**	**-520**	**6**
Net Operational Expenditure	**24,848**	**9,845**	**9,760**	**85**
Recharges				
Premises Support	331	165	165	0
Asset Charges	175	0	0	0
Central Support Services	2,193	1,048	1,048	0
Internal Recharge Income	-1,560	-774	-774	0
Transport Recharges	49	20	20	0
Total Recharges	**1,188**	**459**	**459**	**0**
Net Expenditure	**26,036**	**10,304**	**10,219**	**85**

COMMUNITY & RESOURCES DIRECTORATE

Policy, People, Performance & Efficiency Division

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	1,847	949	932	17
Employee Training	133	31	31	0
Supplies & Services	125	101	94	7
Total Expenditure	**2,105**	**1,081**	**1,057**	**24**
Income				
Fees & Charges	-106	-106	-106	0
Reimbursements & Other Grants	-6	-6	-6	0
School SLA's	-381	-381	-381	0
Total Income	**-493**	**-493**	**-493**	**0**
Net Operational Expenditure	**1,612**	**588**	**564**	**24**
Recharges				
Premises Support	100	50	50	0
Transport Recharges	5	3	3	0
Central Support Recharges	855	427	427	0
Support Recharges Income	-2,942	-1,471	-1,471	0
Total Recharges	**-1,982**	**-991**	**-991**	**0**
Net Expenditure	**-370**	**-403**	**-427**	**24**

Planning & Transportation Department

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspnd) £'000
Expenditure				
Employees	4,555	2,223	2,209	14
Other Premises	222	78	67	11
Hired & Contracted Services	243	45	46	(1)
Supplies & Services	287	122	123	(1)
Street Lighting	2,082	617	617	0
Highways Maintenance	2,290	1,469	1,469	0
Bridges	98	4	4	0
Fleet Transport	1,397	477	477	0
Lease Car Contracts	516	222	222	0
Bus Support – Hopper Tickets	180	80	80	0
Bus Support	525	300	299	1
Out of Borough Transport	51	13	13	0
Finance Charges	406	166	166	0
Grants to Voluntary Organisations	68	34	34	0
Direct Revenue Financing	14	14	14	0
NRA Levy	60	30	30	0
Total Expenditure	**12,994**	**5,894**	**5,870**	**24**
Income				
Sales	-372	-138	-141	3
Planning Fees	-531	-285	-297	12
Building Control Fees	-201	-123	-134	11
Other Fees & Charges	-449	-280	-290	10
Rents	-8	0	0	0
Grants & Reimbursements	-539	-135	-134	(1)
Efficiency Savings	-60	0	0	0
School SLAs	-40	-40	-40	0
Recharge to Capital	-312	0	0	0
Transfer from Reserves	-217	0	0	0
Total Income	**2,729**	**-1,001**	**-1,036**	**35**
Net Operational Expenditure	**10,265**	**4,893**	**4,834**	**59**
Recharges				
Premises Support	642	388	388	0
Transport Recharges	629	301	304	(3)
Asset Charges	7,791	0	0	0
Central Support Recharges	1,935	968	968	0
Departmental Support Recharges	393	196	196	0
Departmental Support Recharges Income	-491	-246	-246	0
Support Recharges Income – Transport	-3,734	-1,700	-1,700	0
Support Recharges Income	-1,022	-396	-396	0
Total Recharges	**6,143**	**-489**	**-486**	**(3)**
Net Expenditure	**16,408**	**4,404**	**4,348**	**56**

Legal & Democratic Services Department

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	1,919	964	942	22
Supplies & Services	337	193	137	56
Civic Catering & Functions	27	1	2	(1)
Mayoral Allowances	22	22	18	4
Legal Expenses	215	66	67	(1)
Total Expenditure	**2,520**	**1,246**	**1,166**	**80**
Income				
Land Charges	-101	-46	-46	0
License Income	-251	-101	-102	1
Schools SLA's	-55	-55	-70	15
Government Grants	-34	-34	-34	0
Other Income	-73	-65	-76	11
Transfers from Reserves	-10	0	0	0
Total Income	**-524**	**-301**	**-328**	**27**
Net Operational Expenditure	**1,996**	**945**	**838**	**107**
Recharges				
Premises Support	132	66	66	0
Transport Recharges	26	13	13	0
Central Support Recharges	425	213	213	0
Support Recharges Income	-2,054	-1,027	-1,027	0
Total Recharges	**-1,471**	**-735**	**-735**	**0**
Net Expenditure	**525**	**210**	**103**	**107**

Finance Department

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	7,421	3,590	3,308	282
Supplies & Services	553	328	351	(23)
Other Premises	86	57	47	10
Insurances	1,614	991	992	(1)
Concessionary Travel	2,127	997	997	0
Rent Allowances	56,000	24,274	24,274	0
Non HRA Rebates	66	32	32	0
Discretionary Housing Payments	387	169	169	0
Local Welfare Payments	150	45	45	0
Total Expenditure	**68,404**	**30,483**	**30,215**	**268**
Income				
Fees & Charges	-224	-69	-69	0
SLA to Schools	-747	-747	-747	0
NNDR Administration Grant	-166	0	0	0
Hsg Ben Administration Grant	-782	-391	-391	0
Council Tax Admin Grant	-208	-208	-208	0
Rent Allowances	-55,600	-27,729	-27,729	0
Clerical Error Recoveries	-398	-284	-284	0
Non HRA Rent Rebates	-66	-36	-36	0
Discretionary Housing Payments Grant	-387	-115	-115	0
Reimbursements & Other Grants	-284	-192	-264	72
Liability Orders	-421	-368	-368	0
Transfer from Reserves	-791	0	0	0
Total Income	**-60,074**	**-30,139**	**-30,211**	**72**
Net Operational Expenditure	**8,330**	**344**	**4**	**340**
Recharges				
Premises	399	199	199	0
Transport	24	12	12	0
Asset Charges	19	0	0	0
Central Support Services	3,546	1,773	1,773	0
Support Services Income	-7,540	-3,770	-3,770	0
Total Recharges	**-3,552**	**-1,786**	**-1,786**	**0**
Net Expenditure	**4,778**	**-1,442**	**-1,782**	**340**

ICT & Support Services Department

	Annual Budget £'000	Budget to Date £'000	Actual to Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	5,546	2,649	2,645	4
Supplies & Services	682	331	228	103
Computer Repairs & Software	641	439	437	2
Communications Costs	332	291	291	0
Other Premises	23	18	19	(1)
Capital Financing	372	205	205	0
Transfers to Reserves	75	0	0	0
Total Expenditure	**7,671**	**3,933**	**3,825**	**108**
Income				
Fees & Charges	-551	-194	-194	0
Reimbursements & Other Grants	-176	-176	-176	0
Internal Billing	-12	-12	-12	0
Transfers from Reserves	-150	0	0	0
SLA to Schools	-556	-510	-509	(1)
Total Income	**-1,445**	**-892**	**-891**	**(1)**
Net Operational Expenditure	**6,226**	**3,041**	**2,934**	**107**
Recharges				
Premises	397	199	199	0
Transport	27	13	13	0
Asset Charges	1,161	0	0	0
Central Support Services	1,121	560	560	0
Support Service Income	-8,932	-4,466	-4,466	0
Total Recharges	**-6,226**	**-3,694**	**-3,694**	**0**
Net Expenditure	**0**	**-653**	**-760**	**107**

Public Health & Public Protection Department

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (underspend) £'000
Expenditure				
Employees	3,121	1,524	1,430	94
Supplies & Services	281	109	105	4
Other Agency	21	21	17	4
Contracts & SLA's	4,193	1,643	1,634	9
Total Expenditure	**7,606**	**3,297**	**3,186**	**111**
Income				
Other Fees & Charges	-64	-32	-24	(8)
Sales Income	-26	-51	-43	(8)
Reimbursements & Grant Income	-59	-38	-38	(0)
Government Grant	-8,786	-2,204	-2,204	0
Transfer from Reserves	30	0	0	0
Total Income	**-8,965**	**-2,325**	**-2,309**	**(16)**
Net Operational Expenditure	**-1,359**	**972**	**877**	**95**
Recharges				
Premises Support	166	83	83	0
Central Support Services	2,180	252	252	0
Transport Recharges	21	6	5	1
Total Recharges	**2,367**	**341**	**340**	**1**
Net Expenditure	**1,018**	**1,313**	**1,217**	**96**

Community & Environment Department

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	12,045	6,141	6,179	(38)
Other Premises	1,182	712	690	22
Supplies & Services	1,570	643	583	60
Book Fund	142	71	74	(3)
Hired & Contracted Services	1,151	437	446	(9)
Food Provisions	652	299	292	7
School Meals Food	2,077	771	755	16
Transport	54	22	13	9
Other Agency Costs	674	249	196	53
Waste Disposal Contracts	5,160	1,545	1,585	(40)
Leisure Management Contract	1,496	547	592	(45)
Grants To Voluntary Organisations	322	161	155	6
Grant To Norton Priory	222	111	117	(6)
Rolling Projects	32	32	32	0
Transfers To Reserves	0	0	0	0
Capital Financing	9	5	0	5
Total Spending	**26,788**	**11,746**	**11,709**	**37**
Income				
Sales Income	-2,229	-1,152	-1,062	(90)
School Meals Sales	-2,180	-717	-725	8
Fees & Charges Income	-3,265	-1,782	-1,727	(55)
Rents Income	-235	-209	-238	29
Government Grant Income	-1,186	-1,170	-1,159	(11)
Reimbursements & Other Grant Income	-548	-402	-425	23
Schools SLA Income	-79	-79	-83	4
Internal Fees Income	-120	-66	-81	15
School Meals Other Income	-2,270	-1,694	-1,700	6
Meals On Wheels	-196	-98	-72	(26)
Catering Fees	-225	-88	-35	(53)
Capital Salaries	-53	-24	-14	(10)
Transfers From Reserves	-44	-23	-23	0
Total Income	**-12,630**	**-7,504**	**-7,344**	**(160)**
Net Operational Expenditure	**14,157**	**4,242**	**4,365**	**(123)**
Recharges				
Premises Support	1,947	997	997	0
Transport Recharges	2,390	707	706	1
Departmental Support Services	9		0	0
Central Support Services	3,146	1,612	1,612	0
Asset Charges	3,005		0	0
HBC Support Costs Income	-382	-382	-382	0
Total Recharges	**10,115**	**2,934**	**2,933**	**1**
Net Expenditure	**24,273**	**7,176**	**7,298**	**(122)**

Corporate & Democracy

	Annual Budget £'000	Budget To Date £'000	Actual Expenditure £'000	Variance To Date (overspend) £'000
Expenditure				
Employee Related	392	163	163	0
Interest Payments	2,480	1,005	805	200
Members Allowances	777	387	387	0
Supplies & Services	163	71	70	1
Contracted Services	63	53	54	(1)
Contingency	500	0	0	0
Precepts & Levies	179	0	0	0
Capital Financing	2,341	2,306	2,128	178
Transfers to Reserves	1,744	342	342	0
Bank Charges	77	38	37	1
Audit Fees	140	26	26	0
Total Expenditure	**8,856**	**4,391**	**4,012**	**379**
Income				
External Interest	-840	-586	-726	140
Government Grants	-4,988	-2,592	-2,593	1
Fees & Charges	-109	-46	-45	(1)
Reimbursements & Other Grants	-25	-22	-22	0
Transfers from Reserves	-6,030	0	0	0
Total Income	**-11,992**	**-3,246**	**-3,386**	**140**
Net Operational Expenditure	**-3,136**	**1,145**	**626**	**519**
Recharges				
Premises	7	3	3	0
Transport	3	2	2	0
Asset Charges	151	0	0	0
Central Support Services	1,840	920	920	0
Support Services Income	-20,387	-209	-209	0
Total Recharges	**-18,386**	**716**	**716**	**0**
Net Expenditure	**-21,522**	**1,861**	**1,342**	**519**

Mersey Gateway

	Annual Budget £'000	Budget to Date £'000	Expenditure to Date £'000	Variance to Date (overspend) £'000
Expenditure				
Other Premises	86	21	21	0
Hired & Contracted Services	18	2	3	(1)
Supplies & Services	0	0	2	(2)
MGCB Ltd	3,438	438	438	0
Finance Charges	148	148	146	2
Total Expenditure	**3,690**	**609**	**610**	**(1)**
Income				
Grants & Reimbursements	-976	-71	-71	0
Recharge to Capital	-2714	-2	-3	1
Contribution from Reserves				
Total Income	**-3,690**	**-73**	**-74**	**1**
Net Operational Expenditure	**0**	**536**	**536**	**0**
Recharges				
Central Support Recharges	39	10	10	0
Total Recharges	**39**	**10**	**10**	**0**
Net Expenditure	**39**	**546**	**546**	**0**

APPENDIX 2

Complex Care Pooled Budget

Note – Halton BC's net contribution towards the Complex Care Pooled Budget is included within the Prevention and Assessment Department statement shown in Appendix 1.

	Annual Budget £'000	Budget to Date £'000	Expenditure to Date £'000	Variance to Date (overspend) £'000
Expenditure				
Intermediate Care Services	3,623	460	442	18
End of Life	192	47	47	0
Sub Acute	1,743	376	369	7
Urgent Care Centres	615	0	0	0
Joint Equipment Store	810	4	4	0
Contracts & SLA's	1,197	125	114	11
Intermediate Care Beds	596	149	156	(7)
BCF Schemes	2,546	436	436	0
Adult Care:				
Residential & Nursing Care	18,185	2,586	2,538	48
Domiciliary & Supported Living	10,921	2,048	2,047	1
Direct Payments	4,436	1,476	1,482	(6)
Day Care	523	64	65	(1)
Contingency	518	0	0	0
Total Expenditure	45,905	7,771	7,700	71
Income				
Residential & Nursing Income	-5,018	-740	-734	(6)
Community Care Income	-1,583	-234	-223	(11)
Direct Payments Income	-193	-58	-64	6
Income from other CCGs	-114	-29	-29	0
BCF Income	-9,451	-2,142	-2,142	0
Contribution to Pool	-12,166	-3,042	-3,042	0
Other Income	-50	-50	-48	(2)
Total Income	-28,575	-6,295	-6,282	(13)
Net Expenditure	**17,330**	**1,476**	**1,418**	**58**

APPENDIX 3

Capital Expenditure to 30 September 2015

Directorate/Department	Actual Expenditure to Date £'000	2015/16 Cumulative Capital Allocation			Capital Allocation 2016/17 £'000	Capital Allocation 2017/18 £'000
		Quarter 2 £'000	Quarter 3 £'000	Quarter 4 £'000		
People & Economy Directorate						
Schools Related						
Asset Management Data	1	1	4	5	0	0
Fire Compartmentation	52	52	62	62	0	0
Capital Repairs	791	791	900	1,015	0	0
Asbestos Management	3	3	10	20	0	0
Schools Access Initiative	26	26	50	75	0	0
Education Programme (General)	15	15	40	70	0	0
Basic Need Projects	0	0	0	0	936	71
School Modernisation Projects	157	157	350	460	0	0
Inglefield	0	0	6	12	0	0
St Bedes Junior School	4	4	4	28	0	0
Ashley School	12	12	12	12	0	0
Early Education for 2 Year Olds	63	63	100	183	0	0
Universal Infant School Meals	0	0	2	2	0	0
Halebank School	0	0	20	30	10	0
Responsible Bodies Bids	66	66	250	475	0	0
St Edwards Catholic Primary	1	1	10	35	0	0
Fairfield Primary School	0	0	10	212	1,100	853
Hale Primary School	0	0	5	10	113	3

Directorate/Department	Actual Expenditure to Date	2015/16 Cumulative Capital Allocation			Capital Allocation 2016/17	Capital Allocation 2017/18
		Quarter 2	Quarter 3	Quarter 4		
	£'000	£'000	£'000	£'000	£'000	£'000
Economy, Enterprise & Property						
Castlefields Regeneration	56	56	60	635	0	0
3MG	52	52	3,000	3,493	0	0
Widnes Waterfront	0	0	100	200	800	0
Johnsons Lane Infrastructure	119	119	250	450	0	0
Decontamination of Land	0	0	0	6	0	0
SciTech Daresbury – Tech Space	5	5	1,704	10,965	0	0
Former Crosville Site	82	82	275	518	0	0
Peelhouse Lane Cemetery – Enabling Works	19	19	36	51	0	0
Peelhouse Lane Roundabout & Cemetery Access	5	5	40	64	66	0
Peelhouse Lane Cemetery	12	12	515	1,019	336	70
Police Station Site	22	22	149	342	8	0
Travellers Site Warrington Road	1209	1,209	1,209	1,162	0	0
Widnes Town Centre Initiative	0	0	10	21	0	0
Lowerhouse Lane Depot - Upgrade	4	4	24	24	0	0
Equality Act Improvement Works	18	18	40	250	300	300
Signage at The Hive	0	0	100	100	0	0
Advertising Screen – The Hive	0	0	100	100	0	0
Prevention & Assessment						
Disabled Facilities Grant	119	250	375	500	0	0
Stairlifts (Adaptations Initiative)	92	125	187	250	0	0
RSL Adaptations (Joint Funding)	55	100	140	200	0	0

Directorate/Department	Actual Expenditure to Date £'000	2015/16 Cumulative Capital Allocation			Capital Allocation 2016/17 £'000	Capital Allocation 2017/18 £'000
		Quarter 2 £'000	Quarter 3 £'000	Quarter 4 £'000		
Commissioning & Complex Care						
ALD Bungalows	1	1	0	200	100	100
Halton Carers Centre Refurbishment	34	34	34	34	0	0
Grangeway Court	1	1	100	360	40	0
Lifeline Telecare Upgrade	0	0	60	100	0	0
Community Meals Oven	0	0	0	10	0	0
Social Care Capital Grant	0	0	206	413	0	0
The Halton Brew	16	16	16	16	0	0
Total People & Economy	**3,112**	**3,321**	**10,565**	**24,189**	**3,809**	**1,397**
Community & Resources Directorate						
ICT & Support Services						
ICT Rolling Programme	1,358	1,358	1,517	1,719	1,100	1,100
Policy, Planning & Transportation						
Local Transport Plan						
Bridge & Highway Maintenance	491	495	1,243	2,228	2,373	2,311
Integrated Transport & Network Management	191	190	550	908	908	908
Street Lighting	234	235	1,350	1,900	1,700	1,700
STEPS Programme	0	0	267	664	540	0
Surface Water Management	7	5	65	122	0	0
Local Pinch Point – Daresbury Expressway	9	10	470	943	0	0
S106 Schemes	0	0	192	314	0	0

Directorate/Department	Actual Expenditure to Date	2015/16 Cumulative Capital Allocation			Capital Allocation 2016/17	Capital Allocation 2017/18
		Quarter 2	Quarter 3	Quarter 4		
	£’000	£’000	£’000	£’000	£’000	£’000
Mersey Gateway						
Land Acquisitions	720	720	4,945	6,192	5,099	919
Development Costs	801	801	1,749	2,491	3,318	2,690
Loan Interest During Construction	1,798	1,805	2,705	3,602	3,917	1,773
Construction Costs	0	0	0	0	70,000	32,500
Mersey Gateway Liquidity Fund	0	0	0	0	0	10,000
Other						
Risk Management	45	45	0	120	120	120
Fleet Replacements	598	600	806	2,174	1,940	624
Brookvale Biomass Boiler	9	9	9	9	0	0
Community and Environment						
Stadium Minor Works	31	30	30	42	30	30
Widnes Recreation Site	544	544	741	741	0	0
Norton Priory	193	200	2,120	2,843	920	50
Norton Priory Biomass Boiler	0	0	0	107	0	0
Open Spaces Scheme	14	14	18	18	0	0
Children’s Playground Equipment	55	55	60	138	65	65
Upton Improvements	1	1	5	13	0	0
Crow Wood Play Area	0	0	2	4	8	0
Runcorn Hill Park	560	250	250	250	0	0
Runcorn Cemetery Extension	0	0	0	9	0	0
Widnes Crematorium Cremators	173	109	109	109	0	0
Landfill Tax Credit Schemes	0	0	0	340	340	340
Litter Bins	0	0	0	20	20	20
Total Community & Resources	**7,832**	**7,476**	**19,203**	**28,020**	**92,398**	**55,150**

Directorate/Department	Actual Expenditure to Date	2015/16 Cumulative Capital Allocation			Capital Allocation 2016/17	Capital Allocation 2017/18
		Quarter 2	Quarter 3	Quarter 4		
	£'000	£'000	£'000	£'000	£'000	£'000
TOTAL CAPITAL PROGRAMME	**10,944**	**10,797**	**29,768**	**52,209**	**96,207**	**56,547**
Slippage (20%)				-10,442	-5,241	-2,809
					10,442	5,241
TOTAL	**10,944**	**10,788**	**29,768**	**41,767**	**101,408**	**58,979**

Agenda Item 6c

REPORT TO: Executive Board

DATE: 19 November 2015

REPORTING OFFICER: Operational Director – Finance

PORTFOLIO: Resources

TITLE: Treasury Management Quarter 2 2015/16

WARDS: Borough-wide

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to provide an update regarding activities undertaken on the money market as required by the Treasury Management Policy.

2.0 RECOMMENDED: That the report be noted.

3.0 SUPPORTING INFORMATION

Economic Outlook

3.1 The following analysis of the economic situation has been provided by Capita Asset Services, the Council's treasury management advisors.

3.2 During the quarter ended 30 September 2015;

- The economic recovery lost some pace;
- Household spending growth moderated slightly, despite strong consumer confidence;
- Wage growth picked up further in response to labour market tightening;
- CPI inflation hovered around 0% and was poised to turn negative;
- The prospect of a 2015 rate increase became extremely unlikely;

3.3 UK Gross Domestic Product (GDP) growth rates in 2013 of 2.2% and 2.9% in 2014 were the strongest growth rates of any G7 country. The 2014 growth rate was also the strongest UK rate since 2006 and the 2015 growth rate is likely to be a leading rate in the G7 again, possibly being equal to that of the United States. However, quarter 1 of 2015 was weak at +0.4% (+2.9% year on year) although there was an improvement in quarter 2 to +0.7% (+2.4% year on year). Growth is expected to weaken marginally to about +0.5% in quarter 3 as the economy faces headwinds for exporters from the appreciation of Sterling against the Euro and weak growth in the EU, China and emerging markets, plus the dampening effect of the Government's continuing austerity programme, although the pace of reductions was eased in the May Budget.

3.4 However, the Purchasing Manager's Index, (PMI), forecasts an even lower growth rate of around +0.3%, in quarter 4, which would be the lowest growth rate since the end of 2012.

3.5 Despite this the Bank of England August Inflation Report included a forecast for growth to remain around 2.4%–2.8% over the next three years, driven mainly by strong consumer demand as the squeeze on the disposable incomes of consumers has been reversed by a recovery in wage inflation, at the same time that CPI inflation has fallen to, or near to, zero. Since August worldwide economic statistics have been distinctly weak, so it would not be a surprise if the next Inflation Report in November were to cut those forecasts.

3.6 The August Bank of England Inflation Report forecast was notably subdued with inflation barely getting back up to the 2% target within the 2-3 year time horizon. However, with the price of oil taking a fresh downward direction and Iran expected to soon re-join the world oil market after the impending lifting of sanctions, there could be several more months of low inflation still to come, especially as world commodity prices have generally been depressed by the Chinese economic downturn.

3.7 There are therefore considerable risks around whether inflation will rise in the near future as strongly as previously expected. This will make it more difficult for the central banks of both the US and the UK to raise rates as soon as had previously been expected, especially given the recent major concerns around the slowdown in Chinese growth, the knock on impact on the earnings of emerging countries from falling oil and commodity prices, and the volatility we have seen in equity and bond markets in 2015 so far.

3.8 The American economy made a strong comeback after a weak first quarter's growth at +0.6%, to grow by 3.9% in quarter 2 of 2015. While there had been confident expectations during the Summer that the Federal Reserve could start increasing rates in September or if not by the end of 2015, the recent news regarding Chinese and Japanese growth and the knock on impact on emerging countries that are major suppliers of commodities, was cited as the main reason for their decision not to raise rates.

3.9 The non-farm payrolls figures issued in October were disappointingly weak and confirmed concerns that US growth is likely to weaken. There are increasing concerns, both in the US and UK, that the growth rates currently being achieved are only being achieved with monetary policy being highly aggressive with central rates at near zero and huge quantative easing in place.

3.10 In the Eurozone, the European Central Bank (ECB) implemented a €1.1 trillion programme of quantitative easing (QE) from March 2015 which is intended to run initially until September 2016. This already appears to have had a positive effect in helping a recovery in consumer and business confidence and a start to a significant improvement in economic growth. However, the recent downbeat Chinese and Japanese growth news has raised questions as to whether the ECB will need to boost its QE programme if it is to succeed in significantly improving growth in the Eurozone and getting inflation up from the current level of around zero to its target of 2%.

Interest Rate Forecast

3.11 The following forecast has been provided by Capita Asset Services.

	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18
Bank rate	0.50%	0.50%	0.75%	0.75%	1.00%	1.00%	1.25%	1.50%	1.50%	1.75%	1.75%
5yr PWLB rate	2.40%	2.50%	2.60%	2.80%	2.90%	3.00%	3.10%	3.20%	3.30%	3.40%	3.50%
10yr PWLB rate	3.00%	3.20%	3.30%	3.40%	3.50%	3.70%	3.80%	3.90%	4.00%	4.10%	4.20%
25yr PWLB rate	3.60%	3.80%	3.90%	4.00%	4.10%	4.20%	4.30%	4.40%	4.50%	4.60%	4.60%
50yr PWLB rate	3.60%	3.80%	3.90%	4.00%	4.10%	4.20%	4.30%	4.40%	4.50%	4.60%	4.60%

Short Term Borrowing Rates

3.12 The bank base rate remained at 0.50% throughout the quarter.

		Jul		Aug		Sep	
	Start	Mid	End	Mid	End	Mid	End
	%	%	%	%	%	%	%
Call Money (Market)	0.48	0.48	0.48	0.48	0.48	0.48	0.48
1 Month (Market)	0.51	0.50	0.51	0.51	0.51	0.51	0.51
3 Month (Market)	0.58	0.58	0.58	0.59	0.59	0.59	0.58

Longer Term Borrowing Rates

		Jul		Aug		Sep	
	Start	Mid	End	Mid	End	Mid	End
	%	%	%	%	%	%	%
1 Year (Market)	1.04	1.07	1.08	1.06	1.05	1.06	1.04
10 Year (PWLB)	2.98	3.11	2.91	2.80	2.77	2.69	2.64
25 Year (PWLB)	3.54	3.64	3.43	3.33	3.35	3.33	3.31

3.13 Market rates are based on LIBOR rates published at the middle and end of each month. PWLB rates are for new loans based on principal repayable at maturity.

Borrowing and Investments

Turnover During the Period

	No of deals	Turnover £m
Short Term Borrowing	-	-
Short Term Investments	10	85

Position at Month End

	Jul £m	Aug £m	Sep £m
Total Borrowing	183	183	173
Total Investments	198	198	188
Call Account Balance	27	26	21

Investment Benchmarking

Benchmark	Benchmark Return %	Performance %	Investment Interest Earned £000
7 day	0.36	0.47	31
1 month	0.38	0.41	3
3 month	0.46	0.90	5
6 month	0.62	0.68	103
12 month	0.93	0.78	253
Total			**395**

3.14 This shows the Council has over achieved the benchmark for most maturities. Due to the Council's strict treasury management guidelines only Counterparties with a very high credit score can be used for 12 months investments. For this reason returns are not as high as the benchmark return.

Budget Monitoring

	Net Interest at 30th September 2015				
	Budget Year to Date £000	**Actual Year to Date £000**	**Variance (o/spend) £000**		**Actual inc M Gateway £000**
Investment	(194)	(384)	190		(778)
Borrowing	763	805	(42)		2,996
Total	**569**	**421**	**148**		**2,218**

3.15 As the borrowing and investments in relation to the Mersey Gateway scheme are to be capitalised they will have no effect on the revenue budget and have therefore been excluded from the budget monitoring figures above.

New Long Term Borrowing

3.16 No new loans have been taken in this quarter.

Policy Guidelines

3.17 The Treasury Management Strategy Statement (TMSS) for 2015/16, which includes the Annual Investment Strategy, was approved by the Council on 04 March 2015. It sets out the Council's investment priorities as being:

- Security of capital;
- Liquidity; and
- Yield

3.18 The Council will also aim to achieve the optimum return (yield) on investments commensurate with proper levels of security and liquidity. In the current economic climate and the heightened credit concerns it is considered appropriate to keep the majority of investments short term and to ensure all investments are in in line with Sector's credit rating methodology.

Treasury Management Indicators

3.19 It is a statutory duty for the Council to determine and keep under review the affordable borrowing limits. The Council's approved Treasury and Prudential Indicators were set out in the Treasury Management Strategy Statement and are reviewed in Appendix 1.

Debt Rescheduling

3.20 No debt rescheduling was undertaken during the quarter.

4.0 POLICY IMPLICATIONS

4.1 None.

5.0 FINANCIAL IMPLICATIONS

5.1 The financial implications are as set out in the report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 There are no direct implications, however, the revenue budget and capital programme support the delivery and achievement of all the Council's priorities.

7.0 RISK ANALYSIS

7.1 The main risks with Treasury Management are security of investment and volatility of return. To combat this, the Authority operates within a clearly defined Treasury Management Policy and annual borrowing and investment strategy, which sets out the control framework

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None.

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

9.1 There are no background papers under the meaning of the Act.

Appendix 1

Treasury and Prudential Indicators – 2015/16 - Quarter 2

	2014/15	2015/16	
Prudential Indicators	**Full Year Actual £000**	**Original Estimate £000**	**Quarter 2 Estimate £000**
Capital Expenditure	32,157	40,202	51,257
Net Financing Need for the Year *(Borrowing Requirement)*	3,787	23,404	20,547
Increase / (Decrease) in CFR *(Capital Financing Requirement)*	853	20,208	17,722
Ratio of Financing Costs to Net Revenue Stream *(Proportion of cost of borrowing to Council's net revenue)*	2.9%	3.4%	2.9%
Incremental Impact on band D Council Tax (£) *(net cost of borrowing compared to tax base)*	8.19	17.21	2.07
External Debt	183,000	153,000	153,000
Operational Boundary *(Limit of which external debit is not epected to exceed)*	252,600	255,313	255,313
Authorised Limit *(Limit beyound which external debit is prohibited)*	270,000	270,000	270,000

Upper Limit for Interest Rate Exposure	**Exposure Limit %**	**2014/15 Actual %**	**2015/16 Estimate %**
Fixed Rate	100	100	95
Variable Rate	30	-	5

Maturity Structure of Fixed Rate Borrowing	**Exposure Limit %**	**2014/15 Actual %**	**2015/16 Estimate %**
Under 12 months	40	16	7
12 months to 24 months	40	5	7
24 months to 5 years	40	5	0
5 years to 10 years	40	0	0
10 years and above	100	73	87

Maximum Principal invested > 365 days	Investment Limit £000	2014/15 Actual £000	2015/16 Estimate £000
Principal Sums Invested over 365 days	30,000	10,000	0

REPORT TO: Executive Board

DATE: 19 November 2015

REPORTING OFFICER: Operational Director – Finance

PORTFOLIO: Resources

SUBJECT: Budget Proposals 2016/17 – 2nd Set

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To recommend to Council further revenue budget proposals for 2016/17.

2.0 RECOMMENDATION: That Council approve the budget proposals for 2016/17 set out in Appendix 1.

3.0 SUPPORTING INFORMATION

3.1 The Medium Term Financial Strategy (MTFS) forecasts potential revenue budget funding gaps for the Council, of approximately £16m in 2016/17 and £9m in 2017/18.

3.2 Budget saving proposals for 2016/17 are currently being developed by the Budget Working Group.

3.3 A first set of proposals totalling £7.8m was approved by Council on 14th October 2015. Appendix 1 presents a second set of proposals. It is proposed to implement these immediately in order to also achieve a part-year saving in 2015/16, which will assist in keeping the Council's overall spending in line with budget. In addition, a number of the proposals will take time to implement and therefore commencing the process as soon as possible will assist with ensuring they are fully implemented by 1st April 2016. Appendix 1 also presents the impact in 2017/18 of certain of the savings proposals.

3.4 The following table summarises the budget proposals of the Budget Working Group and identifies the remaining forecast budget gaps.

	2016/17 £m	2017/18 £m	Total £m
Forecast Budget Gaps as per MTFS	16.0	9.0	25.0
Less: 1st Set of Budget Saving Proposals (approved 14th October 2015)			
Community & Resources Directorate	-3.8	+0.9	-2.9
People & Economy Directorate	-4.0	+3.0	-1.0

Less: 2nd Set of Budget Saving Proposals (as shown in Appendix 1)			
Community & Resources Directorate	-1.7	0	-1.7
People & Economy Directorate	-1.9	+0.8	-1.1
Remaining Forecast Budget Gaps	**4.6**	**13.7**	**18.3**

3.5 The Government will announce the outcome of its Comprehensive Spending Review on 25th November 2015 and then its Grant Settlement for Local Government in late December, at which point the Council's actual budget gap for 2016/17 will be known, along with indications for 2017/18 and 2018/19.

3.6 A third set of budget saving proposals is currently being developed by the Budget Working Group to enable the Council to deliver a balanced budget for 2016/17, which will be recommended to Council on 2nd March 2016.

4.0 POLICY IMPLICATIONS

4.1 The revenue budget supports the Council in achieving the aims and objectives set out in the Community Strategy for Halton and the Council's Corporate Plan.

5.0 FINANCIAL IMPLICATIONS

5.1 The financial implications of these budget proposals are as set out within the report and Appendix 1.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**

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

6.3 **A Healthy Halton**

6.4 **A Safer Halton**

6.5 **Halton's Urban Renewal**

The revenue budget supports the delivery and achievement of all the Council's priorities. The budget proposals listed in Appendix 1 have been prepared in consideration of all the Council's priorities.

7.0 RISK ANALYSIS

7.1 Failure to set a balanced budget would put the Council in breach of statutory requirements. The budget is prepared in accordance with detailed guidance and a timetable, to ensure statutory requirements are

met and a balanced budget is prepared which aligns resources with corporate objectives.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1072

9.1 There are no background papers under the meaning of the Act.

10.0 REASON(S) FOR THE DECISION

10.1 To seek approval for a second set of revenue budget proposals for 2016/17.

11.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

11.1 In arriving at the budget saving proposals set out in Appendix 1, numerous proposals have been considered, some of which have been deferred pending further information or rejected.

12.0 IMPLEMENTATION DATE

12.1 10th December 2015.

	DEPARTMENT/ DIVISION/ SERVICE AREA	DESCRIPTION OF PROPOSAL	TOTAL BUDGET £'000	ESTIMATED BUDGET SAVING		PERM OR TEMP (P / T)	MANDATORY OR DISCRETIONARY SERVICE AFFECTED (M / D)
				2016/17 £'000	2017/18 £'000		
COMMUNITY & RESOURCES DIRECTORATE							
EFFICIENCY OPPORTUNITIES							
1	Legal & Democratic Svcs /Legal Services	Deletion of a part time HBC3 Keyboard Operator/ Clerical Post.	**13**	**13**	**0**	**P**	**D**
2	Legal & Democratic Svcs /Legal Services	Deletion of vacant HBC2 Clerical Officer post.	**17**	**17**	**0**	**P**	**D**
3	Legal & Democratic Svcs /Communications & Marketing	Deletion of vacant HBC6 Marketing Officer post.	**30**	**30**	**0**	**P**	**D**
4	Policy, People, Performance & Efficiency	Restructuring following consolidation of functions into the new Policy, People, Performance & Efficiency Division.	**2,300**	**184**	**0**	**P**	**D**

	DEPARTMENT/ DIVISION / SERVICE AREA	DESCRIPTION OF PROPOSAL	TOTAL BUDGET £'000	ESTIMATED BUDGET SAVING		PERM OR TEMP (P / T)	MANDATORY OR DISCRETIONARY SERVICE AFFECTED (M / D)
				2016/17 £'000	2017/18 £'000		
5	Finance Dept/ Financial Mgt Div	Deletion of a vacant HBC7/8 Finance Officer post.	**40**	**40**	**0**	**P**	**D**
6	Policy, Planning & Transportation	Savings target for the Highways efficiency review currently being undertaken.	**2,836**	**150**	**0**	**P**	**M/D**
OTHER BUDGET SAVINGS							
7	Capital Financing	Revision of the Minimum Revenue Provision Policy in order to lengthen the period over which capital assets are written down within the accounts, to closer match the life of those assets.	**2,306**	**520**	**0**	**P**	**D**
8	Support Services	Use of grant funding rather than HBC core budget, to fund central support recharges provided to Public Health.	**320**	**320**	**0**	**P**	**D**
9	Community & Environment	Review the Youth, Sports and Community grants.	**63**	**55**	**8**	**P**	**D**

	DEPARTMENT/ DIVISION / SERVICE AREA	DESCRIPTION OF PROPOSAL	TOTAL BUDGET £'000	ESTIMATED BUDGET SAVING		PERM OR TEMP (P / T)	MANDATORY OR DISCRETIONARY SERVICE AFFECTED (M / D)
				2016/17 £'000	2017/18 £'000		
10	Community & Environment/ Community Meals Service	Increase the charge for Community Meals by 50p per meal increasing income by £35,000 and make other operational efficiencies. Current charges for meals delivered to home are £3.35 and tea time packs £2.35.	**50**	**50**	**0**	**P**	**D**
11	Community & Environment	Delete vacant Events Officer post and improved operational efficiencies.	**76**	**30**	**0**	**P**	**D**
12	Community & Environment	Establish an SLA between Public Health and the Sports Development Team, to deliver specific services on behalf of Public Health.	**221**	**60**	**0**	**P**	**D**
13	Council Wide	Increase from 2.6% to 3.0% the existing staff turnover saving targets attached to the staffing budgets for all non-trading cost centres, to reflect the delayed/non-filling of vacancies.	**1,637**	**250**	**0**	**P**	**D**
		TOTAL PERMANENT		**1,719**	**8**	**P**	
		TOTAL TEMPORARY (ONE-OFF)		**0**	**0**	**T**	
		GRAND TOTAL		**1,719**	**8**		

	DEPARTMENT/ DIVISION/ SERVICE AREA	DESCRIPTION OF PROPOSAL	TOTAL BUDGET £'000	ESTIMATED BUDGET SAVING		PERM OR TEMP (P / T)	MANDATORY OR DISCRETIONARY SERVICE AFFECTED (M / D)
				2016/17 £'000	2017/18 £'000		
PEOPLE AND ECONOMY DIRECTORATE							
INCOME GENERATION OPPORTUNITIES							
1	Commissioning and Complex Care Dept	Additional income from charging against a client's 'disposable' income (non-residential care taking 100% into account). Relates to around 200 people.	**1,583**	**250**	**0**	**P**	**D**
EFFICIENCY OPPORTUNITIES							
2	Prevention and Assessment Dept	Redesign and deletion of a Practice Manager post in Care Management, following a request for voluntary redundancy from the postholder.	**40**	**40**	**0**	**P**	**M**
3	Prevention and Assessment/ Commissioning and Complex Care	Redesign of Commissioning and Policy with the resulting deletion of two Commissioning Manager posts, following requests for voluntary redundancy from both postholders.	**100**	**100**	**0**	**P**	**M**
4	Commissioning and Complex Care Dept	Supporting People review of services to achieve a permanent on-going saving and also a one-off saving from a managed underspend in 2015/16.	**3,590**	**200** **300**	**0** **-300**	**P** **T**	**D** **D**

	DEPARTMENT / DIVISION/ SERVICE AREA	DESCRIPTION OF PROPOSAL	TOTAL BUDGET £'000	ESTIMATED BUDGET SAVING		PERM OR TEMP (P / T)	MANDATORY OR DISCRETIONARY SERVICE AFFECTED (M / D)
				2016/17 £'000	2017/18 £'000		
5	Prevention and Assessment Dept	One-off service efficiencies carried forward from 2013/14.	**400**	**400**	**-400**	**T**	**D**
6	Policy, Provision & Performance	Delete the advertising budget which publicises the Family Information Service.	**8**	**8**	**0**	**P**	**M**
7	Policy, Provision & Performance	Delete the professional fees budget from the Child Place Planning Team.	**3**	**3**	**0**	**P**	**M**
8	Policy, Provision & Performance	Delete the subscriptions budget, as all subscriptions in Child Place Planning have now ended.	**2**	**2**	**0**	**P**	**M**
9	Policy, Provision & Performance	Cease Childminder Start Up Grants – training is now offered direct by officers to support new start-ups.	**1**	**1**	**0**	**P**	**M**
10	Policy, Provision & Performance	Restructuring within the Department.	**935**	**204**	**0**	**P**	**M**

	DEPARTMENT/ DIVISION/ SERVICE AREA	DESCRIPTION OF PROPOSAL	TOTAL BUDGET £'000	ESTIMATED BUDGET SAVING		PERM OR TEMP (P / T)	MANDATORY OR DISCRETIONARY SERVICE AFFECTED (M / D)
				2016/17 £'000	2017/18 £'000		
11	14-19 & Post - 16 Entitlement	Reduction in the Information Advice and Guidance Budget. This service provides information advice and guidance to 16-19 olds who are not in education, employment and training.	**243**	**105**	**0**	**P**	**D/M**
		One-off saving carried forward from 2015-16 from not recruiting to a Young Persons Case Worker post.	**34**	**34**	**-34**	**T**	**D/M**
12	IYSS & Commissioning	Cease the Play, Learn and Loan Provision. A range of resources are provided to families on loan.	**3**	**3**	**0**	**P**	**D**
13	IYSS & Commissioning	Cease funding the Halton Child Contact Centre. Provides a venue for estranged parents to meet their children.	**2**	**2**	**0**	**P**	**D**
14	IYSS & Commissioning	Cease funding provided to the Brook Centre – the Sexual Health Service is now commissioned by Public Health.	**3**	**3**	**0**	**P**	**D**
15	IYSS & Commissioning	Cease grant for "Halton's Got Talent". The event will now need to generate sponsorship or sufficient income to cover all costs.	**8**	**8**	**0**	**P**	**D**

	DEPARTMENT / DIVISION/ SERVICE AREA	DESCRIPTION OF PROPOSAL	TOTAL BUDGET £'000	ESTIMATED BUDGET SAVING		PER M OR TEMP (P / T)	MANDATORY OR DISCRETIONARY SERVICE AFFECTED (M / D)
				2016/17 £'000	2017/18 £'000		
16	IYSS & Commissioning	Cease funding C-Card a registration system for condoms for young people. This can now be delivered through the Youth Service Contract.	**4**	**4**	**0**	**P**	**D**
17	IYSS & Commissioning	Reduce the budget for Blitz Positive Activities (holiday activities) for young people.	**39**	**20**	**0**	**P**	**D**
18	IYSS & Commissioning	Cease to commission the Young Advisors Service.	**38**	**38**	**0**	**P**	**D**
19	IYSS & Commissioning	Cease provision of funding for Cheshire Fire and Rescue, as home safety advice is now delivered by them as core provision	**3**	**3**	**0**	**P**	**D**
20	IYSS & Commissioning	Cease secondment for the Young Persons Co-ordinated Action Against Domestic Abuse post, providing a one-off saving against the Troubled Families budget.	**34**	**34**	**-34**	**T**	**D**
21	IYSS & Commissioning	Reduction in hours requested for a Contract Manager post.	**40**	**8**	**0**	**P**	**D**

	DEPARTMENT/ DIVISION/ SERVICE AREA	DESCRIPTION OF PROPOSAL	TOTAL BUDGET	ESTIMATED BUDGET SAVING		PERM OR TEMP	MANDATORY OR DISCRETIONARY SERVICE AFFECTED (M / D)
			£'000	2016/17 £'000	2017/18 £'000	(P / T)	
22	IYSS & Commissioning	Restructuring of Integrated Youth Support Service and Commissioning.	**485**	**59**	**0**	**P**	**D**
23	Education Division	Restructure the Early Years Support and Intervention Team with the resulting deletion of one vacant Early Years Consultant Teacher post.	**402**	**45**	**0**	**P**	**D**
24	Education Division	Delete half of a vacant School Setting and Improvement Officer post and to then flexibly commission capacity required.	**60**	**30**	**0**	**P**	**D**
25	Inclusion 0-25 Division	Reduction in one post in the Attendance and Behaviour Team through voluntary redundancy.	**603**	**38**	**0**	**P**	**D**
		TOTAL PERMANENT		**1,174**	**0**	**P**	
		TOTAL TEMPORARY (ONE-OFF)		**768**	**-768**	**T**	
		GRAND TOTAL		**1,942**	**-768**		