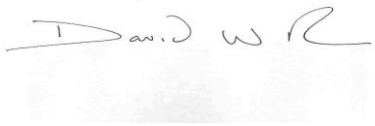
Public Document Pack

Executive Board

Thursday, 15 September 2016 2.00 p.m.
The Boardroom, Municipal Building



Chief Executive

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

PART 1

Item	Page No
1. MINUTES	
2. DECLARATION OF INTEREST 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.	
3. CHILDREN YOUNG PEOPLE AND FAMILIES PORTFOLIO	
(A) CLOSURE OF WESTFIELD PRIMARY SCHOOL RESOURCE PROVISION BASE FOR PUPILS WITH HEARING IMPAIRMENT AND SPECIFIC LEARNING DIFFICULTIES - KEY DECISION	**1 - 21**

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, 20 October 2016

Item	Page No
8. SCHEDULE 12A OF THE LOCAL GOVERNMENT ACT 1972 AND THE LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985 **PART II** In this case the Board has a discretion to exclude the press and public and, in view of the nature of the business to be transacted, it is **RECOMMENDED** that under Section 100A(4) of the Local Government Act 1972, having been satisfied that in all the circumstances of the case the public interest in maintaining the exemption outweighs the public interest in disclosing the information, the press and public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A to the Act.	
9. PHYSICAL ENVIRONMENT PORTFOLIO	
(A) 3MG HBC FIELD	**251 - 254**
10. RESOURCES PORTFOLIO	
(A) INDUSTRIAL ESTATE DISPOSAL OLDGATE, MARSHGATE, DEWAR COURT	**255 - 261**
11. ENVIRONMENTAL SERVICES PORTFOLIO	
(A) WASTE TRANSPORT SERVICES	**262 - 270**

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:	15 September 2016
REPORTING OFFICER:	Operational Director, Education, Inclusion & Provision
PORTFOLIO:	Children, Young People & Families
SUBJECT:	Closure of Westfield Primary School Resource Provision Base for Pupils with Hearing Impairment and Specific Learning Difficulties
WARD(S)	Borough-wide

1.0 PURPOSE OF REPORT

1.1 This report provides a summary of the consultation on the proposal to close the Resource Provision Base for pupils with Hearing Impairment and Specific Learning Difficulties at Westfield Primary School. It seeks permission to commence a four week statutory consultation on the proposal and to present a further report in November 2016.

2.0 RECOMMENDATION: That the Executive Board

1) **note the response to the first phase of the consultation; and**
2) **approve the statutory consultation on the closure of the Hearing Impaired Resource Provision Base at Westfield Primary School.**

3.0 BACKGROUND

3.1 Following approval from Executive Board on 16th June 2016 consultation commenced on the proposal to close Westfield Primary School Resource Provision Base for pupils with Hearing Impairment and Specific Learning Difficulties.

3.2 In September 2016 there will be 3 pupils accessing the Resource Provision Base. All 3 pupils are in Key Stage 2, there are no pupils in Key Stage 1. Feedback from families of children in early years indicates that they would choose for their children to attend their local school with additional Teacher of the Deaf support in line with National Sensory Impaired Partnership (NatSIP) recommended support levels.

3.3 With the advances in technology and the right support children now make greater progress by being a part of a mainstream peer group with language support. To ensure pupils have the right support the proposal seeks to close the Resource Base and reinvest the funding into increasing specialist support for pupils in local schools.

3.4 The Local Authority will continue to provide support to Westfield until the three pupils have completed their primary education. Funding will be provided to support the two teaching assistants and the Specialist Teacher will continue to support the school in line with the NatSIP support levels.

4.0 CONSULTATION

4.1. The first phase of the consultation included: parents at the school and the Resource Base, Governors, staff, all schools, pre-schools with Hearing Impaired pupils, Halton NHS Clinical Commissioning Group, the Chair of Halton Impart, Diocesan Authorities, neighbouring authorities, trade unions, the local MP and local Elected Members. A copy of the consultation document is attached at Appendix A.

4.2 On Wednesday, 29th June 2016 two consultation meetings were held one for staff and governors, the second for parents and the public. The notes from the meeting with staff and governors is attached as Appendix B. The notes from the parents and public meeting are attached as Appendix C.

4.3 The first phase of the consultation commenced on 22nd June 2016 and closed on Wednesday 20th July 2016. A total of 14 responses were received to the consultation. Consultees were asked whether they supported the proposal, they were also given the opportunity to provide their comments.

- 3 of the responses supported the proposal – 2 x Primary Headteachers and 1 x Councillor

- 1 response asked for further information – 1 x Councillor

- 9 of the responses did not support the proposal – these responses included 3 responses linked to one pupil in the current base, 1 response from the two members of staff working within the base, 5 responses from parents – 4 from parents of pupils currently attending the school and 1 from a parent whose child previously attended the school.

4.4 The key issues raised during the consultation included the following:

- Support for the current pupils in the Hearing Impaired Base;
- Viability of current provision;
- Support for pupils should the base close;
- Progress of pupils with Hearing Impairment in a mainstream school;
- Cost cutting;
- Recruitment of Specialist Teachers of the Deaf
- Use of the facilities; and
- Support for other pupils with special needs in the school.

Details of the comments made and the response are included in Appendix D.

5.0 STATUTORY PROPOSAL

5.1 Executive Board is asked to consider the responses received to the consultation and give approval for officers to carry out a statutory consultation on the proposal to close Westfield Primary School Hearing Impaired Base.

5.2 The statutory consultation will commence on 21st September 2016 for four weeks closing on 19th October 2016. The proposal will be to close Westfield Hearing Impaired Resource Base with effect from 31st December 2016 but to continue to support the three pupils in the base until their primary education at Westfield Primary has been completed. Funding will be reinvested into enhancing the specialist support available for pupils with a hearing impairment in schools across the borough. A copy of the proposal is attached as Appendix E.

5.3 Once the representation period has been completed a summary of the responses will be prepared and a further report submitted to Executive Board on 17th November 2016, so that a decision on the proposal can be determined.

6.0 FINANCIAL IMPLICATIONS

6.1 The Resource Base currently receives £10,000 for each of its 6 places giving it a total of £60,000. £20,623 is provided for a Signer each year and an additional £5,081.73 is allocated for each pupil placed in the base.

6.2 Funding will continue to be provided to Westfield Primary School to support the costs of the two teaching assistants until the three current pupils have completed their primary education at the school.

6.3 The funding from the unit will be reinvested into employing specialist staff to support pupils across the borough with Hearing Impairment.

7.0 OTHER IMPLICATIONS

7.1 By increasing the peripatetic team support can be provided to more pupils with a hearing impairment.

8.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

8.1 Children and Young People

Supporting pupils with a hearing impairment in their mainstream local school is more inclusive as it allows pupils to be educated within their own community, alongside their siblings, friends and peer group.

8.2 Employment Learning and Skills in Halton

None identified.

8.3 A Healthy Halton

None identified.

8.4 A Safer Halton

None identified.

8.5 Halton's Urban Renewal

None identified.

9.0 RISK ANALYSIS

9.1 As reducing number of parents are choosing to have their children educated in a HR Resource Base it is becoming more difficult for the base to be financially viable and to be able to recruit the appropriately qualified staff.

9.2 As the majority of families would prefer their child to be educated in a mainstream setting with support we may not be able to provide the appropriate level of support across the borough to meet need unless we can reinvest the resources saved from the closure of the Base.

10.0 EQUALITY AND DIVERSITY ISSUES

10.1 This proposal is aimed at ensuring pupils with Hearing Impairment can be educated within their own local community and is therefore more inclusive.

10.2 An Equality Impact Assessment will be undertaken on this proposal.

11.0 REASON(S) FOR DECISION

11.1 Provide a more inclusive offer for pupils with HI giving them the opportunity to be educated with support alongside their peers.

12.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

12.1 Retaining the current provision. This was rejected as it is less inclusive and more costly.

13.0 IMPLEMENTATION DATE

13.1 A decision will be required by Executive Board prior to the end of November 2016 so that the base can be closed with effect from 31st December 2016.

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

Document	**Place of Inspection**	**Contact Officer**
Statutory Notice January 2010	Rutland House	ann.mcintyre@halton.gov.uk
Executive Board Report 14/07/16	Municipal Building, Widnes	ann.mcintyre@halton.gov.uk

Appendix A

People and Economy Directorate

HALTON BOROUGH COUNCIL

CONSULTATION ON THE PROPOSAL TO CLOSE THE RESOURCE PROVISION BASE FOR PUPILS WITH HEARING IMPAIRMENT AND SPECIFIC LEARNING DIFFICULTIES AT WESTFIELD PRIMARY SCHOOL

Consultation Period: Wednesday 22nd June 2016 – Wednesday 20th July 2016

To: Staff, Governors and Parents of pupils at Westfield Primary School, other local schools, Halton NHS CCG, Trade Unions, Halton Borough Council Ward Members, Diocese, Neighbouring Local Authorities and Derek Twigg MP.

CONSULTATION DOCUMENT

1.0 Introduction

1.1 Halton Borough Council is consulting on the proposal to close the Hearing Impaired (HI) and Specific Learning Difficulties Resource Base at Westfield Primary School, Clayton Crescent, Runcorn, as a result of a decreased demand.

1.2 This consultation document tells you the reasons for our proposal and how the decision making process works. Please take time to read through the document and let us know your views and comments using the attached feedback form. The closing date for responses is **Wednesday 20th July 2016**. We hope you find the document helpful and informative.

2.0 Reasons for the Proposal

2.1 Westfield Primary School has a Resource Provision Base for six pupils with hearing impairment and specific learning difficulties.

2.2 Demand for places at the Resource Base has decreased over recent years as parents of children with significant hearing impairment are choosing to educate their children in a local mainstream provision rather than in specialist HI provision. From September 2016 there will only be 3 pupils accessing provision.

2.3 Children now make greater progress by being part of a mainstream peer group with language support. As a consequence many children with a hearing impairment are now being successfully placed in their local school with a package of support.

3.0 Financial Situation

3.1 The Resource Base currently receives £10,000 for each of its 6 places giving it a total of £60,000. £20,623 is provided for a Signer each year and an additional £5,081.73 is allocated for each pupil placed in the base.

3.2 Removing the Resource Base will release this funding allowing it to be invested in strengthening and increasing the level of peripatetic specialist teaching and non-teaching support. This will allow pupils to be educated in their mainstream setting with additional support when appropriate.

4.0 When will the proposed closure take place?

4.1 Subject to this initial consultation, followed by the statutory consultation which is the next stage, the proposed closure if approved, will take effect from 1st January 2017.

5.0 What are the implications for children attending the Hearing Impaired Unit?

5.1 The pupils will remain at Westfield Primary and will receive appropriate support for the school, staff and the peripatetic specialist team.

5.2 Supporting pupils with a hearing impairment in their mainstream local school is more inclusive as it allows pupils to be educated within their own community.

5.3 This approach is supported by the Head teacher of Westfield Primary School.

6.0 How can I give the Council my views and comments on the proposal?

6.1 Your response to this proposal would be welcome using the feedback form attached. Please return to Catriona Gallimore, People and Economy Directorate, Halton Borough Council, Rutland House, Halton Lea, Runcorn, Cheshire WA7 2GW.

7.0 What are the next steps?

7.1 All responses to the consultation must be received by Wednesday 20th July 2016. The outcome of the consultation will be reported to Executive Board on 15th September 2016 who will then determine whether the consultation can be developed to a formal public notice.

People and Economy Directorate

Proposal to close Westfield Primary School Resource Provision Base for Pupils with Hearing Impairment and Specific Learning Difficulties

CONSULTATION RESPONSE FORM

We would like your views on the proposal to close the Resource Base at Westfield Primary School. Please complete this short form to give your views and comments on this proposal.

Parent/Carer/Guardian/Governor/Staff/Halton Resident/other_____ ***Please delete**

Your Name ……

Your Child's Name (if applicable)……

Today's Date……

Please tell us if you support the Council's proposal to close the Resource Base at Westfield Primary School as shown in the consultation document?

YES - I support the proposal ☐

NO - I don't support the proposal ☐

Please use the space below to give your comments on the proposal to close the Resource Base at Westfield Primary School, continue overleaf if necessary:

……

……

……

All information provided will be treated in accordance with the Data Protection Act 1998.

We will only use this information to help in the decisions made on the future of the Resource Base at Westfield Primary School.

Please return your completed form to: Catriona Gallimore, People & Economy Directorate, Halton Borough Council, Rutland House, Halton Lea, Runcorn, WA7 2GW or by email to: Catriona.gallimore@halton.gov.uk

Please return this form by Wednesday 20th July 2016

Consultation on the proposal to close the Resource Provision Base for Pupils with Hearing Impairment and Specific Learning Difficulties at Westfield Primary School.

Wednesday, 29th June 2016

School Consultation

In attendance:

Ann McIntyre	Operational Director – Education, Inclusion and Provision
Anita Parkinson	Divisional Manager – Inclusion
Julie Metcalfe	Lead Teacher for Hearing Impairment
Claire Dawes	Headteacher Westfield Primary School
Mrs L Le-Surf	Chair of Governors
Ian McIntyre	Associate Governor
Denise Gough	Teaching Assistant –in the Resource Base Westfield Primary School
Joanne Berry	Signer in the Resource Base Westfield Primary School

Ann McIntyre welcomed everyone to the meeting and introductions were made.

Purpose of the Meeting

It was explained that the purpose of the meeting was to commence the stage 1 consultation process on the Local Authority proposal to close the Resource Provision Base for pupils with Hearing Impairment and Specific Learning Difficulties at Westfield Primary School. The rationale behind the proposal would be explained and there would be the opportunity for questions.

Ann advised that Resource Base had the capacity for six pupils with hearing impairment and specific learning difficulties. Demand had decreased so that from September 2016 there would be only 3 pupils accessing provision. Many parents with children with a hearing impairment are now choosing a mainstream school with a package of support. Removing the Resource Base will allow this funding to be invested into increasing the level of peripatetic specialist teaching and non-teaching in Halton so that the needs of those children educated in a mainstream setting that require additional support can best be met.

Subject to the outcome of the consultation the proposal was to close the provision from 31st December 2016.

There would be no change to the support provided to the three pupils in the Resource Base from September 2016. The Local Authority would continue to fund the costs of the Teaching Assistant and the Signer and would provide teaching support from the Local Authority Peripatetic Hearing Impaired Specialist Teachers until all three pupils had completed their education at Westfield Primary School.

The outcome of the stage 1 consultation proposal would be reported to the Executive Board of the Council on 15th September 2016. Executive Board would then determine whether the proposal could be developed to a statutory proposal.

Questions

It was asked whether the closure could be deferred until 2018.

It was explained that although the Local Authority had agreed to fund the costs of the Teaching Assistant and Signer until the pupils from September 2016 had completed their primary education at Westfield Primary School, it was essential that the Local Authority invested in securing additional support to meet the needs of all pupils with a hearing impairment in mainstream settings across the borough.

There are currently children with a range of needs within the school such as ADHD, there is less of a distraction in the base and it has good acoustic conditions.

The school will continue to be able to utilise the hearing impaired base and all its facilities. The Local Authority will continue to provide support for pupils within the Hearing Impaired Unit from the Local Authority's specialist teaching team.

What is the position in terms of the current staff within the Resource Base?

The Local Authority will continue to fund the two staff in the base until the three pupils in the Resource Base in Westfield have completed their primary education at the school, this will be by July 2018 at the latest. If the proposal is agreed discussions will be held with the school, the Local Authority, the schools Human Resources Advisors and relevant trade union in accordance with the schools Redundancy Policy for Support Staff.

What happens to children with Hearing Impairment will they continue to be sent to Westfield Resource Base?

No. Hearing loss is now identified in babies through the Newborn Screening tests. This allows many babies to get hearing aids or/and support from the Local Authorities peripatetic team much earlier. The information we have currently shows that parents want their child to be fully included with their peers and siblings, where possible. In cases where children have more complex needs which include HI an appropriate setting will be identified which best meets their needs.

Consultation on the proposal to close the Resource Provision Base for Pupils with Hearing Impairment and Specific Learning Difficulties at Westfield Primary School.

Wednesday, 29th June 2016

Parents/Carers and Public Consultation

In attendance:

Ann McIntyre	Operational Director – Education, Inclusion and Provision
Anita Parkinson	Divisional Manager – Inclusion
Julie Metcalfe	Lead Teacher for Hearing Impairment
Claire Dawes	Headteacher Westfield Primary School
Mr L Le-Surf	Chair of Governors
Ian McIntyre	Associate Governor
Ingrid Butterworth	Unison

Jane Bethell

Lee Robinson

Kerry Shore

Kathleen Bradshaw

Nicola Magdy

Andrea Williams

An attendance list was circulated for all those present to sign.

Ann McIntyre welcomed everyone to the meeting and introductions were made.

Purpose of the Meeting

It was explained that the purpose of the meeting was to commence the stage 1 consultation process on the Local Authority proposal to close the Resource Provision Base for pupils with Hearing Impairment and Specific Learning Difficulties at Westfield Primary School. The rationale behind the proposal would be explained and there would be the opportunity for questions.

Ann advised that Resource Base had the capacity for six pupils with hearing impairment and specific learning difficulties. Demand had decreased so that from September 2016 there would be only 3 pupils accessing provision. Many parents with children with a hearing impairment are now choosing a mainstream school with a package of support. Removing the Resource Base will allow this funding to be invested into increasing the level of peripatetic specialist teaching and non-teaching in Halton so that the needs of those children educated in a mainstream setting that require additional support can best be met.

Subject to the outcome of the consultation the proposal was to close the provision from 31st December 2016.

The meeting were advised that the Resource Base received £10,000 for each of its 6 places, a total of £60,000. In addition, £20,623 is provided towards the costs of a Signer and for each pupil in the base the school receives top up funding of £5,081.73.

Questions

What support would be available for the pupils currently in the Resource Base?

It was explained that there would be no change to the support provided to the three pupils in the Resource Base from September 2016. The Local Authority would continue to fund the costs of the Teaching Assistant and the Signer and would provide teaching support from the Local Authority Peripatetic Hearing Impaired Specialist Teachers until all three pupils had completed their education at Westfield Primary School.

The acoustics in the base at Westfield are specially designed to support children with a hearing impairment not having access to these facilities will impact on children with a hearing impairment. Will children not lose out on their education?

The meeting were advised that most hearing impaired children now use the FM* system. For those children educated in mainstream schools they are often taken to a quiet room in the school, when appropriate, to access specialist support. Children in mainstream settings will be provided with support from the Local Authority peripatetic team.

When will the Resource Base be closed, how many children are affected and what will be the impact on the current pupils?

It is proposed that the Resource Base will close at 31st December 2016.

The Headteacher advised that there would be no change from the support pupils currently receive. The children will still continue to be able to access the base. There will be three pupils at the Resource Base in September two will be Year 5 and one Year 6.

Pupils in the base currently need additional support just learning to talk. Trying to get the right kind of support is emotionally draining and feels like mental torture. It took until one of the children was 7 to be able to get a cochlear implant and a mainstream primary school could not meet her needs. Why is the Local Authority not advertising the Resource Base to increase numbers?

The Local Authority is the Admission Authority for the Resource Base. In order to meet the admissions criteria for the base children must be severely or profoundly deaf. The views of many of the parents with children with a hearing impairment, is that they would prefer their child to be educated in a local mainstream school with support. For children with more complex needs appropriate specialist provision will be identified which can meet all their needs.

Parents are proud of the school, support the work of the Headteacher and the staff at the school and are proud that the school is very inclusive and that many children and staff are able to sign so that children in the Resource Base can mix with children in the mainstream.

What are the numbers of children with a hearing impairment and how will they be supported if the base closes?

There are currently around 144 children and young people in Halton from babies through to post-16 with a hearing impairment requiring support.

Newborn screening allows the earlier identification of hearing loss. Many of the babies currently have mild to moderate hearing loss. There was no support available in early years previously this is now available with children seen on either a weekly or monthly basis. As a result there is less developmental delay for children starting school.

The cohort and needs of hearing impaired children has changed over the years, many children have cochlear implants earlier, the majority use FM systems other changes in IT and technology enable more children to be educated in a mainstream school. In addition, support can be provided by the Local Authority team.

The same level of support will continue to be provided for the three children who will still be in the Hearing Impaired Resource Base from September 2016. Children will continue to receive support from a specialist teacher for the deaf in line with the NATSIP^ guidelines.

Are children in the base all the time?

No. The amount of time a child is in the base depends on their individual needs. The intention is to increase children's access to the mainstream school with support.

How often is the equipment checked for the children in the base?

The equipment and systems are checked each day

There is a real benefit for all the pupils having a Hearing Impaired Resource Base at the School would support it continuing.

Consultation with parents of younger children with a hearing impairment indicates that they would prefer their child to be educated in a mainstream setting with support so that they can go to the same schools as their brothers and sisters within their local community.

There needs to be better promotion of the base at Westfield. There also needs to be opportunities for parents to meet together where they have a shared interest.

It is planned to start to run events for parents of children with a hearing impairment.

**FM – an FM system is a wireless system designed to help those who use them better identify and understand speech in noisy situations and over certain distances.*

^ *NATSIP is the National Sensory Impairment Partnership*

Appendix D

Response to the Consultation

A total of 14 responses were received to the consultation. Consultees were asked whether they supported the proposal, they were also given the opportunity to provide their comments.

- 3 of the responses supported the proposal – 2 x Primary Headteachers and 1 x Councillor

- 1 response asked for further information – 1 x Councillor

- 9 of the responses did not support the proposal – these responses included 3 responses linked to one pupil in the current base, 1 response from the two members of staff working within the base, 5 responses from parents – 4 from parents of pupils currently attending the school and 1 from a parent whose child previously attended the school.

Detailed in bold are the comments made to the consultation, where a response is needed this is included below the comment.

Comments

1. **I am quietly confident that the support could still be offered within a mainstream setting**

2. **I support the closure of the HI unit as I believe the numbers are too small for it to be a viable unit and strongly believe that the needs of the children are better served when they are educated within a mainstream setting with additional support in situ.**

3. **Children do better in a mainstream school and can help them achieve their goals**

4. **It is a fantastic unit and helps a lot of children be a part of a mainstream environment**

5. **After attending the consultation meeting and hearing of the difficulties in recruiting and retaining staff I wondered how the individually tailored plans spoken of, for each child could be maintained. I think it could result in an oversubscribed service and individual families fighting for what is best for their children. A unit where students and families and school understand each other, I feel, would provide a more nurturing environment.**

   I feel the children who use the unit are in mainstream education with the added bonus of the unit.

   It would be a shame for the unit to close as it is still half full.

Response

It is intended that the funding previously used to support the Resource Base will be reinvested into increasing the level of specialist support available for children and young people with a hearing impairment. This will mean we are better able to meet need and tailor our support to individual pupils requirements in line with the National Sensory Impaired Partnership (NatSIP) recommended support levels.

We are encouraging all schools to promote a nurturing environment. We have funded a number of pilots, Nurture Champion training and in conjunction with Nurture Group Network have established a Halton network for schools.

6. **The school is renowned for its signing – it would be such a shame to lose it. It includes all the children who use it. Need this unit to continue.**

7. **There are 3 main hearing aids 1) air conduction 2) Bone Anchored be-ha 3) Cochlea implant. All types of aids are better if backed up with sign language as they cannot be worn at certain times e.g. swimming, ear infection etc. - even tiredness. After consulting with XXX - speech and language professional at the Cochlea Implant Centre, integrating Hearing Impaired children into mainstream school can work successfully BUT a percentage of children with a greater hearing loss and not fully developed speech - this will not work. It is far more detrimental for the children when it is beyond their capabilities in a mainstream class to develop fully. Therefore the Hearing Impaired Base at Westfield is an asset for these children and should remain open for however many children required it. There is too much distraction and noise to gain a child's attention. There is always going to be children that need extra help which can only be obtained in a classroom like the Base at Westfield. If you were concerned about the education of these children, put more funding into the Base instead of taking a risk with children's futures. BUT THAT MEANS PROMOTING THE BASE INSTEAD OF TRYING TO PUT PARENTS OFF SO THAT YOU CAN CLOSE IT. YOU SHOULD BE ASHAMED. If you are going to adjust the lessons - slow down speech and give these children processing time "which is paramount" you then risk slowing down the education of the rest of the class. Education is the key to our future as well as theirs, so please do the right thing and let these special few children who need extra help use the facilities that are available at Westfield. The family doctor and also the Cochlea Implant Therapists are showing concerns for these children because it will impact on general and mental health problems - this would carry on into adult life (this obviously only applied to the children who need the base) Please promote the base.**

Response

Successful support for children with a Hearing Impairment ensures that individual need is appropriately assessed and met, which involves taking a great many aspects of a child's educational, personal and social circumstances into consideration alongside their deafness.

The majority of families choose for their children to attend their local school with additional Teacher of the Deaf support in line with National Sensory Impaired Partnership (NatSIP) recommended support levels.

Due to advances in technology, for the majority of hearing-impaired children sign support is not necessary and for the small number of occasions where a hearing-aid or Cochlear Implant is not in use, visual support can be achieved through a variety of techniques, of which sign is only one. Where such additional support is required, this can be achieved without resource base provision, for example in support of swimming lessons a range of visual communication can be employed by swimming instructors supported by a peripatetic Teacher of the Deaf.

Peripatetic Teachers of the Deaf are experienced in supporting teachers of mainstream classes to best support deaf children, including ensuring that they have time to process auditory information. This does not require any 'slowing down' of the delivery of lessons in any way, nor would it in a resource base context.

Even in a resource base the aim is for deaf children spend the majority of their time in their mainstream class.

8. **As the proposal has only covered the base being currently accessed by the children with hearing impairments, it is not taking into account the other children throughout the school with specific learning difficulties which is also what the base was designed for.**

   Would it be possible for the children to be in mainstream support as proposed but to use the bae for interventions for the core subjects (Maths and English) and have a teacher to work with the children with specific needs. This does not necessarily need to be a teacher of the deaf, as all sign and hearing aid maintenance can be competently done by the support staff as it would in mainstream.

   We currently have children throughout the school with dyslexia, ASD, Aspergers, English as an additional language, and of course hearing impairments.

   Therefore it would benefit all these children to have timetabled access to the base and greatly improve their learning. This would be an added bonus

for those children who are not at the levels they would be expected to be at and aid them greatly for SATS and assessments and help them achieve their potential.

Although closure has focused on the hearing impaired children it has not considered the children we have throughout the school with specific learning difficulties.

We would be interested to hear your thoughts on this.

Response

Most schools support pupils with special educational needs. Once the current pupils in the Resource Base complete their primary education the funding for the staff at the school will cease, however, the school can continue to use the Resource Base room and its facilities.

9. **Two comments were received which did not support the closure of the Resource base but both contained information about a specific pupil – the specific comments have not been included but a general summary is included below:**
    a. **the base provides intensive support which can assist where there is a mismatch between a child's chronological age and hearing age which impacts on speech, language and communication**
    b. **specialist support is essential for pupils with a disability to support their wellbeing in younger and adult life. Closure of the school will cause detriment in overall wellbeing especially mental health**

Response

There will be no change to the current provision for the child referred to in the two responses. We are not looking to close the school but close the Resource Base. We will continue to provide specialist support until the current pupils complete their primary education. Should the proposal be agreed we will reinvest funding into increasing the level of specialist support available for pupils in mainstream settings across the borough.

10. **I should like to know whether the unit will be based elsewhere. If not how will such provision be affected?**

Response

No – the proposal is to close the Resource Base. (see response to comment 9 above)

11. **A letter was also received from Derek Twigg on behalf of a constituent. The letter detailed concerns about the proposal to close Westfield Hearing Impaired Resource Base. The letter contained information about a specific pupil and member of staff – the specific comments have not been included but a general summary is included below:**

a. **The Resource Base has been in place for many years and is much used and needed**
b. **Closure would have a detrimental effect on vulnerable children**
c. **The previous teacher of the deaf at the school now works at Halton Borough Council**
d. **The closure is a cost cutting exercise.**

Response

There will be 3 pupils in the base in September 2016. Feedback from parents of young children with a hearing impairment is that they would prefer their children to be educated in a mainstream setting with support.

We will continue to fund support for the existing pupils in the Resource Base until they have completed their primary education at Westfield.

The previous teacher of the deaf at Westfield has been recruited to a specialist teacher post working as part of the Local Authority team. The school have tried to recruit a replacement teacher for the school, however, they have been unable to do so as this model of provision in no longer in line with the current ethos for children with moderate to severe hearing impairment.

The closure is not a cost cutting exercise the funding saved will be reinvested into strengthening the level of specialist support available across the authority.

Appendix E

People Directorate

HALTON BOROUGH COUNCIL

STATUTORY PROPOSAL FOR PRESCRIBED ALTERATIONS TO SPECIAL EDUCATIONAL NEEDS PROVISION IN A MAINSTREAM SCHOOL

1. Proposal relating to:

Westfield Primary School, Clayton Crescent, Runcorn, Cheshire WA7 4TR

Proposer: Halton Borough Council, Kingsway, Widnes WA8 7QF

2. Description of Proposed Significant Change:

The proposed significant change will lead to the discontinuance of the Hearing Impaired (HI) and Specific Learning Difficulties Resource Base at Westfield Primary School, Clayton Crescent, Runcorn.

3. Evidence of Demand for Places and Impact on Parental Choice

The Resource Base offers places for up to 6 pupils with hearing impairment and specific learning difficulties.

From September 2016 there will only be 3 pupils in year 5/6 accessing the provision. Demand for places at the Resource Base has decreased over recent years as the majority of parents of children with significant hearing impairment are choosing to educate their children in a local mainstream provision with additional Teacher of the Deaf support, in line with National Sensory Impaired Partnership recommended support levels.

4. Objectives of the Proposal and Educational Standards

The overall objective of the proposal is to discontinue the Hearing Impaired (HI) and Specific Learning Difficulties Resource Base at Westfield Primary School.

Removing the Resource Base will allow the funding to be invested in strengthening and increasing the level of peripatetic specialist support. This will allow pupils to be educated in their mainstream setting with additional support when appropriate.

5. Effect on other Education Establishments in the Area

We do not envisage any negative effects on other local schools, in fact, through reinvestment of resources, mainstream schools with HI pupils should see an increase in specialist support.

The current pupils will remain at Westfield Primary and will receive appropriate support from the school, staff and the peripatetic specialist team.

6. Project costs and Value for Money

The Resource Base currently receives £10,000 for each of its 6 places giving it a total of £60,000. £20,623 is provided for a Signer each year and an additional £5,081.73 is allocated for each pupil placed in the base.

Removing the Resource Base will release this funding allowing it to be invested in strengthening and increasing the level of peripatetic specialist teaching and non-teaching support. This will allow pupils to be educated in their mainstream setting with additional support when appropriate across the Borough.

7. Implementation and any proposed stages for implementation

The Resource Base will cease to operate on the 31st December 2016.

From the 1st January 2017, we will commence recruitment of specialist practitioners.

8. Procedure for Responding to this Proposal

Within four weeks from the date of publication of this proposal, i.e. by Wednesday 19th October 2016, any person wishing to submit any comments either in support of, or objecting to the proposal may do so by sending them to:

Mr M Reaney, Operational Director Legal and Democratic Services, Municipal Building, Kingsway, Widnes WA8 7QF.

Copies of this proposal can be obtained from: Catriona Gallimore, Capital Programme Planner, Rutland House, Halton Lea, Runcorn WA7 2GW or it can be downloaded from: www.halton.gov.uk/westfield

Applicable legislation: The School Organisation (Prescribed Alterations to Maintained Schools) (England) Regulations 2013.

REPORT TO: Executive Board

DATE: 15 September 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health & Wellbeing

SUBJECT: Recognising, Valuing & Supporting Carers in Halton; Joint Carers Strategy 2016 – 2019

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This report presents the strategy that the council, together with NHS Halton CCG, will deliver to continue the development of support for carers in the Borough.

2.0 **RECOMMENDATION: That Executive Board approve Recognising, Valuing & Supporting Carers in Halton; Joint Carers Strategy 2016 – 2019.**

3.0 **SUPPORTING INFORMATION**

3.1 The current National Carers' Strategy has five objectives to be achieved by 2018. They are that carers will be:

1. Recognised and supported as an expert care partner
2. Enjoying a life outside caring
3. Not financially disadvantaged
4. Mentally and physically well, treated with dignity, &
5. Children will be thriving, protected from inappropriate caring roles.

3.2 The Coalition Government refreshed this strategy in 2010, retaining these five aims, but inserting four priority areas:

1. Supporting early self-identification and involvement in local care planning and individual care planning.
2. Enabling carers to fulfil their educational and employment potential.
3. Personalised support for carers and those receiving care.
4. Support carers to remain healthy.

3.3 Recognising, Valuing & Supporting Carers in Halton, Joint Carers Strategy 2016 – 2019, has been developed taking into

consideration;

- national and local priorities for carers
- statutory responsibilities and good practice guidance
- a framework for the continued development of services for carers in Halton
- our proposed actions to deliver the strategy over the next three years

3.4 Halton's Carers Strategy will focus on achieving the following four outcomes;

That carers will be;

1. Supported to stay mentally and physically well.
2. Supported to have a life of their own, alongside caring.
3. Recognised as expert partners, and will be supported in their caring role by integrated and personalised services.
4. Provided with accessible advice and information that will assist them in making informed choices regarding their caring roles.

3.5 The strategy proposes a model of support for carers based around four components.

- Prevention and early Intervention
- Support to care
- Support in a crisis
- Recognition of the caring role

3.6 The body responsible for the delivery of Recognising, Valuing and Supporting Carers in Halton, 2016 – 19, will be the Carers Strategy Group, membership of which is drawn from carers that use our services and key delivery partners.

4.0 POLICY IMPLICATIONS

4.1 Delivery of the strategy will ensure both the Authority's and NHS Halton CCG's compliance with its legal duties.

5.0 FINANCIAL IMPLICATIONS

5.1 The current annual investment in carers services in the Borough by the Authority and NHS Halton CCG is £843,183.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

A young carer's strategy has recently been approved by Children's Social Care.

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

None identified.

6.3 **A Healthy Halton**

This strategy will support the improvement of carers health and well being and ensure that both the Authority and NHS Halton CCG discharge their statutory duties under the Care Act.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

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

9.1 The Executive Board will be required to approve the strategy, the delivery of which will ensure both the Authority and NHS Halton CCG meet their statutory duties under the Care Act.

10.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

10.1 None identified.

11.0 IMPLEMENTATION DATE

11.1 The strategy will be implemented following Executive Board approval.

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

Document	Place of Inspection	Contact Officer
Halton Joint Strategic Needs Assessment 2015/16; Adult & Young Carers	Runcorn Town Hall	Sharon McAteer

NHS
Halton Clinical Commissioning Group

HALTON
BOROUGH COUNCIL

PEOPLE DIRECTORATE

RECOGNISING, VALUING AND SUPPORTING CARERS IN HALTON

2016 – 2019

NHS Halton CCG & Halton Borough Council

Contents

1. Foreword

Cllr Marie Wright

Carers make an enormous contribution to health and social care locally through the provision of essential care and support for relatives, friends and neighbours. Their efforts in providing this care improves the quality of life of the people they care for and often goes unrecognised, even by carers themselves who may not see themselves as 'a carer'.

Halton Borough Council, together with NHS Halton CCG, is pleased to present its Carers Strategy 2016 – 2019, which sets out the key challenges, objectives and priorities to support carers in Halton over the next three years.

The council, together with its health, voluntary sector and community group partners, have achieved a lot over the past years. The Care Act however, has set us a challenge, creating a fundamental shift in the way carers are viewed and supported, focusing on their health and wellbeing and giving them parity of esteem with service users and patients. We are pleased to respond to that challenge, knowing that it will bring improved benefits for carers and the people they care for.

Our strategy, 'Recognising, Valuing & Supporting Carers in Halton', is based on the findings of our Carers Joint Strategic Needs Assessment, national best practice and discussions with our partners in the voluntary sector. It presents our vision of Halton as a place where carers are better-recognised, healthier and happier.

Cllr Marie Wright

Foreword

Cliff Richard

Caring is part of our existence it's part of being human. Caring strengthens communities and holds people and families together. Caring is part of the fabric of our everyday lives.

However for some, the burden of caring is heavy; seeing loved ones struggling with ill-health and needing to be cared for is difficult both physically and emotionally. Many selflessly give their lives over to supporting others who require care. The effort of this is compounded by the emotions involved in caring for a loved one who is struggling and failing before one's eyes.

In Halton we hope to recognise this and do our best to support carers in their role; whether this be support from well organised social services, or good quality healthcare and importantly, recognition of the importance of the caring role. We aim to support carers, and through this strategy, offer what we can to make the job of carers less difficult.

Dr Cliff Richards. M.B.E

Chair NHS HALTON CCG

2. Introduction

Carers play an important role supporting vulnerable people, enabling those cared for to stay in their own homes and local communities. Carers often do this because they want to support their loved ones. We recognise that caring can impact negatively on carers' health and wellbeing and value the key role that carers play in supporting the cared for person.

This is a joint strategy between Halton Borough Council (Adult Social Care) and NHS Halton Clinical Commissioning Group providing a local framework and action plan which:

- embodies both national and local priorities for carers
- addresses statutory responsibilities and good practice guidance
- outlines a framework for the continued development of services for carers in Halton
- details our proposed actions over the next three years

Within this strategy the term carer is taken from the Government's National Carers' Strategy:

"A carer is someone who spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems."

Our definition of carers includes those who no longer do caring for up to a year after the caring role ceases.

This group of carers is not to be confused with paid Care Workers or Personal Assistants, Shared Lives Carers or Volunteer Carers.

3. National Legislation & Policy

3.1 The National Carers Strategy

In 2014, the Government continued its recognition of the importance of carers by releasing the 'Carers Strategy: Second National Action Plan 2014-16'. This national plan prioritised the following issues;

- Identification and recognition; Supporting those with caring responsibilities to identify themselves as carers at an early stage,
- Realising and releasing potential; Enabling those with caring responsibilities to fulfil their education and employment potential
- A life alongside caring; Personalised support both for carers and those they support, enabling them to have a family and community life
- Supporting carers to stay healthy; Supporting carers to remain mentally and physically well

3.2 The Care Act

3.2.1 Adult Carers

The Care Act, brought into effect from April 2015, gives carers the same rights as the person they care for. The Act is based on the principle of promoting wellbeing, meaning that local authorities must make sure that people that live in their area;

- receive services that prevent, reduce and delay their care needs from becoming more serious
- can get the information they need to make good decisions about care and support; and
- have a good range of providers to choose from

The Care Act also ensures that carers have the same rights to assessment and support as the people they care for. This right is based on the appearance of needs regardless of financial resources or level of needs for support. The assessment will consider;

- the impact of caring on the carer
- the day-to-day life outcomes the carer wishes to achieve
- if the carer is able or willing to carry on caring
- whether they work or want to work
- whether they want to study or do more socially

When the assessment is complete, the local authority must decide whether the carer's needs are 'eligible' for support from the local authority, depending on the carer's situation. The Care Act puts in place a national eligibility threshold, setting one national level at which needs are great enough to qualify for funded services.

If none of the needs identified meet the eligibility criteria, the local authority must still provide a written record of advice on what could be done to reduce, prevent and meet needs.

Where the needs identified meet the eligibility criteria and the person they care for lives in the local authority area, the local authority is under a duty to agree with the carer a support plan which will set out how those needs will be met. Carers also have a right to request that the local authority meets some or all of such needs by giving them a direct payment, which will give them control over how their support is provided.

3.2.2 Young Carers

A young carer is 'a person under 18 who provides or intends to provide care for another person'. For the purposes of transition, a young carer is 'a person under 18 who provides or intends to provide care for an adult'. In both cases, care does not include volunteering or employment in care services, but it does include a young person providing practical support, personal care and/or emotional support to an adult (usually a parent, but it can also be a sibling, grandparent or friend of the family) who may, for example, have a disability, serious illness, or needs relating to old age or as a result of the misuse of substances.

Children's Social Care in Halton have recently agreed a young carers strategy from 2016 – 2019. The strategy focuses on 5 priority areas;

- The Young Carers Strategy monitoring group
- Raising awareness of young carers
- Schools awards
- Understanding young carers needs
- Effective commissioning & resources

The Care Act 2014 places a duty on local authorities to conduct a transition assessment when it will be of 'significant benefit' to the person to do so. Significant benefit relates to the timing when the young person is ready to have an assessment and will get the most out of the process

3.3 The National Health Service

The NHS 5 Year Forward View also recognises the contributions made by carers;

'We will find new ways to support carers, building on the new rights created by the Care Act …. This will include working with voluntary organisations and GP practices to identify them and provide better support.'

Guidance issued by the NHS in 2014, Commissioning for Carers, outlines 10 principles to achieve the best outcomes for carers;

1. Think Carer, Think Family; Make Every Contact Count
2. Support what works for carers, share and learn from others
3. Right care, right time, right place for carers
4. Measure what matters to carers
5. Support for carers depends on partnership working
6. Leadership for carers at all levels
7. Train staff to identify and support carers
8. Prioritise carers' health and wellbeing
9. Invest in carers to sustain and save
10. Support carers to access local resources

4. The Impact Of Caring

4.1 A carer may help with tasks such as washing, dressing, using the toilet, getting someone up or helping them to bed, shopping, cleaning, laundry and making meals. The caring role can also include providing emotional support, and childcare responsibilities. The care may mean keeping an eye on people who are confused or at risk if not supervised, or encouraging them to do everyday things for themselves. .Many carers don't see themselves as carers and it takes them an average of two years to acknowledge their role as a carer.

4.2 Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes.

4.3 NHS Commissioning for Carers (2014) identified that;

- Between 2001 and 2011, the number of unpaid carers grew by 600,000 with the largest increase being in those who provide fifty or more hours of care per week.
- Increasing hours of care often results in the general health of carers deteriorating incrementally. Unpaid carers who provide high levels of care for sick, or disabled relatives and friends, are more than twice as likely to suffer from poor health compared to people without caring responsibilities, with nearly 21% of carers providing over 50 hours of care, in poor health, compared to nearly 11% of the non-carer population
- Carers attribute their health risk to a lack of support, with 64% citing a lack of practical support.
- 70% of carers come into contact with health professionals, yet health professionals only identify one in ten carers with GPs, more specifically, only identifying 7%
- There is an increasing prevalence of ‘sandwich carers’, those looking after young children at the same time as caring for older parents.

4.4 National research undertaken by the Carers Trust showed that;

- 58% of carers said that their mental health had been adversely affected by being a carer
- 66% of carers said their relationship had suffered as a result of their caring responsibilities
- Three-quarters had not had a regular break from caring in the past 12 months and just over a third had not had a single day off

- 59% of carers said that being a carer had a negative impact on their working life; with 17% having to stop work; 15% having to reduce their paid working hours; 15% having to use holidays for caring duties
- More than two thirds (67%) of carers reported they were financially worse off as a result of caring.

4.5 A report commissioned by Carers UK titled 'Valuing Carers 2015' found that;

- The economic value of the contribution made by carers in the UK is now £132 billion per year, almost double its value in 2001 (£68 billion). £132 billion is close to the total annual cost of health spending in the UK, which was £134.1 billion in the year 2014-2015
- Carers' contribution is growing. The 2015 figure is 7% higher than the figure for 2011. This is mostly because carers are providing more hours of care (82%) and partly due to the increased hourly cost of paid homecare (18%)
- Care needs are greater because between 2001 and 2015, the number of people nationally aged 85 and over increased by over 431,000 (+38%), and the number of people with a limiting long-term illness increased by 1.6 million (+16%)
- In Halton, the economic contribution made by carers is £351 million

4.6 In December 2015, Marie Curie published a report titled 'The Hidden Costs of Caring', which looked at the impact of caring for someone with a terminal illness. The report concludes that 'carers of people with a terminal illness face significant challenges to getting the high quality and timely support that should be available to them, both while they are caring and after bereavement. These challenges include:

- Not having their needs recognised by support services
- Not being supported to look after their own health, wellbeing and finances, and not knowing where to find support when they need it
- A lack of help with preparing for the future, both following their loved one's diagnosis and after bereavement'

The report recommends the following fundamental principles that should underpin the support available to carers of people with a terminal illness;

- People who provide care for someone who is approaching the end of their life have specific needs, which should be assessed as a matter of priority
- Information for carers should be available and accessible in a form that is most useful to them
- Carers are not trained professionals, and they should not be expected to behave as such. Carers should be treated sensitively by professionals

and, where appropriate, provided with training and support to help them look after their loved one and themselves

- No one providing care to a loved one with a terminal illness should suffer financial hardship as a result of their caring role
- Health and social care professionals need to be ready and able to help carers identify themselves in this role and to plan for their future. This must include a sensitive explanation of what supporting a death at home entails, and a recognition that carers' needs will often continue after bereavement

4.7 In March 2016, the Directors of Adult Social Services (ADASS) produced the 'Guide to Supporting Carers through Technology Enabled Care Services. This guide said that;

- Over 60% of carers surveyed said telecare/telehealth had given them peace of mind as a carer
- One in eight carers said telecare/telehealth had helped them stay in work or return to work alongside caring
- Almost two thirds of carers not using telecare/telehealth were unaware of the support available from technology
- Of carers not currently using telecare/telehealth, one in four would like it but simply did not know where to find it
- When asked about telecare, in a Carers UK/YouGov poll, there was very low awareness of telecare technology, with only 12% of the population saying that they would use it. When the term was explained to them, 79% of people said they would use it and this was even higher for the over 85s

The guide also identified a number of key principles local authorities need to consider when providing technology enabled care services for carers.

- The statutory right to a social care assessment should always include a consideration for technology enabled care and other support services – "think tech"
- All commissioners should develop simple, accessible and easy to find information that lists what technology is available to support carers in their local area. This information
- Providers should take into account the specific needs of carers when developing care services that use technology
- It is absolutely critical that all local authorities providing assistive technology should also provide corporate training on this topic – having information available is not enough

5. Key Issues Identified In The Needs Assessment

5.1 A Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area. Halton's 'Adult & Young Carer, 2016' can be found as an appendix to this strategy.

5.2 The key findings of the JSNA were;

- Unpaid carers make up a significant 'workforce' at 15,010. This will probably continue to rise
- 'Caring' has traditionally been seen as a female role. Whilst there are a higher proportion of carers who are female, the split is not so significantly skewed towards women; with 57% of carers being female and 43% are male. Whilst a higher percentage of carers aged 25-49 are women a higher proportion of those aged 65+ are male
- The health and wellbeing of carers tends to be poorer than their non-carer peers. Levels of poor health amongst carers increases as the number of hours of care per week increases, with those providing 50 hours of more care per week having the poorest health. Halton has the 4th highest percentage of carers providing 50 or more hours care a week and also some of the highest levels of ill health and disability. The mental wellbeing of Halton carers is poorer than that of the general population of the borough
- Only 10% of carers in Halton are known to their GP
- Only 44.9% of people identified as carers on GP records received their annual influenza vaccination in 2014/15. This means that only about 5% of all carers receive an annual vaccination against influenza. At a GP practice level uptake varied from 26.7% to 68.3% so no practice achieved the national target of 75%
- In terms of outcomes of being a carer, data for 2014/15, for those carers known to adult social care, shows Halton carers experience is similar to that seen across the North West and England
- Of known carers, a lower proportion of Halton carers provide help with physical care but more provide emotional support than comparator areas. This reflects the higher proportion who stated they cared for a person with mental health problems. However, the percentages are high across all areas of care showing unpaid carers provide multiple roles
- Census data shows that 14% of carers reported a long-term health problem/disability, which limited their day-to-day activities a lot. A further 17% stated they had a disability that limited their daily lives a little. These proportions were higher than for North West and England carers
- Halton has a higher proportion of people with long-term conditions, including multiple conditions, than the national average. These numbers are projected to rise, especially older people with three or more conditions

5.3 Halton's 'Adult & Young Carer, 2016' JSNA identified the following considerations for the commissioners of carers services;

- To close the gap between the number of carers currently known to services and the number identified through the 2011 Census
- To identify more individuals who are caring for 50+ hours per week, and those carers with a long term disability that limits their day to day activities
- To increase the number of carers registered with their GP
- To improve the uptake of flu vaccinations by carers
- To improve information sharing between social care, NHS services and the voluntary sector to support integrated, personalised care
- To reduce financial hardship through improved access to welfare rights advice
- To improve carers levels of satisfaction with social care services
- To ensure the implementation of NICE guidance, particularly with regards to; mental health; drugs and alcohol; the transition between inpatient hospital settings and community or care home settings for adults with social care needs; dementia - supporting people with dementia and their carers in health and social care; older people with social care needs and multiple long-term conditions; and end of life care
- To ensure that carers receive the support that is appropriate to them maintaining and/or improving their physical and mental health
- To ensure that carers receive advice and information regarding home equipment and assistive technology services
- To ensure the implementation of the' triangle of care' for mental health

6. Achievements From The Previous Strategy

6.1 The previous carers strategy achieved many successes, the most notable of which were;

- The successful implementation of a new carers assessment
- 98% of carers receiving direct payments
- Higher than the national average carer reported quality of life scores
- 79% of carers reporting that they had been included or consulted in the discussion about the person they care for
- 79% of carers reporting they found it easy to find information about support
- Higher than the national average scores for carers reporting that they had as much social contact as they would like
- Pooling and maintaining the level of Halton Borough Council and NHS Halton CCG budgets to more efficiently commission carers services
- Significant investment into refurbishing the Carers Centre

7. Delivering Carer's Services in Halton Today

7.1 Adult Social Care

The Care Act gives local authorities the responsibility to assess a carer's needs for support. In Halton, these statutory assessments are carried out by the borough council's care management teams.

The assessment looks at how caring has an impact on an individual, what support they may need if they want to carry on caring, and what they want to achieve in their day to day life. At the end of the assessment a support plan will be agreed. The support plan will include how a person's needs are going to be met and, if a direct payment is to be made, how much it will be and how often it will be paid.

7.2 Halton Adult Placement Service

Halton Adult Placement Service provides care for people who need support due to age, illness or disability. The Service provides day care and short breaks to enable people to live an ordinary life in the community. The service supports the families of people needing care by providing them with a break from their caring role. The service can also provide a homely environment for adults living alone and missing the company of family and friends.

Adult Placement Carers are members of the local community who have been selected to work for the service after a long and detailed assessment process. This includes checks with the Disclosure & Barring Service and employment, health and character references. Carers are approved by an independent panel. Carers are provided with ongoing training and support to ensure they maintain high standards of care.

7.3 Bredon

Bredon Respite Service is situated in the Palacefields. It is managed by Community Integrated Care (CIC) a non-profit making organisation. They provide short term breaks for up to four adults aged between 18-65 years old with a learning disability or complex health need.

7.4 Halton Carers Centre

Halton Carers Centre provides a range of both universal and targeted services for carers. Commissioned jointly by Halton Borough Council and NHS Halton CCG, the centre aims to improve the quality of life for carers and to prevent or delay peoples need for care and support.

As a primary point of contact for carers in the borough, Halton Carers Centre will;

- Increase the number of carers known to them, particularly within underrepresented groups
- Work with a range of local agencies and initiatives to promote and improve carers' health and well-being
- Provide advice and information which supports carers to make informed choices about issues such as; the care and support which is available; their health and well-being; the types of home equipment, telehealth and telecare facilities that are available; and any changes in the welfare benefits system that may have an impact on them as a carer
- Ensure that carers are an integral part of the design, delivery and quality assurance of both the Carers Centre and health and social care services
- Commission community based peer support groups that help carers to cope with their caring responsibilities and alleviate some of the isolation they experience
- Ensure intensive, short term support is provided where there is a high risk of 'carer breakdown'
- Co-ordinate, provide and publish a programme of training for carers and health and social care professionals
- Offer a range of volunteering opportunities for carers, ex-carers and members of the local community
- Provide an advocacy service that ensures that carers' are assisted and enabled to say what they want, to secure their rights, to represent their interests and to obtain the services they require

7.5 <u>Community Based Support</u>

Each year, small community groups and local organisations apply to the directorate for a small amount of funding to support carers. In their application, groups should be able to demonstrate how they will increase the number of Carers known to them; support individuals to have a life outside of caring and have a positive impact on carers well-being.

At present 16 groups and organisations receive funding supporting people caring for individuals with dementia, learning disability, autism, substance misuse, stroke, mental health and physical disability.

8. Case Studies

8.1 Case Study 1

John is 27 years of age. He has autism, a learning disability and mobility difficulties, which means he requires a calliper for support. John's mum and dad support him with all of his daily living activities and personal care tasks. They receive Direct Payments which are used to increase John's support hours. This means that whilst John's mum and dad can take regular breaks, they rarely have a short break or night out together.

John's mum is happy to continue supporting him for as long as she is able, but feels that she and her partner have limited opportunity to spend time together as a married couple. A carers direct payment has enabled them to take short breaks together and to contribute to their disabled persons holiday club annual membership.

8.2 Case Study 2

Julie cares for her daughter Marie. Marie has had encephalitis, a rare but serious condition that causes the brain to become inflamed, which has affected her mobility and resulted in her becoming epileptic. For the past year she has been admitted to hospital many times. Marie regularly has seizures throughout the day and night and the family use monitors so that she can be observed at all times. Julie regularly has sleepless nights as she cares for her daughter. Marie's illness has greatly impacted on her and her family, both physically and emotionally. They all say that they are at breaking point.

Working with the Complex Care Team, Julie and Marie now receive additional support around Marie's personal care from a specialist agency; some additional assistive technology to help with the monitoring of Marie's medical condition; Julie has been put in touch with a number of local services to help her with advice on her financial situation, where there are leisure activities she might be interested in taking up, and details of a befriending service for people in a similar situation to herself. As the carer, Julie has also been provided with a Direct Payment which she could use to fund a respite break.

9. Our Vision & Principles

9.1 Our vision is that carers in Halton are recognised and valued for their essential contributions to our communities and the people they care for. Our services will provide practical, emotional and social support so that carers are able to live their own lives.

9.2 In delivering this vision, the partners to this strategy commit to the following underlying principles. To;

- Recognise the vital contribution made by carers to the lives of people who are vulnerable, ill, disabled or misusing alcohol and/or substances
- Recognise that the unpaid support provided by carers allows individuals to retain their independence and improves their quality of life
- Work with carers to ensure that they get the support they need from health and social care, to help carers maintain their caring role for as long as they want to
- Develop responses that make a real difference to carers' lives, ensuring that our responses meet their needs
- Recognise carers as 'experts' on the person they care for and we will be putting carers at the forefront of partnership work with commissioners and providers to identify needs, priorities and responses
- Recognise the diverse needs of carers in and will address equality of access to information, appointments, meetings etc.
- Work to ensure that carers not currently known to services are made aware of support available to them
- Recognise the wide range in the ages of carers and will help them to access support that is appropriate to their age
- Work in co-production with carers to ensure that their right to lives of their own is a practical reality
- Build on our co-production practices and build carers' capacity to lead on activities, events and services that affect their lives

10. Recognising, Valuing & Supporting Carers in Halton, 2016 – 19; Outcomes

10.1 Halton's Carers Strategy will focus on achieving the following four outcomes;

Carers will be;

1. Supported to stay mentally and physically well (Outcome 1)

2. Supported to have a life of their own alongside caring (Outcome 2)

3. Recognised as expert partners, and will be supported in their caring role by integrated and personalised services (Outcome 3)

4. Provided with accessible advice and information that will assist them in making informed choices regarding their caring roles (Outcome 4)

11. THE MODEL OF SUPPORT FOR CARERS IN HALTON 2016 – 2019

11.1 The model of support for carers in Halton is based on the principle that most of the time, people are perfectly able, with the support of their families and communities, to manage their lives and respond effectively to any events or crises that occur. Sometimes however, the difficulties bought about by life events mean that people may need some practical and emotional support to achieve this. Our model encourages individuals and communities to find the solutions that work for them so that they retain independence and control over their health, well-being and quality of life. The four components of the model are;

I. Prevention & Early Intervention
- Putting carers on an equal footing with those they care for
- Identifying, assessing and supporting a wider range of carers across the health and social care system
- Providing accessible information to support carers to make informed choices
- Avoiding crisis escalation through early intervention

II. Support to Care
- Providing coordinated, personalised support for carers enabling them to have a family and community life
- Promoting wellbeing
- Strengthening individual and community resilience, through self-sustaining peer support networks
- Improving access to adaptations, equipment and assistive technology

III. Support In a Crisis
- Enabling carers to plan for and manage changes in their caring role thereby reducing the impact of crises
- Supporting improved access to information, advice and advocacy

IV. Recognition of the Caring Role
- Achieving wider awareness and identification of carers across education, employment, health and social care
- Involving carers in the commissioning and quality assurance of services

12. DELIVERY OF THE STRATEGY

12.1 The responsible body for the delivery of Recognising, Valuing and Supporting Carers in Halton, 2016 – 19, is the Carers Strategy Group. Membership of this group is drawn from carers that use our services and key delivery partners.

12.2 To achieve the outcomes identified in the strategy, an action plan has been developed with key partners. The Carers Strategy Group will monitor progress on the action plan on a quarterly basis, with the action plan also being refreshed annually.

12.3 Halton Borough Council and NHS Halton CCG currently commit £841,923 per annum to support the delivery of the strategy. This includes the commissioning of services for carers and the provision of direct payments.

13. Recognising, Valuing and Supporting Carers in Halton, 2016 – 19; Action Plan

I. Prevention & Early Intervention				
Action	**Responsibility**	**Timescale**	**Measure**	**Outcome**
To carry out statutory assessments of carers (adults)	Halton Borough Council	On – going with an annual review	Number of carers assessments	Outcomes 1, 2, 3, & 4
To review the statutory assessment process for young carers in transition and implement a revised process in accordance with best practice and statutory duties	Halton Borough Council Halton Carers Centre	April 2017	Implementation of new assessment process	Outcomes 1, 2, 3, & 4
To increase the number of new carers known to health and social care, particularly from the	Halton Carers Centre	On – going with an annual review	Number assessments of carers not previously known	Outcomes 1, 2, 3, & 4

following priority areas; • Substance Misuse • Long Term Conditions • Mental Health • Over 65s, particularly men • Those caring for 50+ hours per week • Dementia			to HBC	
To increase the number of carers being referred to primary care for health checks	Halton Borough Council Halton Carers Centre	On – going with an annual review	GP carer reed code	Outcomes 1 & 3
To improve access to mental health services to ensure carers at risk of mental health issues are identified at the earliest possible stage and provided with appropriate support and treatment	NHS Halton CCG Halton Carers Centre	On – going with an annual review	Referral process in place	Outcomes 1 & 3
To provide information as to the types of care and support available	Halton Carers Centre	On – going with quarterly monitoring as per contract	Carers Survey. Halton Carers Centre website	Outcome 4

		management arrangements	activity data	
II. Support to Care				
Action	**Responsibility**	**Timescale**	**Measure**	
To increase the number of self-sustaining peer support and activity groups.	Halton Carers Centre	2017 onwards	Number of new peer support groups	Outcomes 1 & 2
To provide signposting to trusted sources of information that will enable carers to make informed choices about improving their health and well being	Halton Carers Centre	On – going with an annual review as per contract management arrangements	Carers Survey. Halton Carers Centre website activity data	Outcomes 1 & 4
To provide a range of volunteering opportunities for ex-carers and members of the local community.	Halton Carers Centre	On – going with a 6 monthly review as per contract management arrangements	6 monthly report	Outcome 1

To provide links to national organisations who provide telephone and on-line support.	Halton Carers Centre	On – going with a quarterly review as per contract management arrangements	Halton Carers Centre website activity data	Outcome 4
To raise awareness of how to raise concerns about the safety and well-being of an adult who has needs for care and support	Halton Borough Council Halton Carers Centre	On - going	Carers questionnaire	Outcome 1
To improve the take up by carers of health related activities	HBC Health Improvement Team Well Being Project	On – going with an annual review	Referral process in place	Outcome 1
To support and signpost carers to obtain the welfare benefits advice & support they require	Halton Carers Centre Halton Borough Council	On – going with an annual review	Referral process in place	Outcomes 1, 3 & 4
To increase the number of carers accessing equipment, adaptations and telecare/telehealth assessments	Halton Borough Council Halton Carers Centre	On – going with an annual review	Number of assessments undertaken by HBC Number of referrals made by	Outcome 3

			Halton Carers Centre	
To increase the number of people registered as a carer with their GP	Halton Carers Centre	On – going with an annual review	GP carer reed code	Outcomes 1 & 3
To increase the take up of flu vaccinations	HBC Public Health NHS Halton CCG	On – going with an annual review	GP carer reed code	Outcome 1
III. Support In A Crisis				
Action	**Responsibility**	**Timescale**	**Measure**	
To increase the range and availability of respite provision	Halton Borough Council	April 2017	Number of respite days provided	Outcomes 2 & 3
To ensure that carers are identified and involved at the earliest opportunity regarding pathways into and out of hospital, residential and nursing	Halton Borough Council Halton Carers Centre	On – going with a 6 monthly review as per contract management arrangements	Identification of carer within assessment process	Outcome 3

care				
To provide intensive, short term support to carers where a high risk of carer breakdown has been identified by health and social care professionals	Halton Carers Centre	On – going with a 6 monthly review as per contract management arrangements	The number of individual carers supported who were 'at risk of carer breakdown'	Outcome 3
To ensure every carer has an 'emergency plan' in place	Halton Borough Council Halton Carers Centre	On-going with an annual review	Annual audit	Outcome 3
IV. Recognition of the Caring Role				
Action	**Responsibility**	**Timescale**	**Measure**	
To ensure that carers are an integral part of the quality assurance of health and social care services.	Halton Carers Centre NHS Halton CCG Halton Borough Council Halton Healthwatch	April 2017	Number of carers involved in quality assurance visits	Outcome 3

To promote and provide 'Caring with Confidence' courses for carers	Halton Carers Centre	On – going with a quarterly review as per contract management arrangements	Number of courses provided Attendance of courses	Outcome 4
To provide advocacy that ensures that carers' are assisted and enabled to say what they want, to secure their rights, to represent their interests and to obtain the services they require.	Halton Carers Centre Halton Healthwatch	On – going with an annual review	Carers questionnaire	Outcome 3
To promote awareness of carers rights	Halton Carers Centre	On – going with a quarterly review as per contract management arrangements	Number of Promotional activities Number of professionals attending carers awareness training courses	Outcome 3
To provide a programme of learning for; • Carers to support them in their caring role. And • Health and Social Care	Halton Carers Centre	On – going with a 6 monthly review as per contract management arrangements	6 monthly report	Outcomes 3 & 4

professionals to increase recognition of carers rights and needs				

V. Delivering Halton Carers Strategy 2016-19			
Action	**Responsibility**	**Timescale**	**Measure**
To review the terms of reference and membership of Halton Carers Strategy Group	Halton Borough Council	December 2016	Terms of reference and membership agreed
To agree a performance framework for Halton Carers Strategy 2016 - 19	Halton Carers Centre	April 2017	Data sets and base line data identified. Improvement targets agreed

14. GLOSSARY

ADASS	Association of Directors of Adult Social Services
CCG	Clinical Commissioning Group
CIC	Community Integrated Care
GP	General Practitioner
JSNA	Joint Strategic Needs Assessment
NICE	National Institute for Health & Care Excellence

Halton Joint Strategic Needs Assessment 2015/16

Adult and Young Carers

Reader information	
Author	Sharon McAteer
Contributors	Steve Eastwood Suzanne Sheppard Jennifer Oultram
Reviewer	Steve Eastwood
Number of pages	69
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Description	The document describes the policy context, estimated prevalence, risk factors and sub-groups of need, current service provision and national best practice in relation to those who provide unpaid care (carers) in Halton.
Contact	Steve.eastwood@halton.gov.uk
Related documents	Halton Carers Strategy 2015-2018

Please quote the JSNA

We would like to know when and how the JSNA is being used. One way, is to ask people who use the JSNA when developing strategies, service reviews and other work to quote the JSNA as their source of information.

List of Abbreviations

ASCOF	Adult Social Care Outcomes Framework
CCG	Clinical Commissioning Group
GP	General Practitioner
HSCIC	Health and Social Care Information Centre
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LE	Life expectancy
LSOA	Lower super output areas
NHS	National Health Service
NEET	Not in education, employment or training
NICE	National Institute for Health and Clinical Excellence
ONS	Office for National Statistics
PUC	Providing unpaid care
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
SWEMWBS	Short Warrick-Edinburgh Mental Wellbeing Scale
TAF	Team around the family
UCE	Unpaid care expectancy
VOICES	Views of informal carers for the evaluation of services

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Key Findings

- Unpaid carers make up a significant 'workforce' at 15,010. This will probably continue to rise
- 'Caring' has traditionally been seen as a female role. Whilst there are a higher proportion of carers who are female, the split is not so significantly skewed towards women, with 57% of carers being female and 43% are male. Whilst a higher percentage of carers aged 25-49 are women a higher proportion of those aged 65+ are male
- The health and wellbeing of carers tends to be poorer than their non-carer peers. Levels of poor health amongst carers increases as the number of hours of care per week increases, with those providing 50 hours of more care per week having the poorest health. Halton has the 4th highest percentage of carers providing 50 or more hours care a week and also some of the highest levels of ill health and disability. Yet, national research shows carers often feel they do not have enough time to look after their own health. Plans need to be developed locally, in collaboration with carers, on how best to support the health of carers
- The mental wellbeing of Halton carers is poorer than that of the general population of the borough
- Only 10% of carers in Halton are known to their GP. Proactive identification is needed to increase this figure
- Only 44.9% of people identified as carers on GP records received their annual influenza vaccination in 2014/15. This means that only about 5% of all carers receive an annual vaccination against influenza. At a GP practice level uptake varied from 26.7% to 68.3% so no practice achieved the national target of 75%. Greater awareness of the benefits and risks is needed both within the carer population and amongst professionals to increase uptake
- Both nationally and locally, most people who provide unpaid care are in employment. Yet national research indicates many carers have to give up work as they are unable to meet of dual needs of their employed work and their caring role. This not only puts the carer in financial hardship but means employers are losing skilled and experienced staff that could have been retained by supportive workplace policies
- In terms of outcomes of being a carer, data for 2014/15, for those carers known to adult social care, shows Halton carers experience is similar to that seen across the North West and England. For example similar proportions stated they have about as much time as they wish and have as much social contact as they want as comparator areas
- Of known carers, a lower proportion of Halton carers provide help with physical care but more provide emotional support than comparator areas. This reflects the higher proportion who stated they cared for a person with mental health problems. However, the percentages are high across all areas of care showing unpaid carers provide multiple roles
- Census data shows that 14% of carers reported a long-term health problem/disability, which limited their day-to-day activities a lot. A further 17% stated they had a disability that limited their daily lives a little. These proportions were higher than for North West and England carers
- Halton has a higher proportion of people with long-term conditions, including multiple conditions, than the national average. These numbers are projected to rise, especially older people with 3 or more conditions. Together with efforts to support more people to remain living in their own homes, there will be an increased need for unpaid carers

Key priorities for commissioning

- To close the gap between the number of carers currently known to services and the number identified through the 2011 Census
- To identify more individuals who are caring for 50+ hours per week, and those carers with a long term disability that limits their day to day activities
- To increase the number of carers registered with their GP
- To improve the uptake of flu vaccinations by carers
- To improve information sharing between social care, NHS services and the voluntary sector to support integrated, personalised care
- Reduce financial hardship through improved access to welfare rights advice
- To raise awareness of carers issues amongst local employers and the need for supportive policies to help carers remain in employment. This will support efforts to reduce financial hardship as well as improve life satisfaction/ reduce social isolation amongst carers.
- To improve carers levels of satisfaction with social care services
- To ensure the implementation of NICE guidance, particularly with regards to; mental health; drugs and alcohol; the transition between inpatient hospital settings and community or care home settings for adults with social care needs; dementia - supporting people with dementia and their carers in health and social care; older people with social care needs and multiple long-term conditions; and end of life care
- To ensure that carers receive the support that is appropriate to them maintaining and/or improving their physical and mental health
- To ensure that carers receive advice and information regarding home equipment and assistive technology services
- To ensure the implementation of the' triangle of care' for mental health

1. Introduction

Carers play an important role in society and have particular challenges that they have to overcome. An enormous amount of personal and community care is provided by family and friends, and social care and health services should be seen in this context. Estimates of how much the equivalent cost of this informal support would be if carers' input had to be replaced run as high as £87 billion per year, which is nearly as much as total spending on the NHS. Indeed at 1.25 million people providing 50 hours of more care per week, this is a greater full-time workforce than the whole NHS.[1] This is without including the numbers who provide between 1-49 hours of care per week which is the majority.

Where services are needed to support people with illnesses, disabilities or addictions, the needs of informal carers should not be neglected, as they are closely linked, and often have a very important bearing on the effectiveness of the interventions for the cared for person.

For some people, having a caring responsibility may only last for a few months at a time and be intermittent; however, for others it may be continuous and last many years. For example, as people born with learning disabilities or with complex health conditions are living longer, it is possible for someone to become a carer in their twenties and remain a carer for most or the rest of their lives.

The provision of unpaid care can be seen as a social good where people give support to family and friends suffering from health conditions or impairments which disable them. Yet, a key finding of the interim report from the independent commission on the future of health and social care in England[2] suggested the current system of means tested social care was a lottery, leading to inequity and a reliance on unpaid care, compared with health care which is free at the point of use. However, there are clearly funding implications for meeting social care needs in the future as the population ages. This will be compounded by the significant budget cuts facing local authorities.

The pressures on carers are such that that over time the effect on their health, social and financial wellbeing can be significant. Carers need support to continue to care - otherwise care can break down, with considerable cost to the individuals and to the health and social care system. For example, the 2011 Census showed the prevalence of unpaid care rose in England between 2001 and 2011 and that this care has disproportionately fallen on women between the ages of 50 and 64. An ageing population increases the risk of becoming an informal carer, especially during working ages. Such care provision has been shown to affect women's participation in the labour market more noticeably than men's.[3][4]

2. Policy Context

National policy, strategy and legislation on carers have changed significantly over the last few years. The most significant change in the 2014 Care Act, which sets out a number of set duties on local authorities and other public sector organisations.

2.1. National Policy

The Care Act (2014)

Under the Care Act, local authorities take on new functions. This is to make sure that people who live in their areas:

- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs
- Can get the information and advice they need to make good decisions about care and support
- Have a range of providers offering a choice of high quality, appropriate services.

Importantly, the Act strengthens the rights and recognition of carers in the social care system, including, for the first time, giving carers a right to receive services. These strengthen significantly the rights of carers and sets out clear duties for Local Authorities and other public sector organisations.

Carers Strategy England 2008-2018 (2010)

The Carers' Strategy has five objectives for carers to be achieved by 2018, so that carers will be:

1. Recognised and supported as an expert care partner
2. Enjoying a life outside caring
3. Not financially disadvantaged
4. Mentally and physically well, treated with dignity
5. Children will be thriving, protected from inappropriate caring roles.

The Coalition Government refreshed this strategy in 2010 retaining these aims but inserting four priority areas:

- Supporting early self-identification and involvement in local care planning and individual care planning.
- Enabling carers to fulfil their educational and employment potential.
- Personalised support for carers and those receiving care.
- Support carers to remain healthy.

Carers Strategy: The Second National Action Plan (2014-2016)

This update to the national carers' strategy provided an overview of achievements since the last update in 2010 and sets out key actions for the next two years. Major progress in identifying and supporting carers is being brought about by the Care Act and the Children and Families Act and the update encourages a refresh of their local carer strategies to ensure all partners are signed up to the latest developments.

The Children and Families Act (2013)

In 2013, the Government tabled an amendment to the Children and Families Bill resulting in young carers being protected by law for the first time. This means that when a child is identified as a young carer, the needs of everyone in the family will be considered. This will trigger both children's and adult's support services into action – assessing why a child is caring, what needs to change and what would help the family to prevent children from taking on this responsibility in the first place.

NHS England Commitment to Carers Policy (2014)

This policy sets out how NHS England will support the NHS to deliver what carers have said is important to them. The document sets out a series of commitments to carers based on what carers outlined is important to them:

- *"Recognise me as a carer"*
- *"Information is shared with me and other professionals"*
- *"Signpost information for me and help link professionals together"*
- *"Care is flexible and is available when it suits me and the person for whom I care"*
- *"Recognise that I may need help both in my caring role and in maintaining my own health and well-being"*
- *"Respect, involve and treat me as an expert in care"*
- *"Treat me with dignity and compassion".*

NHS Five Year Forward View (2014)

The NHS Five Year Forward View recognises that, with an ageing population, increased long term conditions, and funding for health that is not keeping pace with demand, promoting well-being and preventing ill-health will become even more improtant to the capacity and financial viability of the NHS. Providing better support for carers is therefore critical to the future of the NHS. This follows on from NHS England's Commitment to Carers Policy.

> *'We will find new ways to support carers, building on the new rights created by the Care Act …. This will include working with voluntary organisations and GP practices to identify them and provide better support.'*

2.2 Impact of the Care Act (2014) on local authority

Under the Care Act, local authorities have taken on new functions. This is to make sure that people receive services that prevent their care needs from becoming more serious, or delay the impact of their needs.

People can get the information and advice they need to make good decisions about care and support and have a range of providers offering a choice of high quality, appropriate services.

Importantly, the Act strengthens the rights and recognition of carers in the social care system, including, for the first time giving carers a clear right to an assessment of their support needs and to receive funded services.

The change in carers' rights will have an impact on the way services are provided locally and a significant demand on local authorities resources to undertake timely assessments and provide appropriate support.

There is likely to be significant impact on local authorities in terms of how the needs of all carers are going to be met. However, the contribution of informal carers to the health and well-being of the population of Knowsley is hugely significant.

In addition, there are challenges in the following areas;

- To continue to identify adult and young carers and provide them with the information they need
- Identifying unmet needs – whilst adult social care and the third sector carers organisation have contact with a significant number of carers, the challenge is to reach out to those carers who are not in touch with services or who are not even aware that they are carers
- Keeping carers as informed as they wish in relation to the upcoming changes in relation to Transforming Adult Social Care.
- Ensuring that carers are as informed and involved as they wish in the commissioning, delivery and monitoring of appropriate carers support services
- To have an understanding of the impact on carers of any proposed changes to local authority charges and/or changes to adult social care funding criteria
- Welfare reform impact– Reforms to welfare are likely to continue to have a significant impact on carers, many of whom are already struggling financially because of their caring role. Carers UK have continually recommended that an assessment of impact on carers is undertaken

2.3. National Outcome Frameworks

Carers are a priority for Social Care, Public Health and the NHS. This is reflected in all three outcome frameworks, especially the Social Care Outcome Framework.

2.3.1 Social Care Outcome Framework:

- 3B: Overall satisfaction of carers with social services
- 3C: The proportion of carers who report that they have been included or consulted in discussions about the person they care for.
- 3D: The proportion of people who use services and carers who find it easy to find information about support

Also, inextricably linked to a number of other social care outcomes including:

- Permanent admissions to residential and nursing care homes per 100,000 population.

2.3.2. Shared Outcome between the NHS and Adult Social Care Framework:

- Carer-related quality of life

2.3.3. Shared Outcome between the Public Health and Adult Social Care Framework:

- Proportion of people who use services and their carers, who reported that they had as much social contact as they would like.
- Proportion of adults with a learning disability who live in their own home or with their family.
- Proportion of adults in contact with secondary mental health services living independently with or without support.

These outcomes will measure the success of services in supporting carers and will provide an indication of how the NHS, Public Health and Social Care are working together to support carers locally.

2.4. Local Policy

2.4.1. One Halton

One Halton has emerged following the production of the Strategy for General Practice Services in which a new care model was set out focusing on integrated health and social care services working in the community. The goal of One Halton is to create a health care system that:

- works around each individual's needs
- supports people to stay well, and
- provides the very best in care, now and for the future

The objectives that have been developed for One Halton are:

- To work better together regardless of discipline
- To find or identify those 'hidden' people who don't access care
- To treat and care for people at the right time, in the right place by the right people
- To help people stay healthy and keep generally well
- To provide the very best in care, now and in the future

In moving One Halton forward, five areas of focus have been agreed. They are:

- Older people
- People with Long Term Conditions
- People with mental health conditions
- Families and children, and
- The generally healthy

Service for carers will form an important part of delivering the first three of these areas of focus.

2.4.2. Adult Social Care: People and Economy Directorate, Business Plan 2016 – 19

The Transformation Programme is a joint approach between Adult Social Care and the NHS to deliver personalisation and innovative approaches to support self-care, building on the work that has already been progressed in the borough. The 3 objectives of the programme are prevention, early intervention and managing complex care and care closer to home.

Carers' services will potentially have a key role within the following work areas:

- Social care in practice
- Active ageing
- Telecare and telehealth
- Mental health service re-design
- Integrated hospital discharge teams
- Community Multi-disciplinary teams (MDTs)
- End of life services

3. Level of need in the population

3.1. Overall provision of unpaid care

In the 2011 Census, 15,010 Halton residents described themselves as unpaid carers. This represents 12% of the Borough's population and is higher than the national and regional figures (10.2% and 11.1% respectively). This is an increase of 1,482 since the 2001 Census with the percentage increase being similar to the national rate.

Table 1: Total numbers of unpaid carers, 2001 and 2011 Census, Halt on and comparators

	2001		2011		2001 to 2011 change	
	Number	Percentage of total population	Number	Percentage of total population	Number	% change
Halton	13,528	11%	15,010	12%	1482	11%
North West	722,119	10.9	781,972	11.1	59,853	8%
England	4,854,731	10%	5,430,016	10%	575,285	12%

Source: 2001 and 2011 Census, ONS

Whilst the overall proportion of unpaid care increased by 11% , the percentage increase amongst those providing between 1 and 19 hours of care per week increased by less than 1% compared to significant increases in the proportion of people providing 20-49 hours & 50 or more hours of unpaid care per week over this period. This is a similar pattern to that of the North West and England, including local authorities within Merseyside.

Table 2: Hours of unpaid care provided per carer a week in Halton, 2001 to 2011 Census

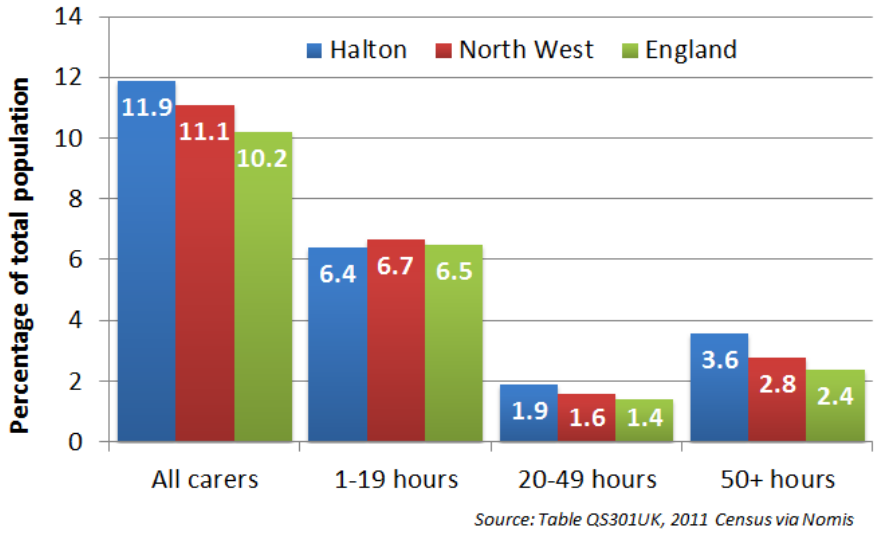
	2001		2011		2001 to 2011 change	
	Number	Percentage of unpaid care	Number	Percentage of total population	Number	% change
Provides care: total	13528	11.4% *(% of total population)*	15,010	12% *(% of total population)*	1,482	11.0%
Provides 1 to 19 hours care a week	7942	58.7%	8,004	53.3%	62	0.8%
Provides 20 to 49 hours care a week	1887	13.9%	2,439	16.2%	552	29.3%
Provides 50 or more hours care a week	3699	27.3%	4,567	30.4%	868	23.5%

Source: 2001 and 2011 Census, ONS

Halton had one of the highest percentage increases between the 2001 and 2011 Census in the proportion of its population providing 50 or more hours unpaid care one of highest levels of 50+ hours of care provision, placed 4th in the country behind East Lindsey, Knowsley and St Helens.[5]

The amount and type of care that carers provide varies considerably. A carer might provide a few hours of care a week, perhaps shopping for a friend or relative, or they may care around the clock. Providing care can range from helping with household tasks on a regular basis to providing continuous care.

Figure 1: Percentage of total population who are carers, by hours of care provided, Halton and comparators, 2011 Census



Source: Table QS301UK, 2011 Census via Nomis

In the annual Personal Social Services Survey of Adult Carers in England 2014/15, carers are asked how many hours of care they provide and also how long they have been a carer for. The survey is administered by councils and sent to those known to be a carer. It thus represents only those known to adult social care as carers and may or may not be representative of carers as a whole. The survey nevertheless provides useful insights into the nature and type of unpaid caring provision locally and also the health and wellbeing of carers. However, it shows a significantly higher percentage of cares known to adult social care providing 50 or more hours of care per week, over 44% compared to Census data which indicates 19.7% of Halton carers provide this level of unpaid care (see Figure 2 in section 3.2.1.).

Table 3: Annual Carers Survey 2014/15 Q19 - About how long do you spend each week looking after or helping the person you care for? – Halton and comparator results

	0-9 hours	10-19 hours	20-34 hours	35-49 hours	50-74 hours	75-99 hours	100 or more hours	Varies - Under 20 hours	Varies - 20 hours or more	Other
Halton	4.6	8.3	8.0	8.9	8.0	7.6	37.0	4.9	5.8	7.0
North West	5.8	7.3	8.8	9.2	6.7	7.9	35.5	2.8	6.6	9.5
England	6.1	7.4	7.6	7.5	6.4	7.5	38.1	3.0	6.6	9.7

Source: HSCIC

Data for 2014/15 shows that 52.6% said they provided at least 50 or more hours of care per week. This is a greater proportion than the North West (50.1%) and England (52%) averages and much higher than the 2011 Census indicated. It may be that it is those who provide more hours of care who are more likely to request a carers assessment to help them manage their caring role.

Table 4: Annual Carers Survey 2014/15 Q19 - About how long have you been looking after or helping the person you care for? - Halton and comparator results

	Less than 6 months	Over 6 months but less than a year	Over 1 year but less than 3 years	Over 3 years but less than 5 years	Over 5 years but less than 10 years	Over 10 years but less than 15 years	Over 15 years but less than 20 years	20 years or more
Halton	0.3	3.3	14.7	19.2	22.2	12.0	8.1	20.1
North West	0.6	2.7	15.7	17.0	23.5	11.6	7.7	21.1
England	0.6	2.7	15.3	17.9	23.6	12.0	7.7	20.1

Source: HSCIC

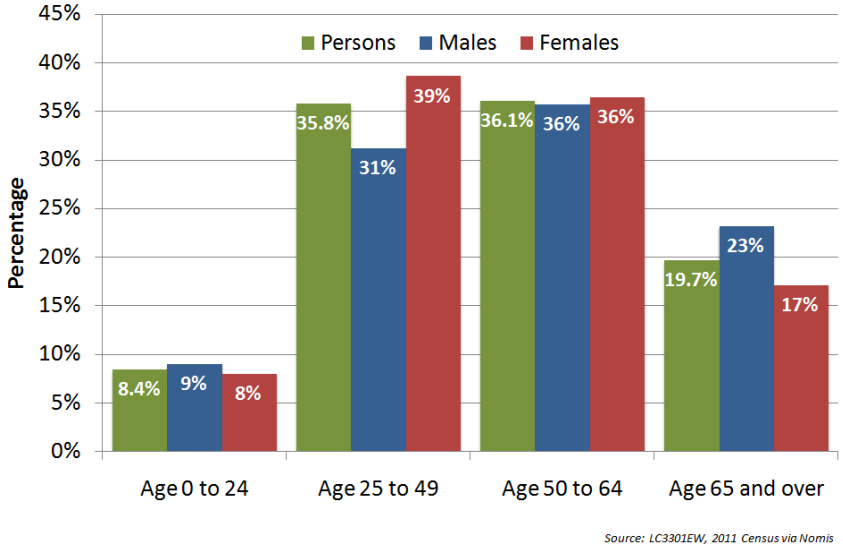
The number of years Halton carers had been a carer for at the time of the 2014/15 survey was broadly similar to the North West and Halton averages. Relatively few carers had been a carer for less than a year, and more than half (62.4%) had been a carer for over 5 years and 8 out of 10 (81.6%) had been a carer for 3 years or more. It may be that at the early stages of a person's caring role they feel able to cope independently but as either their caring role changes or their own health and wellbeing is impacted upon unpaid carers feel the need for formal support.

3.2 Characteristics of Carers

3.2.1 Gender and age

Of the 15,010 unpaid carers in Halton, 8,584 are female and 6,426 are male, making the gender split 57.2% female and 42.8% males. This is a similar proportion seen regionally and nationally.

Figure 2:The proportion of unpaid carers by sex and age in Halton, 2011



Source: LC3301EW, 2011 Census via Nomis

The 2011 Census shows that Halton had 1259 young carers (aged 0-24), a percentage than nationally - 8.4% compared to 7.5% across England as a whole. In Halton, 2,960 people who provide unpaid care were aged 65 and over, which equates to 19.7% of all unpaid carers. This is lower than both the regional figure of 21.4% and the national figure of 22%. It can be assumed that those aged over 65 are likely to need some additional support from the council to support them in their caring role.

In Halton, the highest proportion of unpaid carers are women and 20 to 49 providing 1 to 19 hours of care (40.9%). More men provide 50 or more hours in unpaid care, 799 men compared to 739 women. For males providing 50 or more hours of unpaid care a week, 40.7% are aged 65 and over. For females providing 50 or more hours the largest proportion are of a younger age, 25 to 49.

Table 5: Number and percentages of unpaid care, hours of care per week, by gender age, Halton 2011

Males	All categories: Age	Age 0 to 24	Age 25 to 49	Age 50 to 64	Age 65 and over
Provides unpaid care: Total	6,426	576 (9%)	2067 (32.2%)	2291 (35.7%)	1492 (23.2%)
Provides 1 to 19 hours unpaid care a week	3,403	417 (12.3%)	1194 (35.1%)	1326 (39%)	466 (13.7%)
Provides 20 to 49 hours unpaid care a week	1,059	109 (10.3%)	384 (36.3%)	339 (32%)	227 (21.4%)
Provides 50 or more hours unpaid care a week	1,964	50 (2.5%)	489 (24.9%)	626 (31.9%)	799 (40.7%)
Females	All categories: Age	Age 0 to 24	Age 25 to 49	Age 50 to 64	Age 65 and over
Provides unpaid care: Total	8,584	683 (8%)	3310 (38.6%)	3123 (36.4%)	1468 (17.1%)
Provides 1 to 19 hours unpaid care a week	4,601	443 (9.6%)	1881 (40.9%)	1741 (37.8%)	536 (11.6%)
Provides 20 to 49 hours unpaid care a week	1,380	132 (9.6%)	525 (38%)	530 (38.4%)	193 (14%)
Provides 50 or more hours unpaid care a week	2,603	108 (4.2%)	904 (34.7%)	852 (32.7%)	739 (28.4%)

Source: LC3301EW, 2011 Census, via Nomis

NB: due to the composition & nature of the data-sets generating the overall information, each category is mutually exclusive; therefore the volumes of unpaid carers within each category must be regarded independently of the other.

3.2.3. Types of care provided

From the Annual Carers Survey an understanding of the nature of the care unpaid carers provide can be examined. It shows the type of support given by Halton carers is broadly similar to the North West and England (Table 6). There are higher proportions of adults aged 18-64 being cared for a lower levels of people aged 65+, with the difference being most marked in the 85+ age group, probably reflecting Halton's lower life expectancy (Table 7).

Table 6: Types of support carers have provided for the person they care for in the preceding 12 months, annual Carers Survey 2014/15

	Personal care	Physical help	Helping with dealing with care services and benefits	Helping with paperwork or financial matters	Other practical help	Keeping him/her company	Taking him/her out	Giving medicines	Keeping an eye on him/her to see he/she is all right	Giving emotional support	Other help
Halton	59.3	48.7	85.8	84.1	91.2	82.6	77.3	68.7	89.1	88.2	17.7
North West	66.7	58.1	85.5	84.5	92.6	83.1	78.0	74.9	91.1	84.6	21.7
England	68.6	58.8	86.4	86.4	93.0	83.5	76.4	76.4	91.3	85.1	20.3

Source: HSCIC

Table 7: Age of person cared for

	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Halton	4.5	9.0	10.2	9.9	13.5	17.1	21.3	14.7
North West	4.7	6.0	5.7	8.4	8.4	15.2	26.4	25.1
England	5.3	5.3	5.1	6.8	7.7	13.9	27.1	28.8

Source: HSCIC

A smaller proportion of people cared for by Halton carers have dementia, physical disability and sight or hearing loss, problems connected to ageing and terminal illness compared to the North West and England. Conversely a higher proportion have mental health problems, long-standing illness and alcohol or drug dependency.

Table 8: Conditions cared for person has, 2014/15

	Dementia	Physical disability	Sight or hearing loss	Mental health problem	Problems connected to ageing	Learning disability or difficulty	Long-standing illness	Terminal illness	Alcohol or drug dependency
Halton	22.3	46.6	24.0	34.7	27.3	18.4	42.4	2.7	2.4
North West	31.5	53.5	31.2	22.0	37.0	17.9	41.4	4.8	2.1
England	34.6	55.4	32.5	19.5	38.8	18.1	40.1	5.6	1.5

Source: HSCIC

Living arrangements are similar albeit with a slightly higher proportion of Halton carers caring for a person who does not live with them than the North West and England averages.

Table 9: Living arrangements between carer and person cared for, 2014/15

	With me	Somewhere else
Halton	69.0	31.0
North West	71.5	28.5
England	73.0	27.0

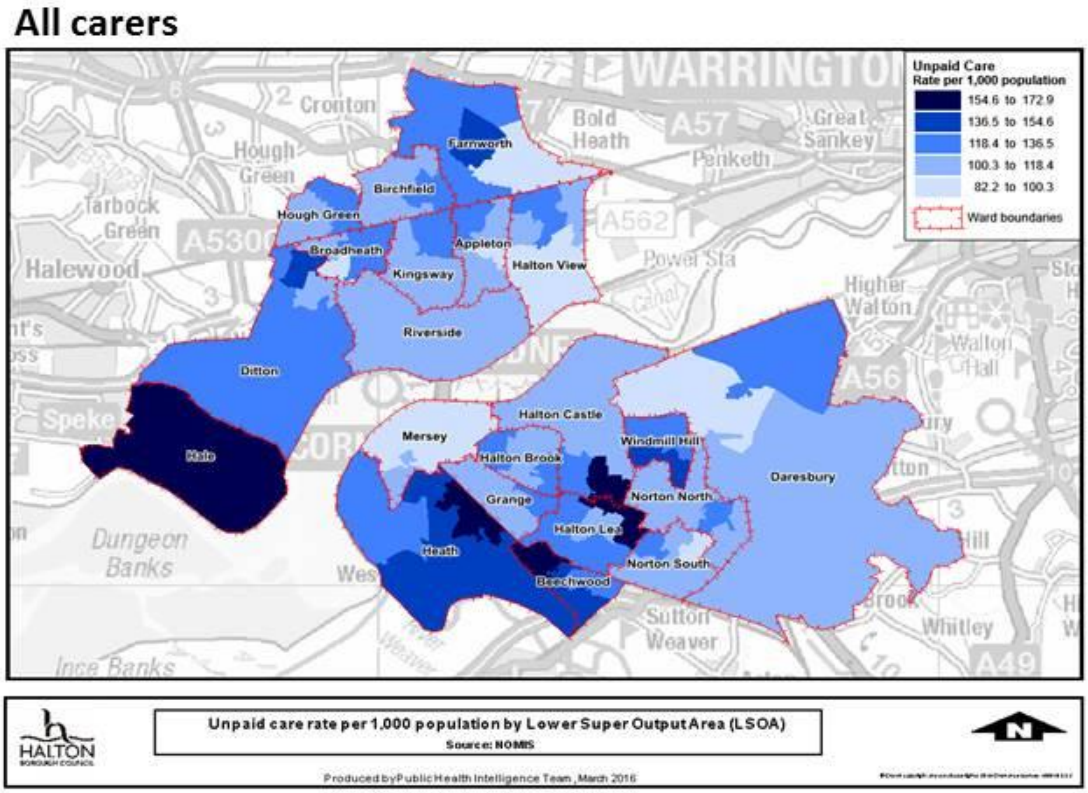
Source: HSCIC

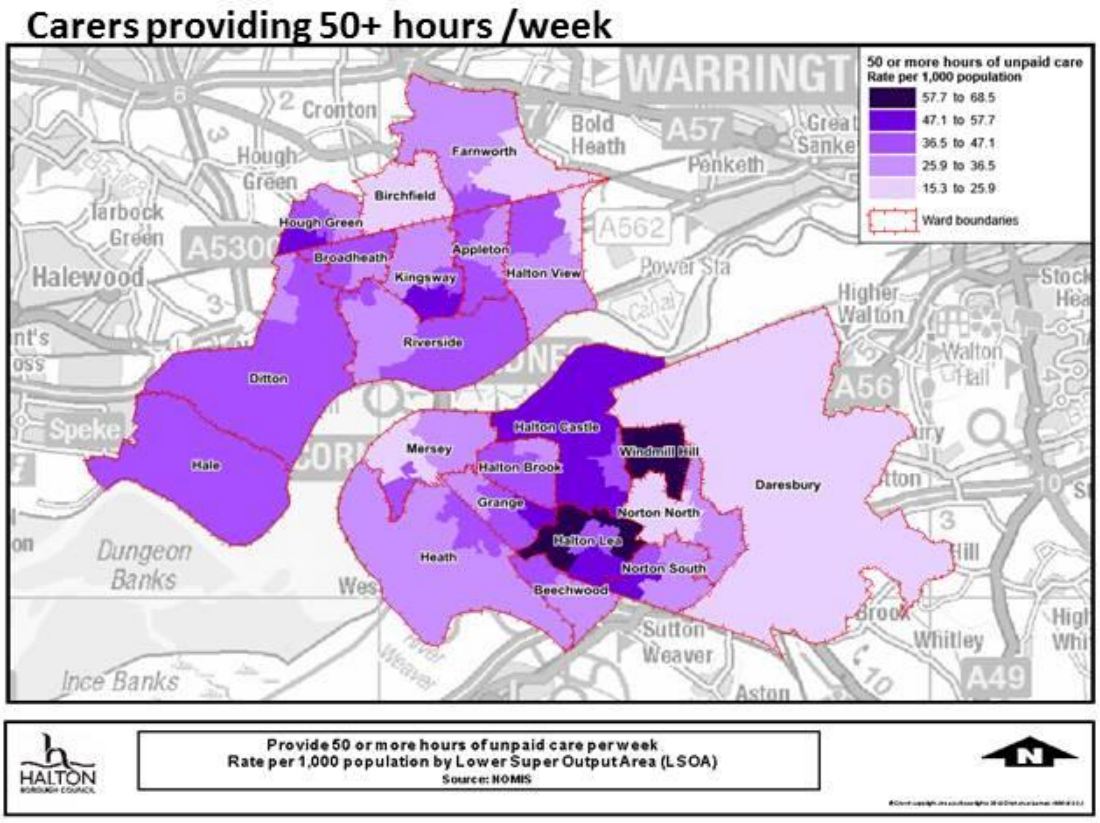
3.2.2 Location of carers - Where do carers live?

Data from the Census also enables the mapping of residents who identified themselves as carers as data is available at a lower super output area (LSOA)[i] as well as ward. Figure x shows the location of residences for carers in Halton with the darker areas representing those locations where the proportion of residents who are carers is highest.

[i] *LSOA is a small geographical area, smaller than an electoral ward, made up of approximately 1,500 households*

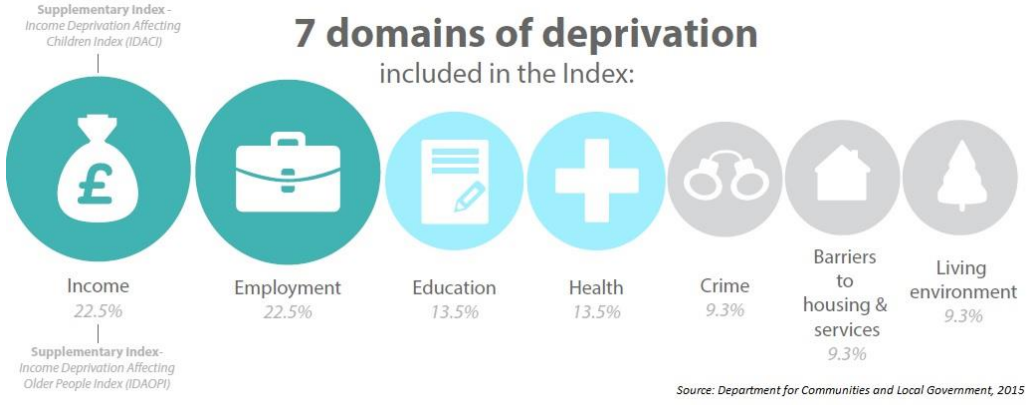
Figure 3: Location of all carers and those providing 50 or more hours of care per week





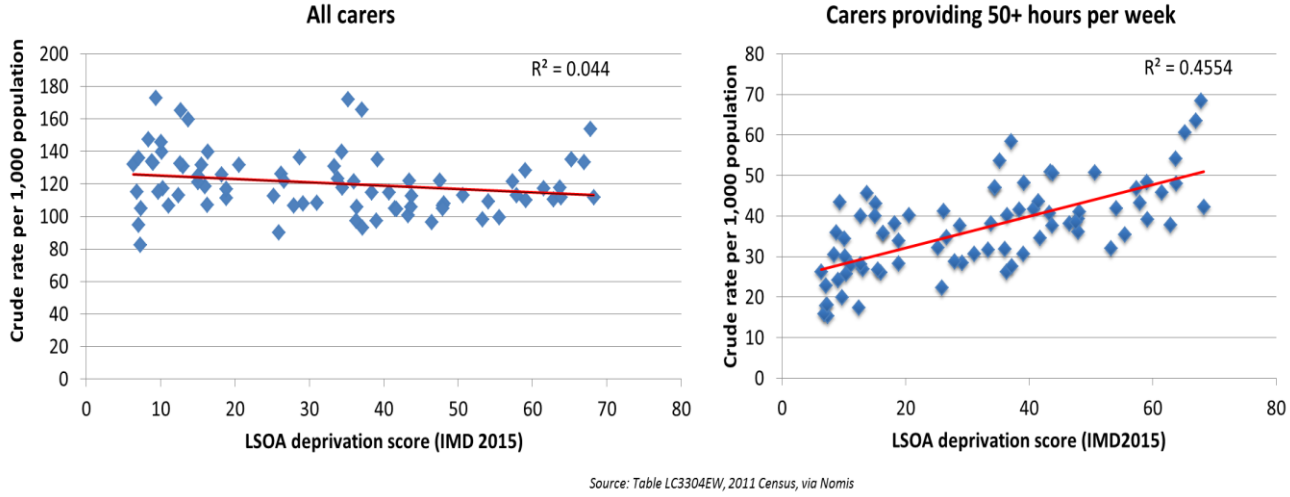
The English Indices of Multiple Deprivation (IMD) measure relative levels of deprivation in 32,844 small areas or neighbourhoods, called Lower-layer Super Output Areas, in England. Produced every couple of years the latest ones were released September 2015, with most of the indicator using 2012/13 data. The English Indices of Deprivation 2015 are based on 37 separate indicators, organised across seven distinct domains[1] of deprivation which are combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2015 (IMD 2015). This is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower layer Super Output Area (LSOA), or neighbourhood, in England. Every such neighbourhood in England is ranked according to its level of deprivation relative to that of other areas.

Figure 4: Index of Multiple Deprivation Domains



As Census data on carers is also available at LSOA level it is possible to analyse the two data sets in a way that helps to see the extent to which geographical deprivation is related to being a carer. This is not to suggest that all carers living in a particular area will be deprived or not deprived as everyone's situation is different and this is not the purpose of the IMD statistics. It shows that there is no correlation between being a carer providing any level of care and deprivation with only a weak-medium strength relationship between carers providing 50+ hours per week and geographical deprivation.

Figure 5: Correlation between carers locations and IMD 2015



3.3 Economic Status of Carers

A UK report on the impact of caring on family finances[6] found that families taking on caring responsibilities often face lasting financial pressure as a result of loss of earnings and rising household costs relating to the extra costs of ill-health or disability.

Carers UK (2013) found that:[7]

- Four in 10 (44%) of carers surveyed have been in debt as a result of caring
- Nearly one in four (58%) carers spend at least 10% of their income on energy bills. Up from 54% in 2011/12
- 36% of carers are struggling to afford utility bills like electricity, gas, water or telephone bills
- 52% of carers say that financial concerns are affecting their health
- 41% of those struggling are cutting back on essentials like food and heating

Many carers struggle to combine work with caring responsibilities and, as a result, may have to leave work, reduce their hours or take lower paid or part-time jobs. Yet being in employment is beneficial for health and wellbeing and reduces social isolation.

Carers UK (2013) found that:

- Nearly two thirds (65%) of carers in work have used annual leave to care while, nearly half (47%) have done overtime to make up for taking time off to care
- One in seven (15%) have taken a less qualified job, turned down or not sought promotion because of caring responsibilities
- A further one in six (17%) continue to work the same hours but find their job is negatively affected by stress, tiredness or lateness. Over half (56%) of carers who gave up work to care spent or have spent over five years out of work as a result
- One in five carers is forced to give up work as a result of their caring responsibilities. This is significant given the importance of 'meaningful activity' (such as employment) to maintaining an individual's positive mental health. Such activity also reduces social isolation

There are multiple pieces of legislation which are relevant to the rights of carers in employment. The Employment Rights Act 1996, as amended by the **Employment Relations Act 1999,** gives carers rights to help them manage work and their caring responsibilities. People who are looking after someone who is elderly or disabled are now protected against direct discrimination or harassment because of their caring responsibilities under the **Equality Act 2010.**

A recent report on supporting working carers highlights the economic benefits of supporting carers to stay in work.[8] Its recommendations include the importance of effective joint working between Local Authorities and care providers to support the development of services that meet carers' needs using Local Enterprise Partnerships and Health and Wellbeing Boards to promote this agenda. Carers UK and major businesses have set up Employers for Carers offering help to employers to retain the one in nine employees who are caring for a family member. Deatials can be found at:

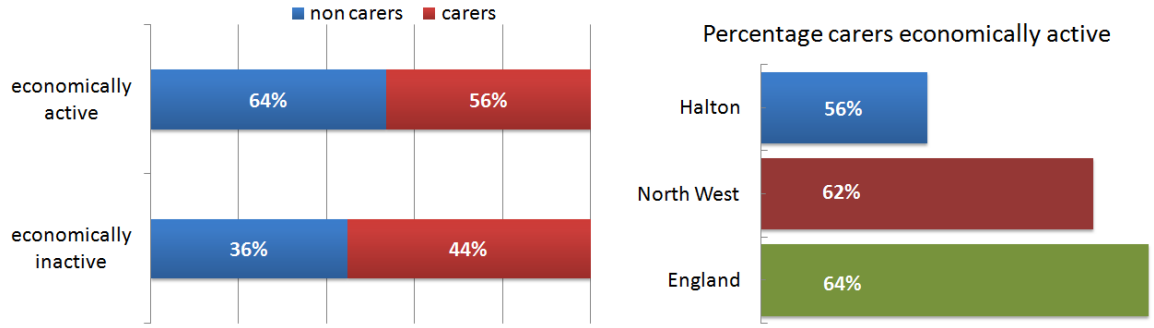
https://www.employersforcarers.org/

Levels of economic activity amongst carers

Economically active people are defined as those people who are in employment and those people who are unemployed and are available to work.

Economically inactive people are defined as those people who are not in employment or those people who are not available to work. This includes people who are retired, those looking after family, those who are long term sick and some students.

Figure 6: Economic status of unpaid carers compared to non-carers, Halton 2011



Source: LC6301EW, 2011 Census, via Nomis

Figure 6 shows that although a smaller proportion of carers are economically active than their non-carer peers, the majority of carers are economically active. However, in Halton a slightly smaller percentage of carers are economically active compared to the North West and England.

Table 10: Economic activity by main types, Halton carers compared to Halton non carers

Economic Activity	Halton		Carers only	
	Provides no unpaid care	Provides unpaid care	North West	England
Economically active: Total	**64%**	**55.8%**	**62%**	**64%**
Of those who are economically active:				
In employment: Total	**58%**	**51.4%**	**57%**	**59%**
Part-time	12.8%	14.6%	13%	13%
Full-time	38.0%	30.8%	34%	35%
Self-employed: Total	**5.5%**	**4.9%**	**7%**	**9%**
Full-time students	2%	1.0%	2%	2%
Unemployed: Total	6%	4.4%	5%	5%
Economically inactive: Total	**36%**	**44.2%**	**38%**	**36%**
Of those who are economically inactive:				
Retired	20%	25.3%	22%	21%
Looking after home or family	3%	8.9%	4%	4%
Long-term sick or disabled	7%	6.3%	5%	4%
Other	2%	1.9%	2%	2%

Source: LC6301EW, 2011 Census via Nomis

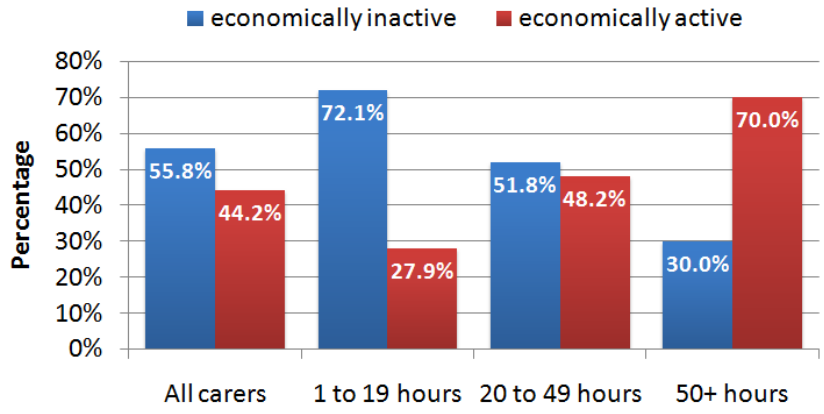
In Halton, 8,184 unpaid carers are economically active, which is equivalent to 55.8% of all unpaid carers. This is lower than the regional average of 56.8% and the national average of 57.9%. Of the economically active unpaid carers in Halton, 7,538 unpaid carers are in employment, which is equivalent to 51.4% of all unpaid carers.

30.8% of Halton unpaid carers are in full time employment. This is a lower proportion than the regional average of 34.1% and the national average of 46.9%.

Assuming that carers who also have a full time job, are in full time education or are economically inactive due to illness or disability are more likely to need support to fulfil their caring role, this equates to 5,633 carers in Halton fitting into this category.

Figure 3 shows that those providing 50 or more hours of unpaid care are much less likley to be economically active, compared to all carers, less than one in three. Conversely more than two out of every three carers providing 1 to 19 hours of care per week are economically active.

Figure 7: Economic activity by hours of care provided



Source: LC6301EW, 2011 Census via Nomis

Carers known to adult social care are less likley to be in employment than all carers, although the percentages for Halton are higher than the North West and England. As seen in the previous sections, carers known to adult social care provide more hours of care than all carers, which is likley to explain this difference, at least in part. A greater proportion indicate they are retired than seen in the 2011 Census.

Table 11: Economic status of carers responding to the 2014/15 Personal Social Services Annual Carers Survey

	Retired	Employed full-time	Employed part-time (working 30 hours or less)	Self-employed full-time	Self-employed part-time	Not in paid work	Doing voluntary work	Other
Halton	44.5	17.3	9.3	1.5	0.6	22.7	4.5	7.8
North West	54.8	9.8	11.5	1.9	2.4	19.0	5.6	7.1
England	58.0	9.1	10.8	1.9	3.0	18.3	5.3	6.1

Source: HSCIC

Carers known to adult social care were also asked about the level of support they received from their employers and if this was adequate. Of those in employment more felt supported than didn't feel supported. 8.1% felt they did not need support from their employer. Despite these small percentages, it may be worth working with employers locally to ensure good practice in supporting those who have a caring role. Especially as this represents only a small proportion of the 51.4% of carers who are employees.

Table 12: Support from employers

	I am in paid employment and I feel supported by my employer	I am in paid employment but I don't feel supported by my employer	I do not need any support from my employer to combine work and caring	I am not in paid employment because of my caring responsibilities	I am not in paid employment for other reasons	I am self-employed or retired
Halton	13.0	8.8	8.1	26.4	11.3	32.4
North West	12.7	5.4	5.8	22.1	12.4	41.6
England	11.9	4.6	5.6	20.5	11.3	46.1

Source: HSCIC

Table 13 shows thay of those providing 50 or more hours of unpaid care, most are in employment with unemployment rates in this group being below that of all carers and indeed non-carers who are economically active. A higher proportion of those providing 50 or more hours of unpaid care are are retired or unable to work due to illness or disability than carers overall and non-carers.

Table 13: Economic activity by number of hours of caring

	All categories: Provision of unpaid care		Provides no unpaid care		Provides unpaid care							
					Provides unpaid care: Total		Provides 1 to 19 hours unpaid care a week		Provides 20 to 49 hours unpaid care a week		Provides 50 or more hours unpaid care a week	
Economic Activity	Number	% of all economic activity	Number	% of all economic activity	Number	% of all economic activity	Number	% of all economic activity	Number	% of all economic activity	Number	% of all economic activity
All categories: Economic activity	100,819	*100%*	86,149	*100%*	14,670	*100%*	7,742	*100%*	2,387	*100%*	4,541	*100%*
Economically active: Total	63,611	*63.1%*	55,427	*64.3%*	8,184	*55.8%*	5,583	*72.1%*	1,237	*51.8%*	1,364	*30.0%*
In employment: Total	57,771	*57.3%*	50,233	*58.3%*	7,538	*51.4%*	5,200	*67.2%*	1,112	*46.6%*	1,226	*27.0%*
Employee: Total	50,469	*50.1%*	43,799	*50.8%*	6,670	*45.5%*	4,588	*59.3%*	984	*41.2%*	1,098	*24.2%*
Part-time	13,175	*13.1%*	11,030	*12.8%*	2,145	*14.6%*	1,344	*17.4%*	357	*15.0%*	444	*9.8%*
Full-time	37,294	*37.0%*	32,769	*38.0%*	4,525	*30.8%*	3,244	*41.9%*	627	*26.3%*	654	*14.4%*
Self-employed: Total	5,466	*5.4%*	4,743	*5.5%*	723	*4.9%*	503	*6.5%*	102	*4.3%*	118	*2.6%*
Part-time	1,447	*1.4%*	1,213	*1.4%*	234	*1.6%*	160	*2.1%*	36	*1.5%*	38	*0.8%*
Full-time	4,019	*4.0%*	3,530	*4.1%*	489	*3.3%*	343	*4.4%*	66	*2.8%*	80	*1.8%*
Full-time students	1,836	*1.8%*	1,691	*2.0%*	145	*1.0%*	109	*1.4%*	26	*1.1%*	10	*0.2%*
Unemployed: Total	5,840	*5.8%*	5,194	*6.0%*	646	*4.4%*	383	*4.9%*	125	*5.2%*	138	*3.0%*
Unemployed (excluding full-time students)	5,157	*5.1%*	4,551	*5.3%*	606	*4.1%*	355	*4.6%*	116	*4.9%*	135	*3.0%*
Full-time students	683	*0.7%*	643	*0.7%*	40	*0.3%*	28	*0.4%*	9	*0.4%*	3	*0.1%*
Economically inactive: Total	37,208	*36.9%*	30,722	*35.7%*	6,486	*44.2%*	2,159	*27.9%*	1,150	*48.2%*	3,177	*70.0%*
Retired	20,782	*20.6%*	17,068	*19.8%*	3,714	*25.3%*	1,363	*17.6%*	573	*24.0%*	1,778	*39.2%*
Student (including full-time students)	3,884	*3.9%*	3,619	*4.2%*	265	*1.8%*	176	*2.3%*	53	*2.2%*	36	*0.8%*
Looking after home or family	3,921	*3.9%*	2,615	*3.0%*	1,306	*8.9%*	260	*3.4%*	279	*11.7%*	767	*16.9%*
Long-term sick or disabled	6,689	*6.6%*	5,766	*6.7%*	923	*6.3%*	277	*3.6%*	174	*7.3%*	472	*10.4%*
Other	1,932	*1.9%*	1,654	*1.9%*	278	*1.9%*	83	*1.1%*	71	*3.0%*	124	*2.7%*

Source: Table LC6301EW 2011 Census, via Nomis

A small proportion of cares may be entitled to and claiming Carers Allowance. This is a taxable benefit and although not means tested, elegibility is dependent on the amount a person earns from other sources. Eligibility depends on a number of factors:

- being 16 years of age or over
- spending at least 35 hours a week caring for someone
- having been in England, Scotland or Wales for at least 2 of the last 3 years
- normally living in England, Scotland or Wales, or living abroad as a member of the armed forces
- not being full-time education or studying for 21 hours a week or more
- earning no more than £110 a week (after taxes, care costs while at work and 50% of personal pension contributions)
- being in receipt of a range of other state benefits including state pension, out-of-work benefits, universl credit and other allowances may affect eligibility. However, having underlying entitlement to carers allowance may increase some of these benefit amounts payable but it may also decrease some benfit amounts
- The person you care for must already be in receipt of one of the following benefits:
    - Personal Independence Payment (PIP) daily living component
    - Disability Living Allowance (DLA) - the middle or highest care rate
    - Attendance Allowance
    - Constant Attendance Allowance at or above the normal maximum rate with an Industrial Injuries Disablement Benefit, or basic (full day) rate with a War Disablement Pension
    - Armed Forces Independence Payment

Table 14: Number of Halton carers receiving Carer Allowance payments, as at May 2015

Age	Male	Female	Total
aged under 18	10	10	10
aged 18-24	50	90	150
aged 25-29	40	130	170
aged 30-34	60	210	270
aged 35-39	70	190	260
aged 40-44	90	240	330
aged 45-49	100	200	310
aged 50-54	120	220	340
aged 55-59	90	210	300
aged 60-64	130	120	250
aged 65 and over	~	30	40
unknown age	~	~	~
Column Total	**770**	**1,650**	**2,420**

Source: Department for Work and Pensions, via Nomis

3.5 Health of Carers

3.5.1. Health risks associated with being a carer

Carers' needs are complex and vary dependent upon the individual's personal circumstances, including the amount and type of caring needs of the person they care for, their individual living and working conditions, their age and family set up amongst other things. Indeed, some carers are at a greater risk of being disadvantaged or becoming ill themselves than other carers. It is therefore important to recognise and respond to those that are at greatest risk whilst at the same time there are general support needs that are applicable to all carers.

There are significant risks associated with caring and maintaining good health and positive wellbeing. These include risks to physical health (strain, injury, exhaustion and lack of sleep), mental health (stress, anxiety, worry and depression) and financial pressures (loss of income from paid employment). Many carers also experience social isolation and find it difficult to maintain relationships and social networks due to the impact of caring for someone. Carers can also receive inadequate support from services to help them with their caring role, resulting in illness and limited support to help them recover.

It is estimated that the unpaid work and support that carers give save the UK purse £119 billion a year. This means that the cost of a single carer having to stop caring could result in additional residential care home costs of over £13,000 per year for each person previously cared for.[9]

Carers UK found that 84% of carers surveyed said that caring has a negative impact on health. Nine out of ten (92%) carers said that their mental health has been affected by caring with only 1% saying that caring has improved their mental health. 67% of carers said their GP is aware of their caring responsibilities but gives them no extra help.[10]Yet data shows only 10% of carers are registered as being carers on GP records. Carers not receiving respite are more likely to have mental health problems (36%), compared with those in receipt of respite (17%).[11]

The health of carers deteriorates more quickly than that of non-carers due to the lack of support (often due to a lack of awareness of support available). 64% reported a lack of practical support and 50% a lack of financial support.[12]

The Royal College of General Practitioners (RCGP)[13] have identified (from various sources) that:

- Carers tend to neglect their own health. The impact on a carer's own physical and mental health is worsened if they are unable to attend their own health-related appointments. They may fail to notice their own health deteriorating and miss routine appointments or check-ups with doctors or dentists. Information from Carers UK shows that two in five carers postpone their own treatments due to lack of support. Care and support is also relied on to take the cared for to appointments if the carer works.
- Caring can limit carers' ability to take exercise
- 40% of carers experience psychological distress or depression, with those caring for people with behavioural problems experiencing the highest levels of distress
- 33% of those providing more than 50 hours of care a week report depression and disturbed sleep

- Those providing more than 20 hours of care a week over an extended period have double the risk of psychological distress over a two year period compared to non-carers. Risk increases progressively as the time spent caring each week increases
- 44% of carers suffer verbal or emotional abuse; 28% endure physical aggression or violence from the person they care for
- Older carers who report 'strain' have a 63% higher likelihood of death in a four year period
- Providing high levels of care is associated with a 23% higher risk of stroke

3.5.1.1. Which Carers are at Greatest Risk of Ill Health?

National evidence suggestes certain types are carers are more at risk of ill health than others due to their caring responsibilities. Using the 'at risk' determinants of: economic activity, health, age and 50+ hours of unpaid care provided per week, the following 'sub-set' of unpaid carers has been identified as being potentially 'at risk' and therefore likely to need additional health and wellbeing support in their caring role.

Table 15: Number of Halton carers at increased risk of ill health

Type of carer at increased risk	Number
Economically active (full-time employment)	4525
Economically inactive (long-term sick/ disabled)	932
Bad/Very bad health	1454
Long-term disability which limits daily life a lot	2147
Providing 50 or more hours of care per week	4567
aged 65 and over	2960

Source: 2011 Census, ONS

3.5.2. Levels of health

The 2011 Census includes a question asking about the respondent's general health, within a number of categories. People were asked to assess whether their health was very good, good, fair, bad or very bad. This assessment is not based on a person's health over any specified period of time.

In Halton most people who provide unpaid care report being in good or very good health – 10,123 out of 15,010 or 67%. Of the remainder 3,433 reported fair health and 1,454 bad or very bad health.

However, the percentage reporting good or very good health was lower than the regional and nartional levels. Conversely the proportion reporting bad or very bad health was higher than these compatarors, as Figure 5 shows.

Figure 8: Health status of unpaid carers, Halton and comparators, 2011

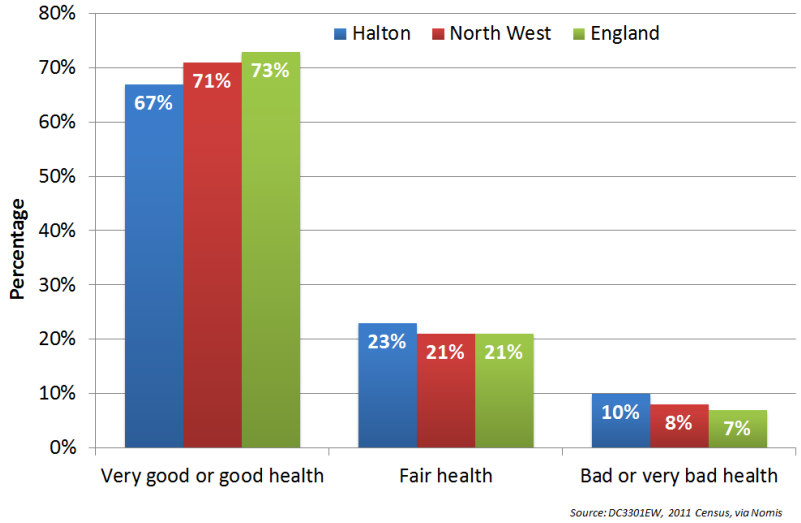
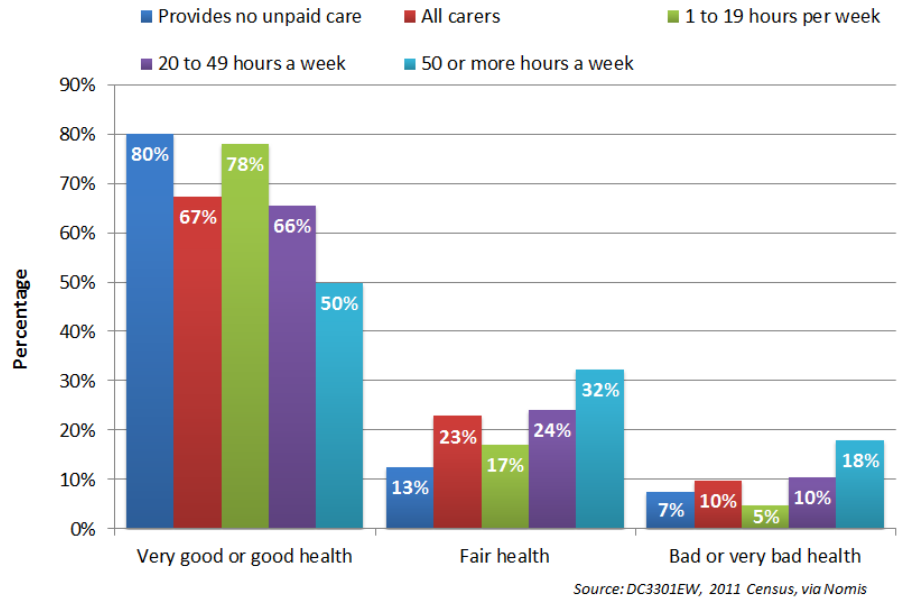


Figure 5 shows that the proportions of those in good or bad health varies by the amount of care provided, with those providing the highest number of hours having disproportionately poorer health. This may partly be an effect of age – those over the age of 65 are more likley to provide 50 or more hours of care a week and are also more likley to find their health worsening. All carers have poorer health than non carers, although for those providing 1 to 19 hours of care a week, the difference between them and non-carers is marginal.

Figure 9: Number of hours of unpaid care provided weekly, by general health of Halton carers



Carers who report bad or very bad health are themselves more likely to need additional support in their caring role and/or are accessing support to address their own health and wellbeing needs. In Halton there are 1,454 carers who report having bad or very bad health and of this group over half, 818, are providing 50 or more hours care per week. Nearly half of these are over age 65.

Table 16: Number and percentage of Halton carers with bad or very bad health, by age

	All carers		Age 0 to 24		Age 25 to 49		Age 50 to 64		Age 65 and over	
	Number	%	Number	%	Number	%	Number	%	Number	%
Provides no unpaid care	8139	7%	329	4%	1642	20%	2797	34%	3371	41%
All Carers	1454	10%	14	1%	267	18%	600	41%	573	39%
1 to 19 hours a week	382	5%	4	1%	92	24%	187	49%	99	26%
20 to 49 hours a week	254	10%	3	1%	58	23%	115	45%	78	31%
50 or more hours a week	818	18%	7	1%	117	14%	298	36%	396	48%

Source: DC3301EW, 2011 Census, via Nomis

Table 17: General health of Halton carers, by number of hours of unpaid care provided and gender

	Males			Females		
	Very good or good health	Fair health	Bad or very bad health	Very good or good health	Fair health	Bad or very bad health
Provides no unpaid care	81%	12%	7%	79%	13%	8%
All Carers	66%	23%	11%	69%	22%	9%
1 to 19 hours a week	77%	17%	5%	79%	17%	4%
20 to 49 hours a week	65%	23%	12%	66%	25%	9%
50 or more hours a week	46%	34%	20%	53%	31%	16%

Source: DC3301EW, 2011 Census, via Nomis

Whilst nearly twice the proportion of carers providing 50 or more hours of care have bad or very bad health compared to all carers (and more than double the proportion compared to those who do not provide unpaid care), a slightly higher percetentage of male carers in this category suffer from poor health compared to the proportion of female carers. In terms of number though there are slighly more females providing 50 or more hours care who are in bad or very bad health than males, 426 compared to 392.

3.5.3. Unpaid Care Expectancy (UCE)

UCE is a new type of analysis by the Office for National Statistics (ONS) using data from the 2011 Census to estimate the average lifespan spent occupying an unpaid carer role. It is useful as a guide to unmet social care need and can be used to assess whether unpaid care is influenced by the relative prevalence of disability between areas.[14]

For this analysis, those who respond to any duration of care per week were classified as a carer for calculation of UCE. These estimates divide expected lifespan into time spent in two distinct states, providing unpaid care and not providing unpaid care. The figures represent a snapshot of the mortality and carer status of the entire specified area population (in this case NHS England Clinical Commissioning Groups) in a given time period. They are not, therefore, the number of years that a person in an area will actually expect to live as a carer or non-carer. This is because:

- mortality rates are susceptible to change in the future
- unpaid carer rates may change because of changes to the criteria for accessing social care
- the impacts of new health care treatments to offset the disabling effects of health conditions
- cultural factors that influence the willingness to provide unpaid care
- the intermittent nature of unpaid care provision for some carers

- migration into and out of a given area which means people will live in a different area for part of their lives

UCEs have been calculated at three selected ages, shown to be significant milestones in unpaid care provision:

- at age 15
- at age 50
- and at age 65

National findings

Males at age 15 can expect to spend on average 7.1 years of their remaining life providing unpaid care, compared with 9.3 years for females. Although males at age 15 have shorter life expectancies than females, they still spend a smaller proportion of their lives providing unpaid care at 11.0% compared with 13.6% for females. Such figures point to females dedicating longer durations of their life providing care than males. It is at age 50 that both genders have the highest proportion of lives providing unpaid care; 15.7% for men and 17.1% for women.

While these estimates show a marked gender inequality in unpaid care provision at younger ages, this reverses at age 65. Men at this age were providing unpaid care for a similar number of years to women, but because of their shorter life expectancy, have a greater proportion of their remaining years of life providing unpaid care. At age 65 men are expected to spend on average 2.7 years of their remaining 18.6 years of life providing unpaid care while for women it is 2.6 years. This reversal at age 65 is likely to be partly explained by men's later retirement age after which men have greater freedom to take up caring responsibilities.

Table 18 shows that levels of UCE are higher in Halton than for England as a whole and the difference is statistically higher, life expectancy is lower indicating a higher level of ill health; thus the proportion of life spent providing unpaid care (PUC) is also higher than England.

Males in Halton at age 15 can expect to spend on average 8.0 years of their remaining life providing unpaid care, compared with 10.1 years for females. Although males at age 15 have shorter life expectancies than females, they still spend a smaller proportion of their lives providing unpaid care at 12.8.0%compared with 15.4% for females. Such figures point to females dedicating longer durations of their life providing care than males. It is at age 50 that both genders have the highest PUCs; 18.1% for men and 18.4% for women, with the gender gap being narrowest at this age.

While these estimates show a marked gender inequality in unpaid care provision at younger ages, this reverses at age 65. Men at this age were providing unpaid care for a similar number of years to women, but because of their shorter life expectancy, have a greater proportion of their remaining years of life providing unpaid care.

Table 18: Unpaid care expectancy (UCE), proportion of life providing unpaid care (PUC) and life expectancy (LE) at ages 15, 50 and 65, NHS Halton CCG compared to England, 2010/12

Age	Sex	UCE (Years)	Statistical significance compared to England	LE(Years)	PUC (%)	UCE Rank	LE Rank
England							
At age15	Females	9.3		68.4	13.6		
	Males	7.1		64.7	11.0		
At age 50	Females	5.9		34.4	17.1		
	Males	4.9		31.3	15.7		
At age 65	Females	2.6		21.1	12.4		
	Males	2.7		18.6	14.8		
Halton							
At age15	Females	10.1	*	65.9	15.4	20	203
	Males	8.0	*	62.6	12.8	10	193
At age 50	Females	5.9		32.2	18.4	102	201
	Males	5.3	*	29.4	18.1	25	197
At age 65	Females	2.7		19.3	13.8	79	201
	Males	3.0	*	17.0	17.9	10	200

* = statistically higher than England; blank = not statistically different

Source: Office of National Statistics, 2014

3.5.4. Carers with Long-Term Disabilities

Unlike the previous section which only asks if a person thinks their health is good or bad, the Census also contains questions asking about long-term ill health or disability. This data may include people who answered that their health was good or bad but the questions take it further by quantifying both the period of time that is considered 'long' (has lasted, or is expected to last, at least 12 months) and also the whether the condtion(s) limit the respondent's daily life. This includes problems that are related to old age.

Table 19 shows the proportion of unpaid carers reporting a long-term disability, which limits their day-to-day activities either a lot or a little. Whilst 81% of people who did not provide care reported that they did not have a long-term health problem/disability (limiting their day-to-day activities), only 68% of carers reported being disability-free, whereas 14% reported a long-term health problem/disability, which limited their day-to-day activities a lot. A further 17% stated they had a disability that limited their daily lives a little. These proportions were higher than for North West and England carers.

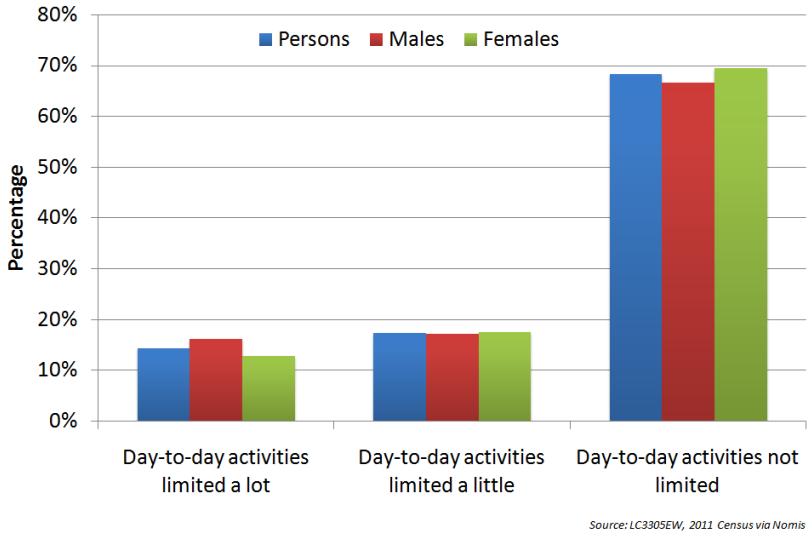
Table 19: Proportion of unpaid carers with long term disabilities

	Halton		North West		England	
	no unpaid care	provides care	no unpaid care	provides care	no unpaid care	provides care
Day-to-day activities limited a lot	11%	14%	10%	12%	8%	10%
Day-to-day activities limited a little	9%	17%	9%	17%	8%	17%
Day-to-day activities not limited	81%	68%	81%	71%	84%	73%

Source: Table LC3305EW, 2011 Census via Nomis

There is a slightly higher percentage of males carers reporting having a long-term health problem or disability that limits their daily lives a lot. This is likely to reflect the older age structure of male carers.

Figure 10: Proportion of Halton carers with long term disabilities, by gender



Of those carers known to adult social care who responded to the 2014/15 annual carers survey a greater proportion of Halton carers have physical impairment or disabilites, mental health problems or long-standing illnesses than the North West or England averages. A lower percentage have no health problems. This supports the findings from the 2011 Census and underlines the additional disease burden locally.

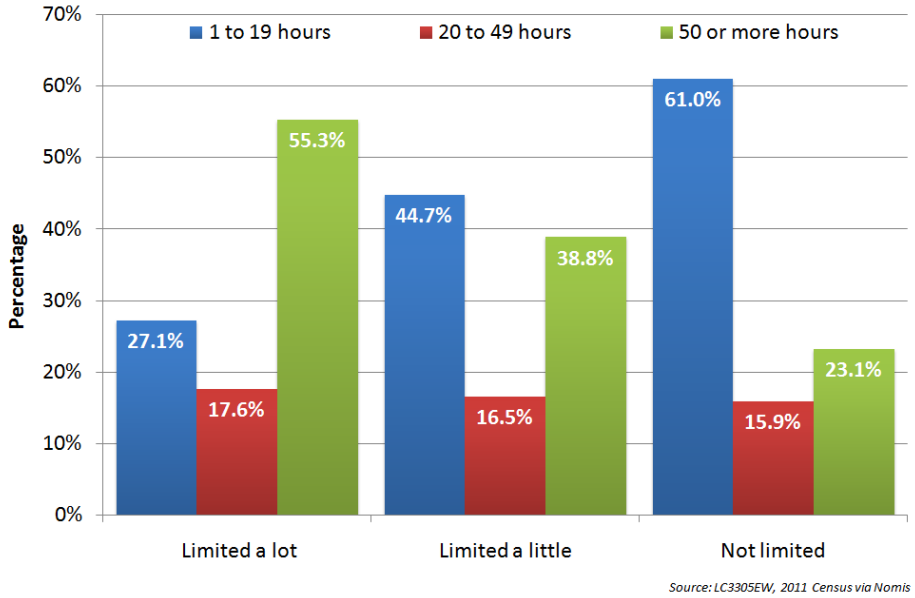
Table 20: Health problems of carers responding to the 2014/15 annual Carers Survey

	A physical impairment or disability	Sight or hearing loss	A mental health problem or illness	A learning disability or difficulty	A long-standing illness	Other	None of the above
Halton	21.8	12.8	11.5	3.1	29.0	14.6	37.4
North West	19.5	15.7	8.5	2.2	26.0	12.7	42.0
England	19.9	16.0	7.5	2.4	24.2	13.7	42.8

Source: HSCIC

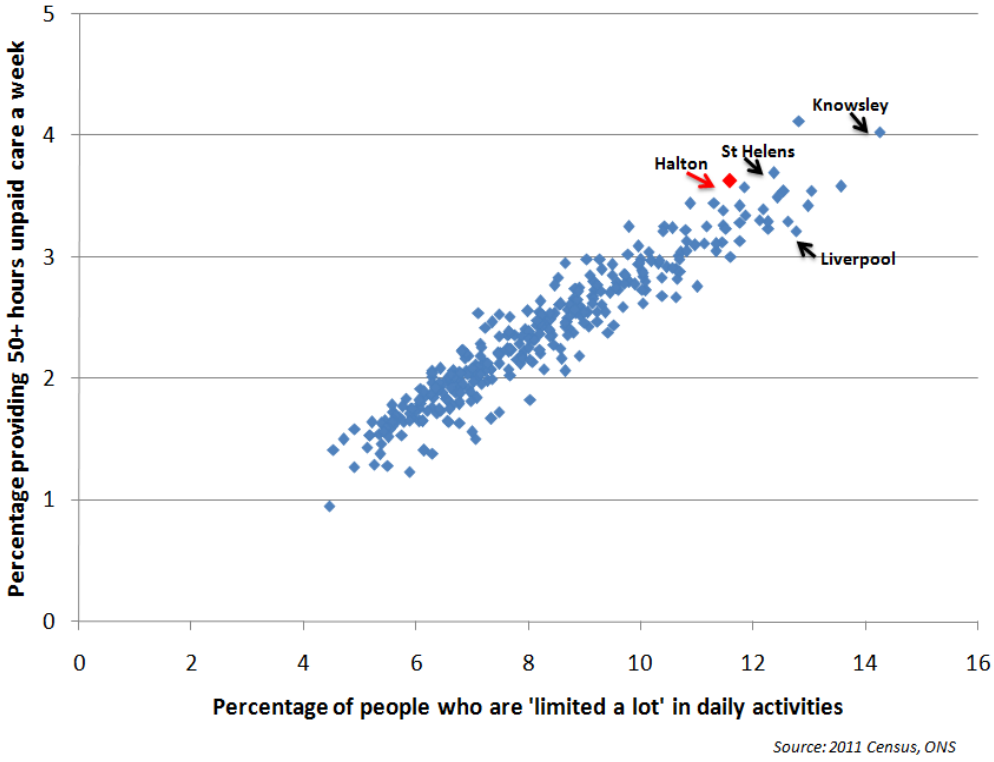
Figure 8 shows that the proportion of carers reporting a long-term health problem or disability that limits their lives a lot increases as the number of hours unpaid care they provide increases. This in part will refect that a high proportion of people providing 50 or more hours unapid care are older. However, it is also likely to reflect that carers often report not having enough time to look after their own health and the strain, both physical and emotion, of their caring role. As a result, these carers are more likely to need additional health and social care support to maintain their caring role. Conversely, the majority of unpaid carers whose day-to-day activities are not limited by long-term illness/disability are those who provide 1 to 19 hours of unpaid care per week.

Figure 11: Proportion of Halton unpaid carers with long term disabilities against amount of unpaid care a week provided



As care is often related to health problems and disabilities which limited daily activities, it is expected that unpaid care would be higher in those authorities with the highest prevalence of people who are 'limited a lot' in daily activities and have older age structures. Figure 9 plots the percentage of an authority's usual residents who provide 50 hours or more care per week against its percentage of people who are 'limited a lot' in daily activities.

Figure 12: Percentage 'limited a lot' and percentage providing 50 hours or more unpaid care, by local authority in England in 2011



It shows a consistent increase in the highest levels of care provided (that is 50 or more hours per week) with increases in activity limitation. While this is to be expected, there is clearly an additional burden on relatives, friends and other informal carers in authorities with higher prevalence of activity limitations, such as Halton and, therefore, greater reliance on unpaid carers to support the social care needs of its residents.

The 2011 Census information on whether those providing unpaid care had a health problem or disability which limited their normal day-to-day activities either a lot, a little or not at all is useful in examining the relationship between an area's prevalence of people with pronounced disability and its prevalence of residents providing unpaid care at a level of 50 hours or more per week. Assuming that for those responding that their daily activities were limited a lot will have greater levels of dependency and need for social care than those who were limited a little or not at all, this helps to judge whether pronounced disability prevalence could predict unpaid care supply and whether it affects female supply more than male supply. Such information can provide clues as to whether unpaid care need depends on concentrations of dependency and poses questions as to why areas with similar concentrations of dependent residents have different supplies of unpaid care at this level.

There is a large difference in the prevalence of pronounced disability across CCG populations; those CCGs with a higher prevalence of pronounced disability generally have a higher proportion of residents providing unpaid care at 50 or more hours per week. The highest instances of unpaid care at this level are clustered in four NHS CCGs in Merseyside, some of which are among the most deprived authorities in England. Halton is one of these areas.

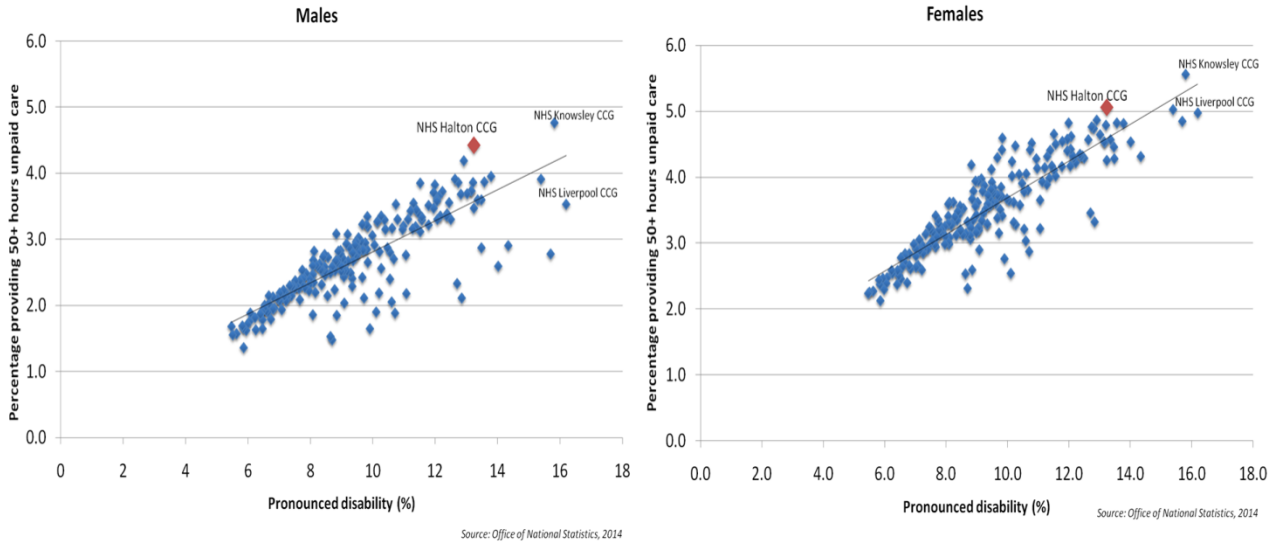
Table 21: CCGs with the highest (top 4) age-standardised prevalence (all persons aged 15 years or above) of unpaid care provision at 50 or more hours per week and the prevalence of people (all persons) with pronounced disability.

	50+ hours/ week (%)	50+ hours/ week Rank	Pronounced disability (%)	Pronounced disability/Rank
NHS Knowsley	5.1	1	15.8	2
NHS Halton	4.7	2	13.2	13
NHS St Helens	4.5	3	12.9	18
NHS Liverpool	4.4	4	15.4	4

Source: 2011 Census, Office for National Statistics

ONS tested the relationship between the prevalence of unpaid care at 50 or more hours per week and the prevalence of residents with pronounced disability using correlations for males and females separately. Figure 10 shows a mainly linear relationship between the age-standardised prevalence of residents with pronounced disability and the prevalence of unpaid care at a level of 50 or more hours per week for males and females respectively across the 211 CCGs.

Figure 13: Prevalence of residents(all persons) with pronounced disability and prevalence of males and females providing 50 or more hours unpaid care per week by CCG.



Strong correlation coefficients of 0.82 and 0.88 were present for males and females respectively (as shown by the closeness of each data point to the best fit lines). This suggests the likelihood of providing care at this level is somewhat related to a CCG's relative social care need based on pronounced disability prevalence.

This general relationship can be used alongside other data such as social care provision by the state to assess the likely effect on the prevalence of people providing unpaid care at 50 or more hours per week that a percentage rise in the prevalence of people with pronounced disability would have. For males, this shows that should an area experience a one percentage point rise in the number of people with pronounced disability, the percentage prevalence of care provision at 50 or more hours per week is likely to grow by 0.24 of a percentage point; for females it would be likely to grow by 0.28 of a percentage point. Such information is helpful in determining the impact of greater levels of dependency that may arise from population ageing in future years.

3.5.5. Mental and Social wellbeing of carers

Research indicates that many carers have poorer mental wellbeing than their non-carer peers and struggle to find time for themselves. A survey of over 2,000 carers[15]conducted April to June 2015 found those surveyed had considerably lower wellbeing scores than the national average (18.9 versus 23.6 using the SWEMWBS[ii] tool) and 20% considered themselved to have mental health problems. Yet many carers find it difficult to find time to focus on their own health needs, especially those undertaking 50 or more hours of unpaid caring a week.

Halton has recently introduced the SWEMWBS tool into its carers assessments. Comparising the percentage of carers with low, moderate and high mental wellbeing scores with the results of the 2013 Mental Wellbeing Survey[16] which used the same tool, it can be seen than although, as with

ii) Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)

the overall percentages, the majority of carers rate their mental wellbeing as moderate, the percentage rating it as low was higher than the overall population score and the percentage rating it high was lower.

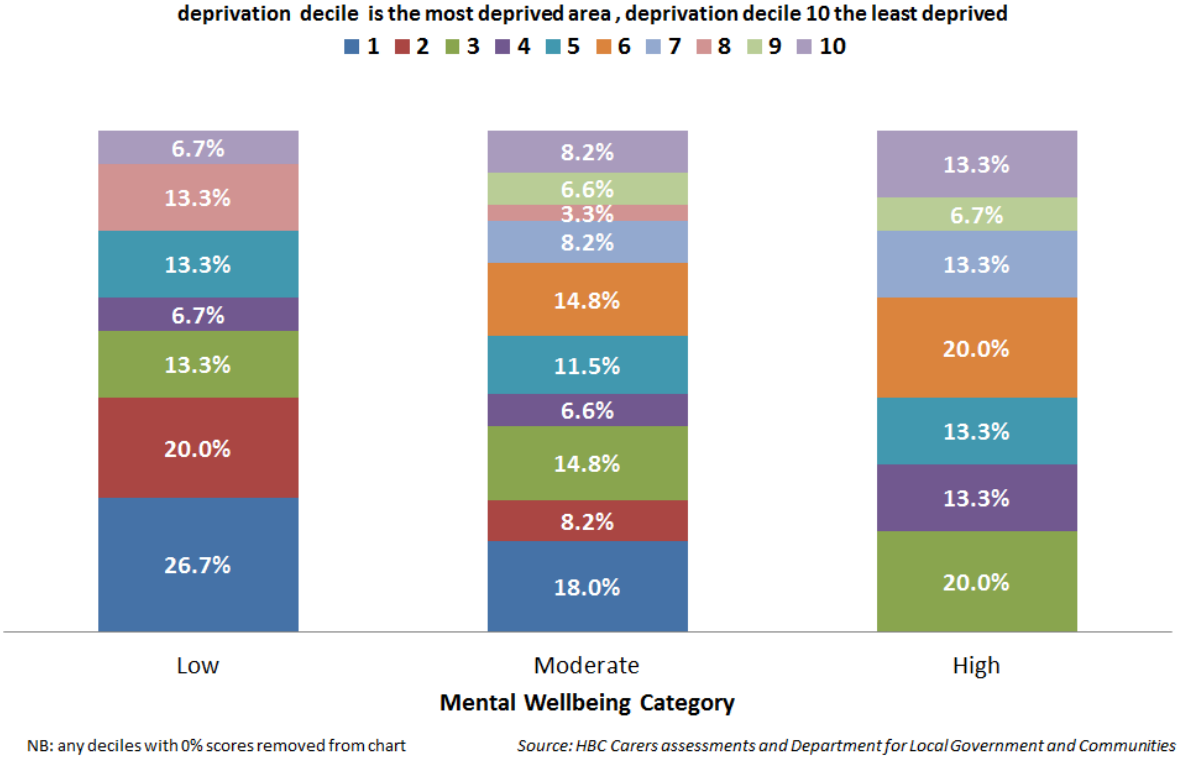
Table 22: Results of the 2013 Mental Wellbeing Survey of Halton adults and Halton carers assessments 2015

	Overall	Carers
Low	13.4%	17.0%
Moderate	62.8%	68.1%
High	23.9%	14.9%

Source: McHale, Hughes and Jones 2013 and HBC

Further analysis of the 2013 Mental Wellbeing Survey showed that there was a relationship with deprivation, with low scores being more prominent in the more deprived quintiles. Analysis of the Halton carers scores by deprivation decile shows a similar pattern, with 60% of carers with a low mental wellbeing score living in the 3 most deprived decile areas compared to41% of those with a moderate score and 20% of those with a high score.

Figure 14: Mental Wellbeing score category by local deprivation decile, Halton carers 2015



NB: any deciles with 0% scores removed from chart

Source: HBC Carers assessments and Department for Local Government and Communities

8 out of 10 carers have felt lonely or isolated as a result of caring, with 55% of carers reporting they are not able to get out of the house much (rising to 64% for those providing 50 or more hours of care a week). 61% don't have time to participate in social activities, with nealry half (45%) not able to afford to. Over half (54%) struggle to pay household bills wth 35% cutting back on essentials like

food and heating to make ends meet. 40% of carers say they rarely or never feel optimistic about the futute, with parent carers especially worried about the future care of the children.

As seen in section 3.5.4., Table 20, a greater proportion of Halton carers have mental health problems than across the North West and England. However, in relation to feeling able to spend time doing things they want, having enough support and socal contact, Halton carers known to social care rate similar or slightly better than these comparators.

Table 23: Responses to Q7 to 12, 2014/15 Annual Carers Survey

		Halton	North West	England
Which of the following statements best describes how you spend your time?	I'm able to spend my time as I want, doing things I value or enjoy	23.8	20.9	20.4
	I do some of the things I value or enjoy with my time but not enough	62.0	64.9	64.7
	I don't do anything I value or enjoy with my time	14.2	14.1	14.9
Which of the following statements best describes how much control you have over your daily life?	I have as much control over my daily life as I want	30.3	27.1	26.6
	I have some control over my daily life but not enough	59.1	61.8	60.6
	I have no control over my daily life	10.7	11.2	12.9
Thinking about how much time you have to look after yourself - in terms of getting enough sleep or eating well - which statement best describes your current	I look after myself	56.5	58.0	57.5
	Sometimes I can't look after myself well enough	28.2	27.1	27.6
	I feel I am neglecting myself	15.3	14.9	14.9
Thinking about your personal safety, which of the statements best describes your present situation?	I have no worries about my personal safety	86.8	85.7	84.9
	I have some worries about my personal safety	11.7	13.0	13.7
	I am extremely worried about my personal safety	1.5	1.3	1.4
Thinking about how much social contact you've had with people you like, which of the following statements best describes your social situation?	I have as much social contact as I want with people I like	39.2	39.5	38.5
	I have some social contact with people but not enough	47.8	47.1	47.0
	I have little social contact with people and feel socially isolated	13.1	13.4	14.5
Thinking about encouragement and support in your caring role, which of the following statements best describes your present situation?	I feel I have encouragement and support	45.2	40.7	39.7
	I feel I have some encouragement and support but not enough	42.7	42.6	43.3
	I feel I have no encouragement and support	12.1	16.7	17.0
				Source: HSCIC

Table 24: The proportion of carers who reported that they had as much social contact as they would like - carers survey Q11

	Total	Males	Females	18-64	65+
Halton	39.2	37.9	39.8	34.3	44.5
North West	39.5	43.1	37.5	36.9	43.7
England	38.5	40.2	37.7	36.3	40.0

Source: ASCOF: 1I(2) (Carers Survey Q11), HSCIC

A slightly higher percentage of females said they had as much social contact as they wanted. The percentage was greatest amongst older carers. This probably reflects the limited amount of free time working carers have for themselves.

Aggregating data from questions 7 to 12 of the carers survey, a quality of life score can be calculated. Data from 2014/15 (Table 24) shows that overall Halton rates were slightly higher than the North West and England. This includes higher scores for both men and women and for those aged over 65.

Table 25: Carer-reported quality of life score

	Total	Males	Females	18-64	65+
Halton	8.1	8.2	8.1	7.8	8.5
North West	8.0	8.2	7.8	7.8	8.3
England	7.9	8.1	7.8	7.6	8.1

Source: ASCOF 2014/15: 1D (based on Carers Survey Q7-12), HSCIC

3.5.6. Domestic Violence

There is very little research about domestic abuse against carers. Research by Queen's University in Belfast[17] includes case studies from women who experienced domestic abuse from their husband for a number of years then, in later years, became the main carer for their abuser. This potential switch of control in the relationship can lead the carer to experience emotional conflicts such as anger versus feelings of love and sympathy for the abuser. If the abuse continues, this can cause further conflict for the carer between wanting to protect themselves, and any dependent children, versus knowing the abuser is dependent on them for day to day support.

Findings from a study focusing on older female carers[18] supported the need for awareness that ageing caregivers can be placed at risk by verbally and physically abusive behaviours of the elders for whom they provide care.

Both these pieces of research indicate that carers need specialised support if they are in an abusive relationship as the emotional conflict they may experience about being the main, or sometimes only, care giver to their abusive spouse brings with it a raft of additional complexities. In such cases, it is imperative that services work together to support the carer and to ensure safeguarding of the vulnerable perpetrator.

In Halton, the issue of adult safeguarding is taken very seriously, and reports to the Adult Safeguarding Board already include the issue of domestic violence. However, the experiences of carers around domestic abuse have not, thus far, been considered and this may be necessary to ensure that processes and services for carers are delivering the best possible support. Local data on the number of carers subjected to domestic violence is not currently available.

3.5.7. Health and Wellbeing of Young Carers

A Young Carer is a young person (under the age of 18 years of age) who cares for or gives support to someone at home such as their parent, sister, brother, grandparent or a family friend. This care could include looking after someone who is unwell, disabled or has a mental health problem, or providing care for and support to a member of the family affected by drug or alcohol misuse.

Young carers are children and young people who often take on practical and/or emotional caring responsibilities that would normally be expected of an adult. The tasks undertaken can vary according to the nature of the illness or disability, the level and frequency of need for care and the structure of the family as a whole. A young carer may do some or all of the following:

- Practical tasks, such as cooking, housework and shopping
- Physical care, such as lifting, helping a parent on stairs or with physiotherapy

- Personal care, such as dressing, washing, helping with toileting needs
- Managing the family budget, collecting benefits and prescriptions
- Administering medication
- Looking after or "parenting" younger siblings
- Emotional support
- Interpreting, due to a hearing or speech impairment or because English is not the family's first language

Some young carers may undertake high levels of care, whereas for others it may be frequent low levels of care. Either can impact heavily on a child or young person.

Nationally, in 2011, there were 177,918 young unpaid carers (5 to 17-years-old) in England and Wales. Of these, 54% were girls and 46% were boys. Within England, the North West had the highest proportion of young carers providing unpaid care at 2.3% (2.1% of males and 2.5% of females aged 5-17), whereas the South East had the lowest proportion at 1.9%.

An increase in the number of unpaid carers aged 5 to 17 was observed in all regions between 2001 and 2011. In England, the number of young unpaid carers increased by 19.5% during this period. In the North West the increase was 7.2%, a smaller increase but based on a higher baseline level in 2001.

Local authority level data from the 2011 Census is broken down only by broad age bands, 0-15 year olds and 16-24 year olds. It shows that Halton has a slightly higher level of young people who are carers than across the North West and England. This is the case for young carers under age 16 i.e. 0-15 years of age and young adults age 16-24 years of age (unfortunately this national dataset does not provide the ability to show the date by under 18 years of age).

Table 26: Provision of unpaid care by age band, 2011 Census

	All categories: Provision of unpaid care	Provides no unpaid care	Provides unpaid care: Total	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
Halton 0 to 15 year olds	24,927	24,579	348	267	53	28
Halton 16 to 24 year olds	14,493	13,579	914	596	188	130
Percentages						
Halton 0 to 15 year olds		98.6%	1.4%	1.1%	0.2%	0.1%
North West 0 to 15 year olds		98.8%	1.2%	1.0%	0.1%	0.1%
England 0 to 15 year olds		98.9%	1.1%	0.9%	0.1%	0.1%
Halton 16 to 24 year olds		93.7%	6.3%	4.1%	1.3%	0.9%
North West 16 to 24 year olds		94.6%	5.4%	3.8%	0.9%	0.7%
England 16 to 24 year olds		95.2%	4.8%	3.5%	0.8%	0.6%

Source: Nomis, 2014

Halton has a higher number of young carers aged 0-24 than nationally at 8.4% compared to 7.5% across England as a whole (the number of Halton young carers is 1259).

Given that young carers are over twice as likely to live in households where at least one adult has a limiting disability[19] and that there is a high level of limiting disability in the borough this may be an underestimate. Also, as the Census is completed by parents the figures reported may underestimate due to stigma and fear about the perceived consequences of revealing that their child is a carer. Children themselves may not wish to be recognised as a carer for fears of bullying, stigma or

embarrassment. These issues are seen in national surveys and also in the kind of feedback received from Halton young carers and their families. For example, a survey of secondary school children conducted by the the BBC and the University of Nottingham found that 1 in 12 reported caring responsibilities.[20] Applying this figure to the number of Halton residents aged 0-24 would give a figure of 3,276, just over 2.5 times as high as the census indicates.

In 2015/16, there were 520 young people and 0-18 years of age registered in contact with Halton Carers Centre. Data from 2013 showed 109 new young people have been registered as carers within the preceeding year whilst 73 have been deregistered. (48% due to reaching their 18th birthday, 52% due to a change in their circumstances). 57% (number = 196) were female and 43% (number = 152) were males.

Table 27: Residence Location of Young Carers, 2013

Location	Number	Percentage
Runcorn	224	64.4%
Widnes	119	34.2%
Out of Borough*	5	1.4%

*Warrington, Helsby, Liverpool

Table 28: Age profile of Young Carers, 2013*

Age	Halton Number	Halton Percentage	National Percentage (2011 Census)
5-7yrs	8	2	6
8-9yrs	44	13	7
10-14yrs	149	44	41
15yrs	56	16	13
16-17yrs	85	25	33

* 6x DOBs not available at time of writing

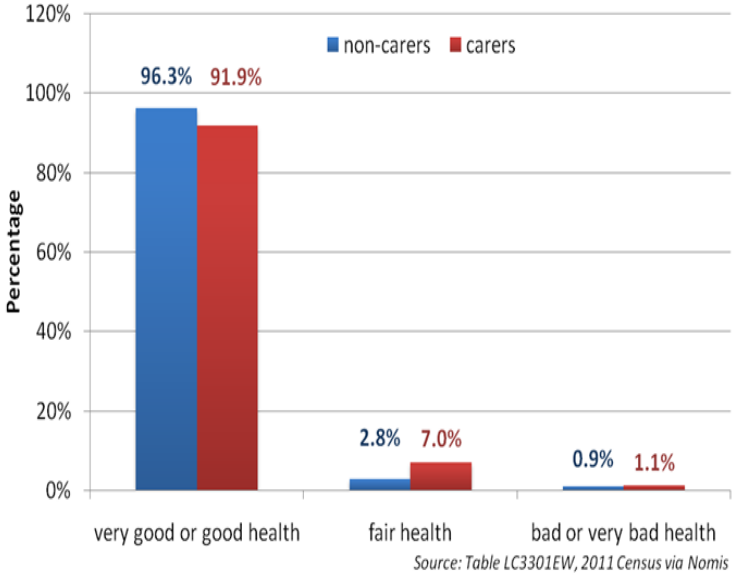
These figures put the rate as a percentage of the overall under-18 population of Halton at 1.2%. The 2011 Census is 1.4% of the 0-15 year old population.

Analysis of Census data also showed that young carers are likely to report that their health is not good compared to their non-carer peers. As the number of hours of unpaid care rose so did the level of self-reported 'not good' health.[21] This is supported by the Longitudinal Survey of Young People in England found that young carers are 1.5 times more likely to have a disability, long-term illness or special educational needs, 1.5 times more likely to be from a black, Asian, or minority ethnic community and twice as likely to not speak English as their first language.[22] Young carersare significantly more likely to grow up in poverty, with all the associated needs and risks this brings. Thus young carers may not only be at greater risk of poor health and risk-taking behaviours during childhood but this may continue into adulthood, further impacting on their lives even if their caring responsibiities change.

Analysis of 2011 Census data for Halton carers aged 0-24substantiates these findings, although not to the same degree.. Levels of good, fair and poor health amongst Halton carers aged 0-24 is broadly similar to that seen by carers aged 0-24 across the North West and England. The most clear disparity can been seen when considering the health of carers aged 0-24 providing different levels of care, with 92% of all Halton carers aged 0-24 having very good or good health compared to 87%

amongst those providing 50+ hours of care per week. Thus the Census data may be showing an under reporting not only of the number of young people providing unpaid care but of the health problems they face.

Figure 15: Health status of Halton residents aged 0-24 providing unpaid care, 2011 Census



Source: Table LC3301EW, 2011 Census via Nomis

	Very good or good health	Fair health	Very bad or bad health
Halton	91.9%	7.0%	1.1%
North West	91.8%	6.7%	1.5%
England	91.3%	7.0%	1.6%

Source: Table LC3301EW 2011 Census via Nomis

	very good or good health	fair health	bad or very bad health
All	96%	3%	1%
non-carer	96%	3%	1%
All carers	92%	7%	1%
1-19 hours	93%	7%	0%
20-49 hours	93%	6%	1%
50+ hours	87%	9%	4%

Source: Table LC3301EW 2011 Census via Nomis

Further impacts were revealed by a study of 15,000 pupils aged 13 and 14:[23]

- Young carers are one and half times more likely to have a special educational need or a long-standing illness or disability
- One in 12 young carers is caring for more than 15 hours per week
- Around one in 20 miss school because of their caring responsibilities
- Young carers have significantly lower educational attainment at GCSE level - the equivalent to nine grades lower overall than their peers
- Young carers are more than one-and-a-half times as likely to be from black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language
- The average annual income for families with a young carer is £5,000 less than families who do not have a young carer
- Young carers are more likely than the national average to be 'not in education, employment or training' (NEET) between the ages of 16 and 19
- Young carers, especially those caring for adults with mental health or substance misuse issues, are likely to go on to become service users themselves. They are also more likely to become known to social care and to become a child in care
- Despite improved awareness of the needs of young carers, there is no strong evidence that young carers are any more likely than their peers to come into contact with support agencies and to become a child in care

Nationally, around a third of young carers are caring for a person with a mental illness. It is likely the actual number is higher and research has suggested that around a third of young carers are involved in inappropriate and excessive caring with consequent knock-on effects on schooling and other areas of their lives.

This information shows that caring responsibilities can place a great deal of pressure on the carer and this can be compounded when the carer is a child or young person. The risks include the risk of truancy, under-achievement, isolation, mental and physical ill health, poverty and stress.

Inappropriate caring tasks can represent a safeguarding concern. It could be inappropriate if a child or young person is undertaking personal care for an adult of the same or opposite gender. This risk is compounded if they are the only person having physical contact with that adult.

Locally, it is important to continue to raise awareness of young carer's identification and needs amongst key workers, together with an improved shared working practice between Adults and Children's services. This together with a proactive approach to 'early help' for the wider family when supporting adults would help embed safer preventative practice with vulnerable families. The Team Around the Family (TAF) division, through IWST, Family Work and Intensive Family Work teams are well positioned to explore such joint working initiatives.

For over a decade, there has been considerable consultation of the needs of young carers and their families. The messages have been very consistent: [24]

- They want time to have fun and socialise, getting breaks from caring.
- They want more help for the person they care for.
- They need to be less isolated and have people they can turn to.
- They need more money in their families.
- They need help at school with attendance, homework, course work and bullying.
- They need to be helped to get the best from learning and work towards an independent future.
- They need to be meaningfully involved in the planning for their cared for person, and given information and knowledge about the practicalities of caring.
- They need emotional support with worry, anxiety and low self-esteem
- They need help planning for and dealing with family crises.

3.5.8. The needs of carers of people with mental ill-health

Caring for someone with mental health needs presents different challenges for their carer compared with a physical illness or disability. These include:[25][26][27][28][29][30]

- The fluctuating nature of poor mental health. The need for, and levels of, support may therefore be unpredictable. Dependence on the carer can be really intense and prolonged at times yet minimal at others
- Poor mental health is not necessarily as evident as a physical health problem or disability, therefore may be less understanding or support forthcoming for the carer as there is with other health conditions
- Because of the stigma surrounding mental ill-health, carers may be less willing to seek support or share with family members and friends. This may mean they have less of a social network to draw on themselves with a resulting risk of poor mental health in the carer themselves
- Many people say dealing with the stigma surrounding mental health is worse than coping with the condition itself
- Carers play a key role in the recovery of people with poor mental health conditions. This is a significant level of responsibility
- Often mental ill-health is associated with other conditions, so this is not the only condition the carer is required to deal with

- There are a number of legal and ethical issues surrounding mental health that can make the role of caring even harder
- Carers need information, advice and support about carrying out their caring role, but also about understanding and coping with mental health conditions. Carers of people with poor mental health are dealing with taking on a caring role as well as learning how to respond to the behaviours and emotions associated with the condition

As a result of these issues, caring for someone with mental health needs may be even more emotionally draining than any other caring role. Family and friends bereaved by a suicide, or affected by those at risk of suicide, are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves. Keeping family and friends informed and providing the relevant advice and support in a timely manner can prevent this.[31][32] Suicide prevention research and recommendations all cite the need to include, support, identify and listen to carers.[33]

The Triangle of Care report[34]emphasises the need for better involvement of carers and families in the care, planning and treatment of people with mental ill-health with the purpose of supporting recovery and sustaining wellbeing of both service user and carer. It was developed to address the clear evidence from carers that they need to be listened to and consulted more closely. The guide outlines key elements to achieving this as well as examples of good practice. Key elements include: The carers involved in patient care are identified as soon as possible.

- Professionals are 'carer aware' and equipped to involve carers effectively
- Protocols are in place regarding the sharing of information and confidentiality
- Specific professional roles are identified with carer responsibility
- Carers are able to meet with staff and are provided with information throughout the care and treatment pathway
- A range of support services are provided for carers

Fundamental to the Triangle of Care approach is the importance of understanding what carers need to carry out their role effectively: skills, information, advice, support, regular breaks. Not just focusing on the impact of the caring role, but the causes of the stresses in the first place. If the right information, advice, support and services are not available then a detrimental effect from the caring role will still ensue.

NICE guideline[35] includes recommendations on the need for mental health services to offer carers of people with psychosis or schizophrenia an assessment of their own needs, provide information about the condition (including negotiation with service users about how their information will be shared), include carers in decision making if the service user agrees and, in addition, advise carers about their statutory right to a formal carer's assessment. The guidance recommends that all carers of people with psychosis and schizophrenia should be offered a carer-focused education and support programme, which may be part of a family intervention, as early as possible. It it likely that the same applies to people caring with other types of mental illness.

There is often a link between mental health and alcohol dependence. The NICE quality standard on alcohol dependence[36] recommends that families and carers involved in supporting a person who misuses alcohol should have the opportunity to discuss concerns about the impact of alcohol misuse on themselves and other family members.

3.5.9. The needs of carers of people with dementia

One in three will care for a person with dementia in their lifetime. A report by the Carers Trust identified a number of critical points along the caring journey where information and support is most valued and needed by carers and what professionals can do to help at these times. It should be noted that these may be quite different to the critical points experienced by the person with dementia in their journey. The critical points for the carer are: [37]

- When dementia is diagnosed
- When the carer takes on an active caring role
- When the capacity of the person with dementia declines
- When the carer needs emotional support and/or a break from caring
- When the person with dementia loses their mobility
- When the person with dementia has other health problems
- When the carer has to cope with behaviour problems
- When the carer's own circumstances change
- When the person with dementia becomes incontinent
- When decisions about residential care and end of life have to be made

What is key at these points is that the carer knows where to go to for advice, knows what support is available, that the professionals they are in contact with are knowledgeable regarding dementia and that they engage with both the carer and the person with dementia and they understand the carers needs and issues not just those of the person with dementia. This research is being cited by Public Health England as a means of mapping the needs of carers of people with dementia

3.5.10. The needs of parent carers

Parent carers look after one or more children with a learning difficulty, a disability and/or an additional need. The role of parent carers blurs between being a parent and being a carer, as parents naturally 'care' for their children. However, parent carers are those that have children that need additional support 'to live ordinary lives' as a matter of course. Similar to other carers, parent carers are not always identified as they are parents first. This is especially true for parents of children that have additional needs who are not eligible for social care, short breaks or a statement of educational need. These are the carers that get the least support and often feel very alone. We do not know how many there are as they are usually unknown to services. However these parents can get support from the voluntary sector, especially parent support groups. 'Disabled children and their families have the same human rights as others, including the right to the same quality of life as those who do not live with disability.

A lack of support can result in parent carers having mental health issues, physical health issues, and relationship difficulties.

3.5.11. The needs of carers of people with a learning disability

Growing numbers of people (with a learning disability) experience a mid-life transition when their parents or family carer's who they have lived with since childhood become too ill to care for them or they die. It is important that carers of adults with a learning disability are supported both emotionally and practically to plan early for this transition. In addition to this, it is important the person with the learning disability's rights to care for their loved one is recognised. Services for the

older person and the person with the learning disability providing the care need to be joined up to ensure the needs of both are met.

3.5.12. The needs of carers for people at the end of life

It is estimated there are around half a million people in the UK at any one time providing care for someone with a life-limiting illness. While the needs of these carers will in many ways be similar to those of other groups of informal caregivers, there are specific issues that face people caring for someone at the end of their life, such as:

- Possible sudden diagnosis and onset of the caring role
- Uncertainty as to the length of time until death
- Likely rapidly changing care needs
- Information needs on the dying process and associated complex medical and nursing care
- Psychological and emotional strain of knowing that they will face bereavement
- Practical and emotional issues at the time around the death, and in the months and years following bereavement

In common with other groups, people caring for those at the end of life may not identify themselves as 'carers' and so may be unaware of, or reluctant to access, available support. The National Palliative Care Policy is based around a strong preference for death at home. In order to achieve this supporting the needs of family carers is paramount.

The 2015 Marie Curie report[38] on the impact of caring for someone with a terminal illness concluded that carers of people with a terminal illness face significant challenges to getting the high quality and timely support that should be available to them, both while they are caring and after bereavement. These challenges include:

- not having their needs recognised by support services
- not being supported to look after their own health, wellbeing and finances, and not knowing where to find support when they need it
- a lack of help with preparing for the future, both following their loved one's diagnosis and after bereavement'

The report recommends the following fundamental principles that should underpin the support available to carers of people with a terminal illness:

- People who provide care for someone who is approaching the end of their life have specific needs, which should be assessed as a matter of priority
- Information for carers should be available and accessible in a form that is most useful to them
- Carers are not trained professionals, and they should not be expected to behave as such
- Carers should be treated sensitively by professionals and, where appropriate, provided with training and support to help them look after their loved one and themselves
- No one providing care to a loved one with a terminal illness should suffer financial hardship as a result of their caring role
- Health and social care professionals need to be ready and able to help carers identify themselves in this role and to plan for their future. This must include a sensitive

explanation of what supporting a death at home entails, and a recognition that carers' needs will often continue after bereavement

Carers in the end of life context often describe three priority areas of need:

1. Practical help as a co-worker e.g. with turning bed-bound patients, or with symptom relief
2. Information as to what is likely to happen as the illness progresses and the likely consequences
3. Allocated professional time for attending the patient to allow the carer to have respite from their role

More personal support, such as addressing spiritual, psychological and emotional needs is reported to be less valued. Qualitative data suggest that carers often find it difficult to focus on their personal needs, as they perceive that such focus will take professional time and resources away from the person cared for. The Department of Health End of Life Care Strategy 2008 highlighted the importance of considering carers' opinions and needs, and commissioned the Office for National Statistics to conduct the VOICES (views of informal carers for the evaluation of services) survey since 2011. Analysis of the combined 2012 and 2013 results by NHS Area Team shows that the Merseyside had a higher percentage of respondents stating that they were given enough help and support by the healthcare team at the actual time of death of their loved one; 62.3% compared to 60.1% nationally although the difference was not statistically different. When considering whether the carer felt they were as involved in decisions about their loved ones care as they wanted to be, a slightly lower proportion in Merseyside answered yes compared to England, 76.2% compared to 77.9%. Again the differences were not statistically different. Analysis at a national level also highlighted significant inequalities in the standard of care and support provided, both by geography/socio-economic status and by cause of death of the loved one.

The impact on carers' health and wellbeing

Caring for a loved one, who is dying, carries with it the same risks to the carer's health and wellbeing as in other care situations, but with the additional strain of coping with an impending death. This is likely to have an impact on the physical health and wellbeing of the carer. For example elderly carers for heart failure patients who have pre-existing health problems of their own, are more likely to experience deteriorating health.[39] In addition, there is a suggestion that the greater the strain and burden reported, the more likely the carer's physical and mental health will have deteriorated. It should not be forgotten that there are positive aspects to a caring role; caring for a loved one when they are most vulnerable can be a valuable experience, potentially boosting self-esteem, confidence and assertiveness and reinforcing relationship bonds. There is little evidence that discrete 'carer support' services within palliative care are necessary; instead, repeated checking of carer needs by those providing 'usual care' in an end of life context is thought to be helpful. The evidence base for specific interventions to improve the health and wellbeing of carers is weak.

Bereavement

Inevitably, carers of people who are dying will have to face bereavement and a change in their role. Bereavement has long been recognised as a risk factor for poor psychological and physical health. Research shows that there is an early increased risk of death from a variety of causes, including

suicide and 'dying from a broken heart' – meaning the psychological distress, loneliness and secondary consequences of loss such as changes in eating habits, economic status and social support. A few authors have found this risk to persist after six months. The recently bereaved are also more likely to have physical health problems; widowed people in general consult with their GP more frequently than the non-widowed, but also may be less likely to consult when they need to. This indicates that there is likely to be significant met and unmet need in terms of the physical and mental health of the recently bereaved, particularly those bereaved of spouses.[40]

The evidence suggests that it is neither necessary nor desirable for all bereaved people to undergo 'bereavement counselling'. Around 85% of bereaved people will manage their own path through grief using existing social support. 5% will need specialist help to manage their extreme grief reactions, and the remaining 10% need something in between, such as a befriending or counselling service.[41] However there are no reliable tools for identifying which group an individual falls into and so a network of universally available first-line services is necessary to allow people to access care if they feel they need it.

3.5.13. Other specific groups

This chapter is not exhaustive, only having picked out a few specific groups of carers. Other groups not covered in any detail in this JSNA may have needs which are different from others because of their caring situation, for example so-called 'Sandwich' Carers' who care for people of different generations, for example, caring for a disabled child (of whatever age) and also an elderly parent.

4. Service provision and uptake

4.1. Service Provision

4.1.1. Adult Social Care

The Care Act gives local authorities the responsibility to assess a carer's needs for support. The assessment looks at how caring has an impact on an individual, what support they may need if they want to carry on caring, and what they want to achieve in their day to day life. At the end of the assessment a support plan will be agreed. The support plan will include how a persons needs are going to be met and, if a direct payment is to be made, how much it will be and how often it will be paid. In Halton, these statutory assessments are carried out by the borough council's care management teams

4.1.2. Halton Carers Centre

Halton Carers Centre provides a range of both universal and targeted services for carers.Commissioned jointly by Halton Borough Council and NHS Halton CCG, the centre aims to improve the quality of life for carers and to prevent or delay peoples need for care and support.

As a primary point of contact for carers in the borough, Halton Carers Centre will:

- Increase the number of carers known to them, particularly within underrepresented groups
- Work with a range of local agencies and initiatives to promote and improve carers' health and well-being
- Provide advice and information which supports carers to make informed choices about issues such as; the care and support which is available; their health and well-being; the types of home equipment, telehealth and telecare facilities that are available; and any changes in the welfare benefits system that may have an impact on them as a carer
- Ensure that carers are an integral part of the design, delivery and quality assurance of both the Carers Centre and health and social care services
- Commission community based peer support groups that help carers to cope with their caring responsibilities and alleviate some of the isolation they experience
- Ensure intensive, short term support is provided where there is a high risk of 'carer breakdown'
- Co-ordinate, provide and publish a programme of training for carers and health and social care professionals
- Offer a range of volunteering opportunities for carers, ex-carers and members of the local community
- Provide an advocacy service that ensures that carers' are assisted and enabled to say what they want, to secure their rights, to represent their interests and to obtain the services they require

From 1st April 2015 to 31st March 2016 Halton Carers Centre registered **1,009** new carers (776 adult carers & 233 young carers). **1,630** carers were deregistered (1,452 adult carers, 178 young carers) due to their caring role ending. This means from 1st April 2016 there were **5,263** carers registered with the centre (4,743 adult carers and 520 young carers).

Table 29: Age breakdown of Carers registered with Halton Carers Centre 2015/16

Age group	Number
5-18	520
19 – 25	266
26 – 34	432
35 – 45	621
46 – 54	1096
55 – 70	1448
70 plus	880
Total	5,263

Source: Carers Centre

All carers (5,263) received the newsletter and 5,106 had a service from the centre in the year. Services include review, information and advice, advocacy, referral/signposting to another service, trips, training, forums, therapies and podiatry.

Postcode level data was only available for 1,846 carers, 488 providing 49 hours of care a week or less and 1358 providing 50+ hours. This constitutes significantly different relative proportions than in the Census which showed 69.9% of unpaid carers provideding 1-49 hours of care per week and 30.4% providing 50+ hours. This compares to 73.6% of the postcode level data being for carers providing 50 or more hours care per week. Indeed, data for June 2015[42] shows this is similar to the total Carer's Centre users.

Table 30: Breakdown of hours care provided by adult users of the Halton Carers Centre, as at June 2015

Hours per week	Numbers	Percentage
1 to 19	436	9.3%
20 to 49	1,037	22.1%
50+	3,217	68.6%
Total	4,690	100%

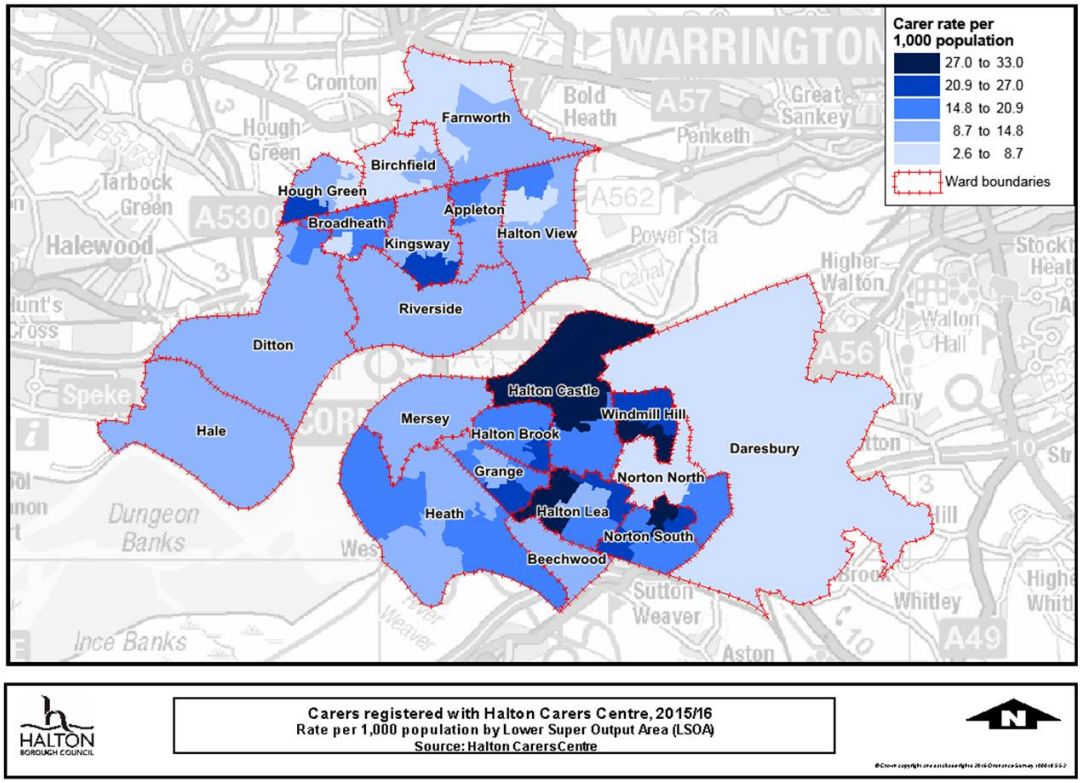
Source: Halton Carers Centre

Of note is that the Census showed 4567 Halton carers stating they provided 50+ hours care per week with the Carers Centre having some level of contact with 3,217 cares providing 50+ hours per week.

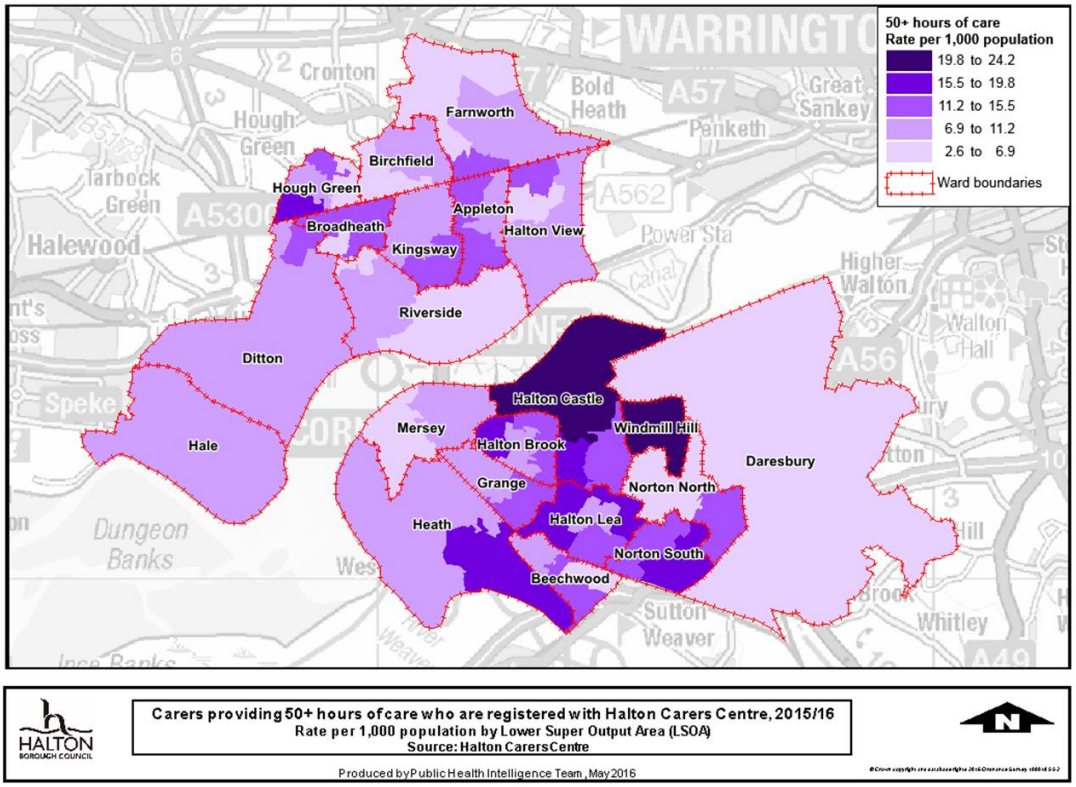
The geographical spread of carers accessing the Carers Centre is fairly similar to that identified earlier from the 2011 Census analysis. There is a slightly higher rate of carers providing any level of care accessing the Carers Centre from Halton Castle, Halton Lea and Windmill Hill than indictated in the Census. However, as particular deprived areas of the borough, this may reflect carers with particular need. When considering only those carers who provide 50+ hours of care a week, the gepgraphical spread is similar to the Census picture.

Figure 16: Location of carers accessing Halton Carers Centre: all carers and those providing 50 or more hours of care per week

All Carers



Carers providing 50+ hours/week



4.1.3. Community Based Support

Each year, small community groups and local organisations apply to the directorate for a small amount of funding to support carers. In their application, groups should be able to demonstrate how they will increase the number of Carers known to them; support individuals to have a life outside of caring and have a positive impact on carers well being.

At present 17 groups and organisations receive funding supporting people caring for individuals with dementia, learning disability, autism, substance misuse, stroke, mental health and physical disability.

4.1.4. Support from GPs

As at December 2015 there were 1,590 people registered with Halton GPs who were known to be carers. This represents just 10.6% of the total number of carers identified in the 2011 Census. This is based on the influenza vaccination return and so will not include those aged 65 and over. Thus it under-represents the true picture, despite this, does show a considerable variation from the census figures.

Table 31: Number of patients registered as carers, 2014/15, per GP practice

Practice code	Practice	No. of patients registered as a carer
N81035	Appleton	76
N81011	Beaconsfield	177
N81096	Brookvale	77
N81019	Castlefields	127
N81066	Grove House	145
N81618	Heath Road	15
N81119	Hough Green	49
N81072	Murdishaw	95
N81064	Newtown	82
N81619	Oaks Place	55
N81045	Peelhouse	272
N81037	The Beeches	51
N81057	Tower House	118
N81651	Upton Rocks	35
N81054	Weaver Vale	119
N81625	West Back	25
Y02512	Windmill Hill	72
01F	Halton CCG	1590

Source: NHS England and HSCIC

Despite this low figure a considerable proportion of respondents to the annual GP survey stated they had caring responsibilities

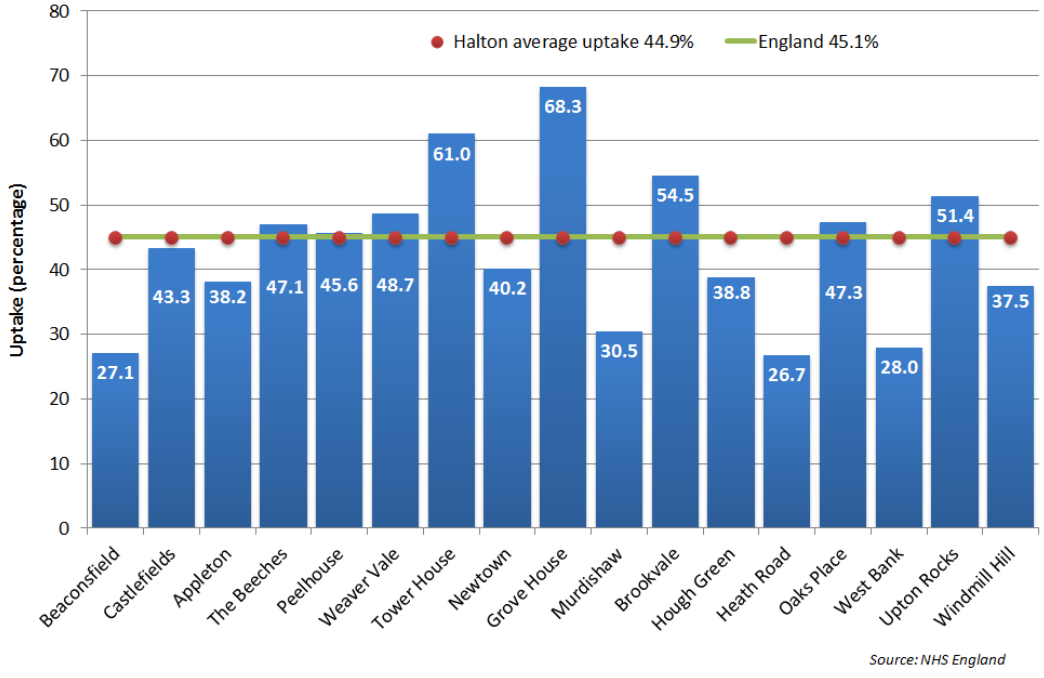
Table 32: Percentage of respondents to the GP survey stating they have caring responsibilities, GP practice, Halton CCG and England, 2011/12 to 2014/15

Practice Code	Practice Name	2012/13	2013/14	2014/15
N81035	Appleton	28.9	22.0	22.1
N81011	Beaconsfield	22.8	13.7	31.4
N81096	Brookvale	21.2	23.8	22.4
N81019	Castlefields	24.1	20.1	25.7
N81066	Grove House	21.9	29.2	25.8
N81618	Heath Road	15.0	17.8	22.0
N81119	Hough Green	28.1	18.6	14.1
N81072	Murdishaw	19.9	23.2	27.3
N81064	Newtown	17.7	28.5	20.4
N81619	Oaks Place	19.6	12.1	22.4
N81045	Peelhouse	20.7	16.9	18.8
N81037	The Beeches	24.2	23.5	14.1
N81057	Tower House	22.8	19.5	25.7
N81651	Upton Rocks	29.2	25.7	25.1
N81054	Weaver Vale	18.5	21.3	21.2
N81625	West Bank	22.5	20.8	19.5
01F	Halton CCG	22.3	21.0	22.8
England		18.6	18.4	18.2

NB: no data for Windmill Hill — *Source: GP survey via PHE*

Despite both the Royal College of General Practitioners[43] and NHS England[44] recognising the vital role than carers play and the impact this role can have on their health, there is vitually no routinely collated data on the health status of carers from either GP records or that can be gleened from hospital admisisons. The only data available is that relating to annual influenza vaccinations. In regognition of the need to support carers to remain health, all registered carers, irrespective of their age, are eligible for a free influenza (flu) vaccination. Data for 2014/15 shows only 44.9% of Halton eligible carers (aged under 65 years, not at-risk, not pregnant and fulfils the 'carer' definition) received their vaccination, slightly lower than the England figure.

Figure 17: uptake of influenza vaccination amongst Halton eligible carers, 2014/15, per GP practice



4.2. Carers assessments

There has been an increase in the number of carers receiving an assessment over the last three years.

Table 33: Number of carers assessments

2012/13	Number
Carers Assessed	1044
Number Assessed who were assessed in 2013/14	512
Total number Assessed who were assessed in 2014/15	380
2013/14	
Carers Assessed	1128
Total number Assessed who were assessed in 2012/13	516
Total number Assessed who were assessed in 2014/15	529
2014/15	
Carers Assessed	1166
Total number Assessed who were assessed in 2012/13	380
Total number Assessed who were assessed in 2013/14	527

Source: Care First 6, Halton Borough Council

There have been substantially more women receiving a carers assessment than men for the last three full reporting periods, with the difference being more marked amongst carers aged 18-64. For both male and females carers aged 18-64, mental health is the primary support reason of the person cared for, followed by physical support. Whilst the numbers vary year on year, this pattern is consistent. However, for carers aged 65+, physical support is the primary need, reflecting the development of multiple long term condtions and the effects of ageing.

Table 34: Carer assessments, gender, age group and primary support reason[iii]

Carer Age Group - 18-64	2012/13		2013/14		2014/15	
	Male	Female	Male	Female	Male	Female
Total Number of Carers Assessed	193	452	191	368	239	542
Of Which Total Number of Carers Assessed and with Services	166	376	178	342	206	463
Prime/Primary Support Reason of Person Cared For:-						
Learning Disability	<10	44	10	72	<10	<10
Physical Support	79	170	72	125	<10	16
Mental Health	80	163	102	161	<10	<10
Social Isolation	<10	<10	<10	<10	<10	<10
Unknown	27	73	<10	<10	213	509
Carer Age Group - 65+	**2012/13**		**2013/14**		**2014/15**	
	Male	Female	Male	Female	Male	Female
Total Number of Carers Assessed	151	234	174	380	151	232
Of Which Total Number of Carers Assessed and with Services	112	185	135	304	131	183
Prime/Primary Support Reason of Person Cared For:-						
Learning Disability	<10	11	<10	<10	0	0
Physical Support	84	141	122	291	19	42
Mental Health	29	46	40	65	<10	<10
Social Isolation	<10	<10	<10	<10	<10	<10
Unknown	30	34	<10	11	129	183

NB: figures under 10 (<10) supressed for confidentiality

Source: Care First 6, Halton Borough Council

iii There were a small number of records each year for which the age of the carer was not recorded. When broken down by gender all figures are under 10 and so are not reported in Table 29

4.3. Service Uptake and Outcomes

Data for 2014/15 shows that those receiving carer-specific services in Halton are more likley to receive self-directed support and direct payments that those across the North West and England as a whole. The differences are substantial and apply to carers at all ages.

Table 35: Proportion of carers receiving carer-specific services in the year to 31 March who received self-directed support and direct payments

		Halton	North West	England
Proportion of carers who received self-directed support	Total	**98.5**	**75.6**	**77.4**
	Carers under age 65	99.5	77.1	81.1
	Carers aged 65-84	95.9	72.7	73.1
	Carers aged 85+	100.0	76.6	68.0
Proportion of carers who received direct payments	Total	**98.5**	**67.3**	**66.9**
	Carers aged 64 and under	99.5	71.8	72.5
	Carers aged 65 to 84	95.9	61.5	60.5
	Carers aged 85 and over	100.0	54.5	51.6

Source: ASCOF 2014/15: 1C(1B) & 1C(2B), HSCIC

Less than half of all carers known to adult social care were staisfied with their experiecne of care and support. Men were slightly more satisfied than women with no differences by age. Whilst these figures may appear low they are higher than the North West and England. It would be helpful to understand why levels of satisfaction are so low.

Table 36: Proportion of respondents who were satisfied with their experience of care and support

	Total	Males	Females	18-64	65+
Halton	48.9	51.6	47.5	49.4	50.0
North West	42.9	45.5	41.5	41.6	44.9
England	41.2	43.3	40.2	38.8	43.6

Source: ASCOF 2014/14: 3B, HSCIC

A greater percentage of Halton carers known to adult social care received emergency breaks or breaks for more than 24 hours. In terms of the person they care for, there was less use of personal assistants, home care/home help, day centres, use of equipment or adaptations and permanent residence in a care home. Conversely, there was a greater percentage using meals servcies, lunch clubs and Lifeline Alarm.

Table 37: Services Halton carers received from Halton Borough Council, 2014/15

		Halton	North West	England
Carer received services to provide a break from caring at short notice or in an emergency	*Yes*	*20.4*	*14.9*	*16.1*
	No	76.3	82.0	81.1
Carer received services to provide a break from caring for more than 24 hours	*Yes*	*27.8*	*21.5*	*22.3*
	No	70.5	76.3	75.8
	Don't know	1.8	2.1	1.8
Carer received services to provide rest from caring for between 1 and 24 hours (e.g. sitting service)	*Yes*	*22.3*	*19.4*	*24.6*
	No	76.6	78.4	73.3
	Don't know	1.1	2.1	2.1
Person cared for has used a personal assistant	*Yes*	*12.5*	*13.7*	*14.8*
	No	86.7	84.5	83.5
	Don't know	0.8	1.8	1.8
Person cared for used home care/home help	*Yes*	*25.4*	*35.3*	*40.6*
	No	73.9	63.7	58.4
	Don't know	0.7	0.9	1.0
Person cared for used a day centre or day activities	*Yes*	*21.2*	*26.6*	*29.8*
	No	78.4	72.6	69.3
	Don't know	0.4	0.8	0.9
Person cared for used a lunch club	*Yes*	*6.6*	*3.1*	*3.8*
	No	92.7	96.0	95.1
	Don't know	0.8	0.9	1.1
Person cared for used Meals Services	*Yes*	*7.3*	*3.9*	*5.5*
	No	92.0	95.0	93.5
	Don't know	0.8	1.1	0.9
Person cared for used equipment or adaptation to their home (such as a wheelchair or handrails)	*Yes*	*56.8*	*57.5*	*59.8*
	No	42.5	41.9	39.5
	Don't know	0.7	0.6	0.7
Person cared for used Lifeline Alarm	*Yes*	*37.0*	*33.8*	*36.6*
	No	62.0	65.2	62.3
	Don't know	1.1	1.0	1.0
Person cared for permanently resident in a care home	*Yes*	*8.1*	*8.4*	*10.0*
	No	91.5	91.0	89.3
	Don't know	0.4	0.6	0.7

Source: HSCIC

The majority of Halton carers reported that they had been included in discusssions about the person they care for, slightly more women tna men and higher percntages than the North West and England averages.

Table 38: The proportion of carers who report that they have been included or consulted in discussion about the person they care for CSQ15

	Total	Males	Females	18-64	65+
Halton	**78.8**	77.9	79.2	78.6	78.3
North West	**71.6**	71.7	71.5	72.4	71.6
England	**72.3**	71.7	72.7	71.6	72.9

Source: ASCOF 2014/15: 3C (Carers Survey Q15), HSCIC

A substantially higher proportion of Halton carers reported findings information about support available to them was fairly or very easy.

Table 39: The proportion of carers who find it easy ('very easy' or 'fairly easy') to find information about support (CS Q13)

	Total	Males	Females	18-64	65+
Halton	81.5	88.5	78.2	78.1	85.9
North West	68.2	69.6	67.5	65.8	72.2
England	65.5	67.2	64.8	61.2	69.8

Source: ASCOF 2014/15: 3D(2) (Carers Survey Q13), HSCIC

5. User views

National Views of Carers

A national surveyof 4,500 carers showed that more than 82% of carers feel that caring has a negative effect on their health, 2% more than in 2014[45]

- 74% of carers find it difficult to get a good night's sleep as a result of caring, 5% more than 2014
- Nearly half (47%) struggle to maintain a balanced diet
- Four in ten (41%) have experienced an injury or their physical health has suffered as a result of caring
- 84% said that they feel more stressed, 78% said they feel more anxious, and 55% reporting that they have suffered from depression as a result of their caring role – significantly more than in 2014
- Over three quarters (76%) of carers responding to our survey are concerned about the impact of caring on their health over the next year
- Well over half (62%) of those carers who are struggling to make ends meet said they were cutting back on seeing friends or family to save money.
- Over half (53%) of respondents said that they are concerned about the impact of caring on their relationship with the person they care for over the next year and 3 in 5 (61%) are worried about the impact their caring role will have on relationships with their friends and family over the next year
- 45% said that financial worries were affecting their health. Over half (52%) were worried about the impact of cuts to social security over the next year and a similar number (54%) were worried about their finances
- 60% of working carers were worried about their ability to remain in work
- Over half (53%) of carers responding to our survey have experience of social care services such as home care or respite care. Of these, over a quarter (27%) of carers with experience of social care services such as home care or respite report positive experiences. However, worryingly, a third (33%) said that they had refused or stopped using a service altogether because of concerns over quality

The Carers Manifesto 2014[46] set out what good support would mean for carers and what they want. It identified the following;

In terms of income and finances, carers want:

- To be able to maintain financial resilience which enables them to have a life alongside caring and which means they aren't left in debt, with little or no savings and facing financial hardship into retirement
- For carers' benefits to recognise their huge contribution to society rather than highlight how poorly valued they are
- A social security system which supports rather than prevents carers working or studying alongside caring
- For all financial support to rise with the cost of living and for the additional costs of caring in household bills and transport costs to be recognised through additional support

In terms of health and care, carers want:

- Good quality, reliable and affordable care services which enable them to have a life alongside caring
- Health and care services which recognise carers as expert partners in care
- Health services which recognise that carers' have their own health needs and provide flexible support which proactively seeks to reduce carer ill-health
- Reform of funding for social care

In terms of employment and training, carers want:

- To have access to good quality, reliable and affordable replacement care services so they can have confidence in the care being provided whilst they are at work
- Flexible, understanding employers who recognise the value of supporting carers to combine work and caring
- Rights at work which recognise and value caring as much as other family responsibilities and allow carers time off to care
- Support to return to work when caring comes to an end
- A benefits system which supports carers to work or study alongside caring, rather than makes it harder

In terms of recognition, information and advice, carers want:

- Their role to be recognised and respected as a crucial part of society
- Government and the media to proactively combat myths about families receiving disability and carers benefits
- Advice, information and support to be easily accessible wherever carers are, rather than them having to seek it out. Health and social care professionals, workplaces and community settings should work to identify carers and guide them to support
- Caring to be given the same political and economic prominence as becoming a parent – so that 'supporting families' financially, through services and in workplaces is not just about childcare but about caring across the life course

6. Future Demand – Projecting Number of Carers and Support Needed

In England and Wales, the number of people reporting that they were an unpaid carer as part of teh census increased from 5.2 million to 5.8 million between 2001 and 2011. The greatest rise has been amongst those providing over 20 hours care, which can have a significant impact on the health and wellbeing of the carer, including their ability to retain paid employment alongside their caring responsibilities. It is predicted that the number of carers will increase significantly to 9 million by 2037.

The number of carers in the borough and their needs are likely to change dramatically over the next ten years and beyond. Population changes will mean that there will be an increasing number of people that will require support from a carer. Below highlights the changing population demographics and how this will have an impact.

6.1. Increase in Ageing Population

The number of people aged over 65 in the borough is expected to increase by 42% between 2012 and 2037 This means:

- There will be an additional 14,123 people aged over 65 by 2037
- The greatest proportion increase is anticipated to occur in the 85 and over, age group where an additional 4,305 people are expected to be residing in the Bbrough by 2019 (a 67% increase)
- By 2037 the overall older people's dependency ratio on those of working age in Halton will be larger than the child dependency ratio

The implications of an ageing population are three fold in relation to carers:

- There will be more people requiring caring support because of age-related conditions
- There will also be potentially more old carers, who will have their own needs to meet also and thus may find it more difficult to care for others
- The older people's dependency ratio will potentially mean that there are less working age people available to provide the carer support

6.2. Increase in dementia prevalence

A particular issue for Halton will be dealing with the rising rates of dementia. In 2015 the number of people suffering from dementia in Halton is estimated to be 1,343 of which 893 are known to services (based on GP registers 2014/15). This is expected to rise to 2,262 by 2030. Of this figure around 11% of cases are expected to be severe. During the later stages of ageing the problems of dementia increase rapidly. The future expansion of services for dementia sufferers and their carers will present special challenges to the health and social care system, particularly where a greater proportion of the population are able to remain living in their own homes for longer.

6.3. Increase in survival rates

More people are living longer and surviving with chronic diseases and complex care needs. This requires a different approach to longer term care and a new way of supporting people to manage illness. The impact in Halton is likely to be greater than national as the borough currently experiences high levels of poor health. Areas with previously poor health are characterised by an effect described as "adding years to life but not life to years", which points out the impact of people growing old with long-term limiting conditions. Life is prolonged but without health improvement, resulting in an associated demand for all health and social care services. The level of disability free life expectancy at age 15, 50 and 65 is lower in Halton than the North West and England.

6.4. Increase in numbers with long term conditions, including multiple conditions

In England, more than 15 million people have a long term condition (LTC) - a health problem that can't be cured but can be controlled by medication or other therapies. This figure is set to increase over the next 10 years, particularly those people with 3 or more conditions at once. One in three people are living with at least one chronic condition, such as hypertension, diabetes or depression. By 2018 nearly three million people, mainly older people, will have three or more conditions all at once. Data for Halton[iv] shows that not only does the borough have higher prevalence of each of the main long term conditions but, based on current prevalence rates, the numbers are predicted to rise as the population ages. The borough also has a higher proportion of its population with multiple long-term conditions than the national average. All of these factors will have an influence on the need for more people to take on unpaid carer roles. Data earlier in this report also shows that unpaid carers in Halton themselves are more likley to have limiting life-long conditions. This makes it especially important to ensure the health and support needs of unpaid carers adequatey addressed.

6.5. Patterns of care home admissions

In line with national policy there has been substantial efforts made to support people to be able to reamin independent, living in their own homes. The Halton Care Homes JSNA shows that despite an increase in the older population, i.e. those aged 65 and over, the rate of admissions to care homes has remained steady. However, even with a constant prevalence rate the numbers entering care homes will increase as the number of older people in our population increases.

6.6. Potential decrease in people undertaking caring roles

While the number of people needing care is set to rise, social trends could, in the future, have an effect on the number of available carers. The growth in the number of lone parents, falls in birth rates, higher divorce rates, the increase in the numbers of people living alone and greater family mobility may all have an impact on the numbers of people available to assume a caring role. In addition, the growing number of women who are employed outside the home will have implications for the number of carers, since women have traditionally fulfilled the caring role.

iv. See Long Term Conditions JSNA chapters: Long term conditions, cardiovascular disease, diabetes, respiratory health and others at http://www4.halton.gov.uk/Pages/health/JSNA.aspx

6.7. Welfare reforms and public sector funding reductions

Welfare reforms and a significant reduction in public sector funding are increasingly creating significant challenges. Welfare reforms are having a direct impact on carers through reductions in housing, welfare and benefits support to themselves and individuals with disabilities / caring needs exacerbating existing financial pressures. In addition, an increasing demand for support services alongside a significant reduction in public sector funding means that services to support carers and those that they care for are likely to be reduced. This is likely to mean increased reliance on unpaid carers to provide services that would previously have been provided by the formal care system, putting extra strain on carers.

7. Best practice interventions

There are a number of national sources of evidence and guidance on the types of services, support and interventions that have a positive impact on carers. Below is a brief summary of the evidence.

The Carers Trust

The Carers Trust provides extensive resources for the effective commissioning of services to support carers. The Carers Hub (below) is an interactive model based on the outcomes of the National Carers Strategy for England and contains practical guidance and innovative examples of service design and delivery.

The Royal College of General Practitioners (RCGP) Guidance

The RCGP recommends that all carers routinely receive an assessment from their GP in relation to their health and wellbeing. They provide a range of evidence based resources to help GPs and primary healthcare staff in their support of people with caring responsibilities.

The RCGP, in collaboration with NHS England and NHS Improving Quality, also regularly facilitates Carers Evidence Summits, which identify best practice examples of what is working well for carers across the UK, with topics including:

- Carers' break - health and wellbeing
- Carer support
- Dementia
- Eating disorders and substance abuse
- Education, information and signposting
- End of Life Care
- Identification and recognition
- Mental health
- Young carers

Carers UK

A systematic review of interventions directly targeted at carers was undertaken to support local commissioning of services.[47] The review included those concerned with supporting carers to access services; those targeted at carers' physical health; interventions focused upon emotional and social support; education and training for carers; employment-related interventions; and carer breaks.

The Royal College of Nursing (RCN)

The RCN provides a wealth of guidance, information and support for carers, those working with carers and those commissioning services to support carers. Assessment tools, strategies and information documents are available.

National Institute for Health and Social Care Excellence (NICE) Guidance

NICE provides specific guidance identifying recommendations for carers including:

- (CG185, 2014) NICE recommends that carers of people with bipolar disorder are offered an assessment, provided by mental health services, of their own needs and discuss with them their strengths and views.

- (CG178, 2014) In their updated guidance on treating and managing psychosis and schizophrenia in adults, NICE recommends that carers' needs should be assessed to ensure they get the right level of support.

- (CG42, 2012) In their guidance for supporting people with dementia and their carers, NICE recommends that wherever possible and appropriate, agencies should work in an integrated way to maximise the benefit for people with dementia as well as their carers.

Department of Health Guidance: School Nurse Programme

The Government provides evidence around what works locally in providing seamless support and local solutions to support the health and wellbeing of young carers.

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REPORT TO: Executive Board

DATE: 15 September 2016

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Halton Affordable Warmth Strategy 2016-2020

WARD(S) Borough wide

1.0 **PURPOSE OF THE REPORT**

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

2.0 RECOMMENDED: That the Board approve the Affordable Warmth Strategy and support the implementation of the Action Plan.

3.0 SUPPORTING INFORMATION

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

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

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

3.4 Fuel Poverty can be caused by three main factors:

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

- Low household income.

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

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

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

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

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

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

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

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

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

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

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

To achieve this, we will:

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

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

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

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

- produce and regularly update a directory of affordable warmth related services within Halton and beyond

- make this directory accessible to all relevant agencies
- work with the 'external funding team' to identify and secure external funding to tackle fuel poverty
- ensure that this information is disseminated to all relevant partners working with people who are vulnerable to the cold.

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

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

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

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

4.0 POLICY IMPLICATIONS

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

5.0 OTHER/FINANCIAL IMPLICATIONS

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

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

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

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

6.2 Employment, Learning & Skills in Halton

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

6.3 A Healthy Halton

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

6.4 A Safer Halton

None.

6.5 Halton's Urban Renewal

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

7.0 RISK ANALYSIS

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

8.0 EQUALITY AND DIVERSITY ISSUES

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

9.0 REASON(S) FOR DECISION

To provide a co-ordinated approach to reduce harms from fuel poverty in Halton.

10.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

None.

11.0 IMPLEMENTATION DATE

15 September 2016.

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

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

Halton Affordable Warmth Strategy

2016 -2020

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

Table of Contents

Foreword

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

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

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

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

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

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

Executive Summary

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

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

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

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

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

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

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

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

Introduction

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

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

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

Our Vision, Outcomes and Objectives

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

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

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

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

2. Reduce inequalities and protect the vulnerable.

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

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

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

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

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

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

What is Fuel Poverty?

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

How many households are in Fuel Poverty?

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

In 2013:

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

What causes Fuel Poverty?

Fuel Poverty can be caused by three main factors:

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

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

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

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

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

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

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

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

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

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

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

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

For adolescents and young people,

- Fuel poverty can lead to poor mental health.

For adults, Fuel Poverty can:

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

We also know that:

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

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

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

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

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

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

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

What is the Cost of Fuel Poverty?

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

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

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

Return on investment

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

Policy Drivers

National policy context

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

Table 1: National Policies Underpinning Fuel Poverty

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

Local policy context

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

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

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

Links to local strategies

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

Figure 1: Affordable Warmth and associated local strategies

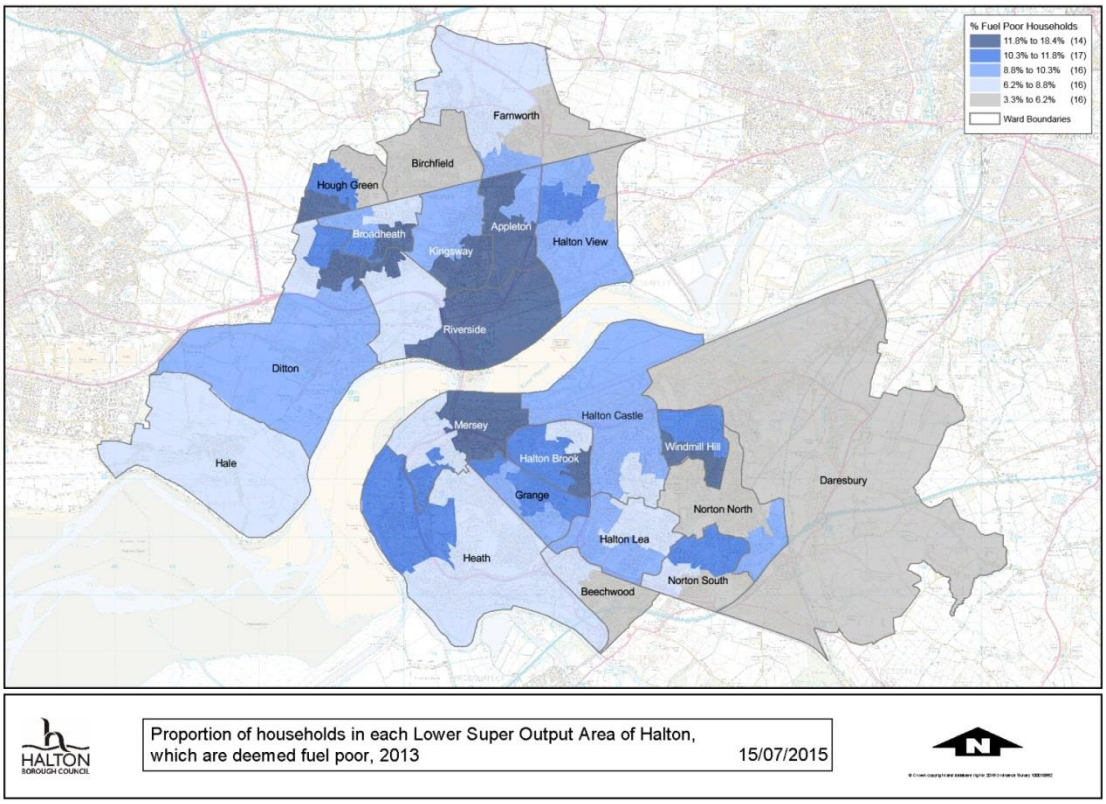
About Halton

Fuel Poverty in Halton

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

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

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



Source: Department of Energy & Climate Change

Fuel Poverty Risk Factors in Halton

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

Population estimate (2012)

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

Deprivation, Income and poverty

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

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

Health Status

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

Housing in Halton

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

Occupancy level

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

Housing Tenure and Decent homes

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

Data from the 2009 Halton Stock Condition Survey showed that:

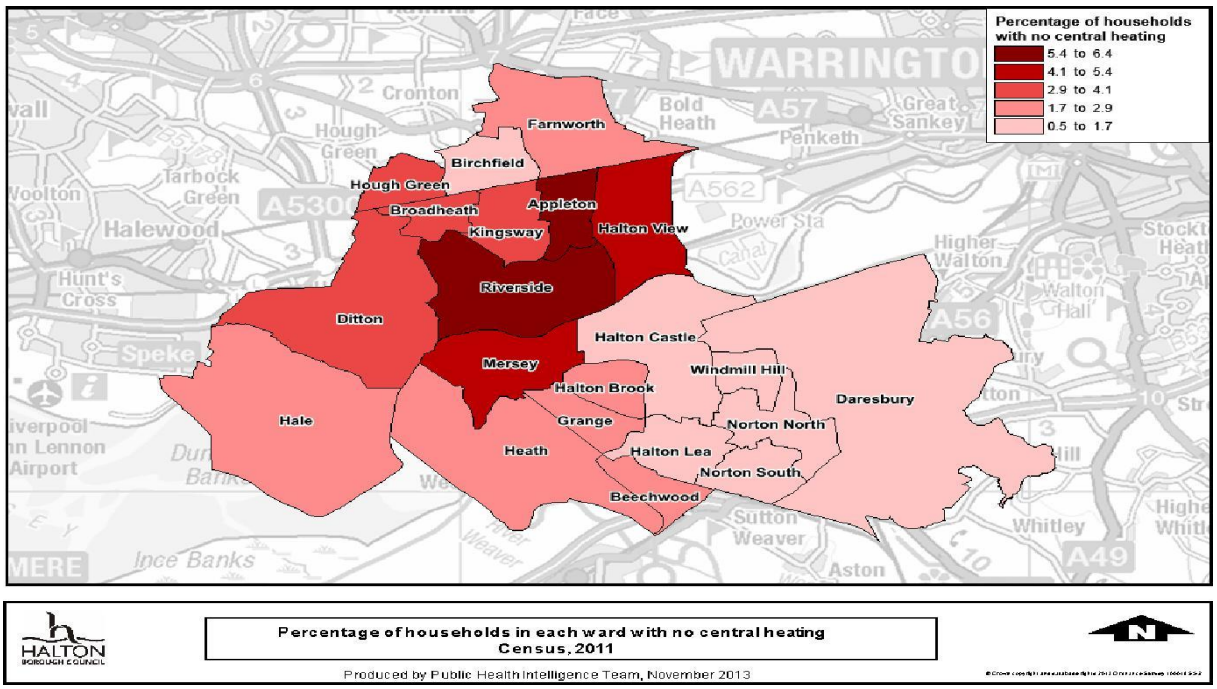
- All social housing stock in Halton met the Decent Homes Standard
- 26.2% of private sector dwellings in Halton (10,500 dwellings) failed the Decency Standard

Thermal comfort: Central Heating in homes across Halton

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

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

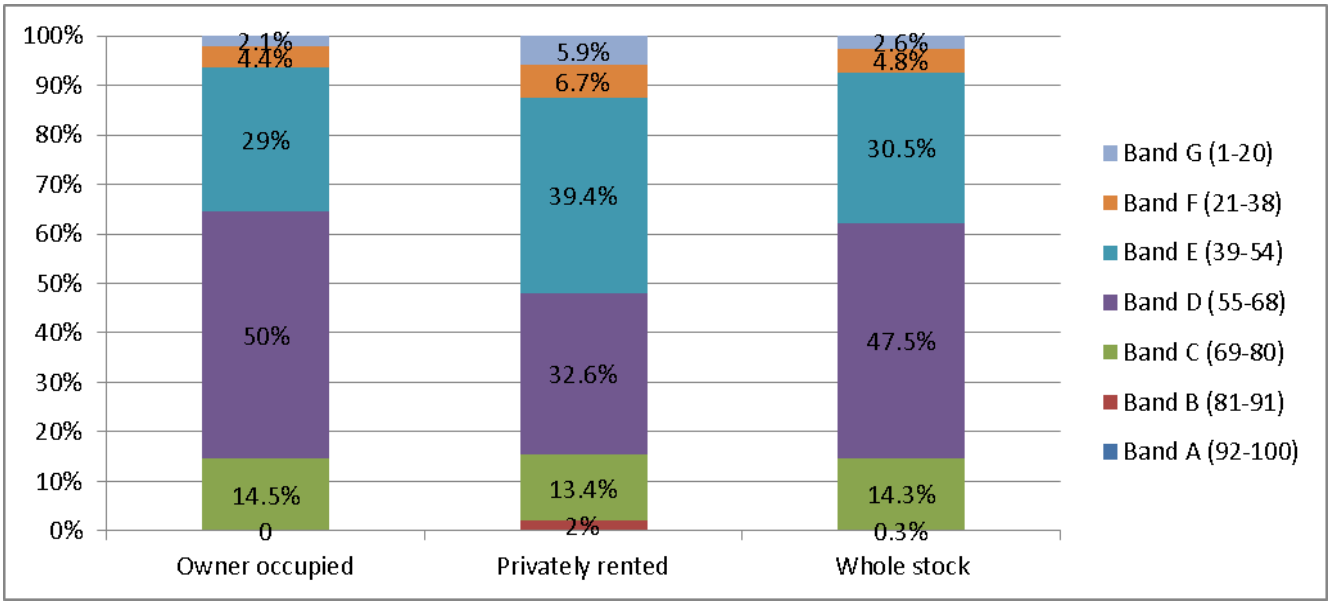
Figure 3: Central Heating in Dwellings in Halton (2011)



Energy efficiency of dwellings in Halton

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

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



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

Strategy Review Process

Fuel Poverty Needs Assessment

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

Strategy consultation and engagement

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

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

The partners involved in reviewing this strategy are outlined below.

Halton Affordable Warmth Strategy Review Contributors

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

Taking Action to Reduce Fuel Poverty in Halton

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

We aim to:

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

This section outlines how we will achieve these aims.

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

Objectives:

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

Current activities in Halton

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

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

Gaps in activity identified in Halton

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

To increase awareness of fuel poverty, we will:

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

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

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

Our objectives

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

Current activities

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

Gaps in activity identified in Halton

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

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

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

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

Our objectives

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

Current activities

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

Gaps in our provision

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

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

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

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

Objectives

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

Current activities

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

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

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

Gaps we have identified

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

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

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

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

Our Objective:

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

Current activity in Halton

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

Gaps in our provision

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

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

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

Delivering this Strategy

Expenditure on reducing cold home -related harm

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

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

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

Appendices

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 3: National Policies

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

Health Policies

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

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

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

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

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

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

Policies targeting Fuel poverty

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

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

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

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

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

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

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

Environmental policy

The Climate Change Act 2008

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

Policy Targeting Household Energy

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

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

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

Energy efficiency policy and programmes aimed at those in fuel poverty

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

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

The Energy Act 2013

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

The Energy Company Obligation (ECO)

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

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

Household energy savings policy

Collective Switch Scheme

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

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

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

Social and housing policy

Housing Health and Safety Rating System (HHSRS)

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

Decent Homes Standard 2000–2010

The Decent Homes Standard was launched by government in 2000 and updated in 2006 to reflect the Housing Act 2004. It is a standard for public housing in the United Kingdom. The NHS uses four broad criteria to assess housing conditions. A dwelling should:

A -be above the legal minimum standard for housing (measured by the presence of category 1 hazards under the Housing, Health and Safety Rating System), and
B - Be in a reasonable state of repair, and
C - Have reasonably modern facilities (such as kitchens and bathrooms) and services, and
D - Provide a reasonable degree of thermal comfort (effective insulation and efficient heating).

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

- efficient heating; and
- Effective insulation.

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

Income measures

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

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

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

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

Energy tariff measures

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

Others

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

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

Appendix 4: Respondents to Survey

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

Appendix 5: Fuel Poverty and Energy Efficiency of Dwellings

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 6: Existing Referral options for fuel poverty in Halton

Statutory sector

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

Voluntary sector

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

FUEL POVERTY IN HALTON

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

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

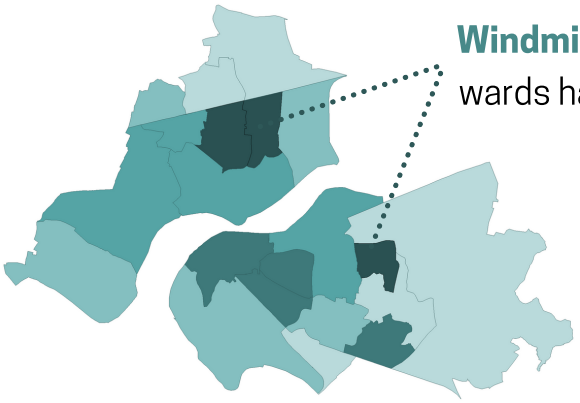
WHAT IS THE ISSUE?

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

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

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

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



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

CAUSES OF FUEL POVERTY

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

RISK FACTORS

INCOME

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

Unemployed people are more likely to live in fuel poverty.

Vulnerable people will be affected by cuts to benefits.

HOUSING

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

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

HEALTH CONDITION OR DISABILITY

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

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

AGE

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

WHAT ARE THE EFFECTS?

COST

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

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

INEQUALITIES

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

HEALTH & WELLBEING

children

Living in a cold home can:

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

young people

Fuel poverty can lead to poor mental health.

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

adults

Living in a cold home can:

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

WHAT CAN WE DO?

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

>>>> But there is more work to do

THE VISION

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

OBJECTIVES

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

WE WILL ACHIEVE THESE BY

Making every contact count.

Working together to maximise efforts of various agencies.

REPORT TO: Executive Board

DATE: 15 September 2016

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Public Health

SUBJECT: Halton 0-5 Public Health Service Contract 2017

WARDS: Borough-wide

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to seek Executive Board approval for the granting of a direct contract for the delivery of Health Visiting and Family Nurse Partnership services between April 2017 and August 2017.

2.0 RECOMMENDATION: That the Executive Board

1) **Notes the content of the paper; and**

2) **Support the recommendation to grant a Direct Award to Bridgewater Community Health NHS Foundation Trust for the delivery of Health Visiting and Family Nurse Partnership services from 1st April 2017 to 31st August 2017.**

3.0 BACKGROUND

3.1 In October 2015, responsibility for commissioning the Health Visiting and Family Nurse Partnership services transferred to the Local Authority from NHS England. The contract was with Bridgewater Community Health NHS Foundation Trust and was novated for a period of eighteen months to March 2017.

3.2 Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are set in place during pregnancy and in early childhood. What happens during these early years has lifelong effects on many aspects of health and wellbeing, educational achievement and economic status. Universal and specialist public health services for children are important in promoting the health and wellbeing of all children and reducing inequalities including:

- Delivery of the Healthy Child Programme (HCP);
- Assessment and intervention when a need is identified; and
- On-going work with children and families with multiple, complex or safeguarding needs in partnership with other key services including early years, children's social care and primary care.

3.3 The Health Visiting Service and the Family Nurse Partnership work across a number of stakeholders, settings and organisations to lead delivery of the Healthy Child Programme 0-5 (HCP), a prevention and early intervention public health programme that lies at the heart of the universal service for children and families and aims to support parents at this crucial stage of life, promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity. This includes safeguarding children and working to promote health and development in the '6 high impact areas' for early years – which can be found at https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children

- Transition to parenthood and the early weeks
- Maternal mental health (perinatal depression)
- Breastfeeding (initiation and duration)
- Healthy weight, healthy nutrition and physical activity
- Managing minor illness and reducing hospital attendance and admission
- Health, wellbeing and development of the child age 2 – 2.5 year old review (integrated review) and support to be 'ready for school'.

3.4 The School Nurse Team promotes the holistic health of the school aged population (5 – 19), thereby enabling them to realise their potential. They encourage children and young people to think about their health and support them to become responsible for their own health and wellbeing as they progress through childhood and adolescence.

The role is varied and includes:

- Keeping children and young people safe from harm and protecting them from injury and abuse in accordance with LSCB policies.
- Offering health advice and universal health surveillance, incorporating early intervention and support to children and young people and their families. The school nurse works in partnership with colleagues in education, allied health professionals and children and young people's services to promote early intervention to support children, young people and families to reach their full potential.
- Working with all settings (schools, colleges etc.) to develop health policies, e.g. sexual health.
- Contribute to the Personal Social Health Economic (PHSE) education curriculum and support the delivery of this programme as appropriate.
- Reviewing the health status of children and young people and facilitating care plans (e.g. for long term conditions) as required.
- Offering a choice of services that are accessible and confidential to children, young people and families (e.g. 'drop in' or appointments)
- Health protection of school age population, i.e. provide a trained and proficient immunisation workforce as required by Public Health England and aim to achieve full immunisation uptake

- Training educational staff in health issues and to support children's health care plans as appropriate.

3.5 In order to maximise the impact of the two teams (the 0-5 service and the 5-19 service as described above), Halton is seeking to create an integrated 0-19 service (or up to 24 for young people with a disability or complex health care need) that will deliver the Healthy Child Programme and provide both universal and targeted support services to help improve the health and wellbeing of children, young people and families in Halton.

4.0 CURRENT POSITION

4.1 Bridgewater Community Health NHS Foundation Trust has held a contract with Halton Borough Council since it was novated over from NHS England in October 2015. The current annual contract value is c. £2,600,000 per year for the delivery of the Health Visiting Service and the Family Nurse Partnership Programme. The contract for the delivery of the Health Visiting and Family Nurse Partnership service is due to expire in March 2017 with no allowance for any extension.

4.2 Halton Council has started a process of redesign in how it will deliver public health services to children, young people and families. With mandated elements of the Healthy Child Programme at the heart of a service, the Council is seeking to incorporate the current Health Visiting, Family Nurse Partnership and School Nursing Contracts into one integrated function that provides the best possible support to help local people to be as healthy as they can be.

4.3 It is anticipated that such an arrangement will be in place by September 2017. In order to minimise disruption to local people, services and to local schools, it is proposed that the two contracts be brought into alignment (to coincide with the end of the academic year) before being put out to procurement as an integrated 0-19 service that will commence operation in September 2017. As well as seeking innovation in supporting local people, it is anticipated that such a development will also lead to the realisation of financial savings.

5.0 PROPOSAL

5.1 It is proposed that the current provider of the Health Visitor and Family Nurse Partnership Service be given a direct award of a contract for the period of 5 months from 1st April 2017 to the 31st August 2017.
Such an award will:

- minimise the impact on local families, staff and the wider health and social care economy;
- enable operational efficiencies commenced in October 2016 to be fully realised;
- bring the contract in line with the School Nursing contract to enable a full, open and transparent procurement of a 0 -19 service to take place.

The direct award of a contract for the provision of Health Visiting and the Family Nurse Partnership is requested to support effective and meaningful consultation on the development of a new service specification that brings together the three elements of the service and also ensure continuity of service for local people between the end of the current contract date and the commencement of a new service contract in September.

5.2 The extended timescale will ensure that financial efficiencies can be investigated and realised and the impact on service delivery of any change within the middle of an academic year will be minimalised. The direct award will also support staff and other stakeholders to effectively manage operational change so that, when the service is opened up to wider procurement, it is already fit for purpose.

5.3 As the value of the proposed contract will exceed the EU threshold for services of this type, we are seeking Executive Board approval to publish the Direct Award of a contract to 31st August 2017 to be given to the current provider, using a '*Voluntary Ex-Ante Transparency Notice'* (VEAT) notice through which the contracting authorities must give sufficient information as to the justification for direct award of a contract without OJEU advertising and observe a minimum 10 day standstill period before the contract is awarded.

5.4 If the proposal to provide a direct award is not agreed, or if there is a significant challenge as part of the VEAT process, Executive Board approval is sought to commence a full, open and transparent procurement exercise for a six month contract for the delivery of the Health Visiting and Family Nurse Partnership Service.

6.0 POLICY IMPLICATIONS

6.1 The method of procurement complies with the Council's procurement policy and Procurement Standing Orders, and will utilise a VEAT Direct Awards as described in section 5.1.

7.0 FINANCIAL/RESOURCES IMPLICATIONS

7.1 As outlined in the report the provision of 0-5 Health Visiting and Family Nurse Partnership services in Halton currently costs £2.6million and therefore represents a significant proportion of the total Public Health grant income. An efficiency target of £200,000 is currently being negotiated with the provider for the current financial year, meaning a five month contract would have a value of c. £1,000,000.

8.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

8.1 Children and Young People in Halton

Local Authorities are well placed to identify health needs and commission

services for local people to improve health. The Government's aim is to enable local services to meet local needs. The Healthy Child programme is a critical component in giving every child in Halton 'the best start in life', and improving child development, which is a Halton priority. Improving the Health and Wellbeing of Children and Young People is a key priority in Halton and will continue to be addressed through the delivery of an effective and efficient Health Visitor Service that supports the delivery of both national and local strategies and action plans whilst at the same time meeting the needs of children and their families**.**

8.2 Employment, Learning and Skills in Halton

Employment, Learning and Skills is a key determinant of health and wellbeing and is therefore a key consideration when developing strategies to address health inequalities. An effective service will support children and their families in reducing the impact of ill health on their life chances and also encourage and support "school readiness".

8.3 A Healthy Halton

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

8.4 A Safer Halton

Reducing the incidence of crime, improving Community Safety and reducing the fear of crime have an impact on health outcomes particularly on mental health. There are also close links between the service and on areas such as mental health, alcohol and domestic violence.

8.5 Halton's Urban Renewal

None identified.

9.0 RISK ANALYSIS

9.1 A full risk analysis will be completed as part of the procurement exercise.

10.0 EQUALITY AND DIVERSITY ISSUES

10.1 An Equality Impact Assessment (EIA) is not required for this report.

11.0 REASON(S) FOR DECISION

11.1 As the value of the proposed contract will exceed the EU threshold for services of this type, we are seeking Executive Board approval to publish the Direct Award of a contract to 31st August 2017 to be given to the current provider, using a 'Voluntary Ex-Ante Transparency Notice' (VEAT) notice through which the contracting authorities must give sufficient information as to the justification for direct award of a contract without OJEU advertising and observe a minimum 10 day standstill period before

the contract is awarded.

12.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

12.1 The procurement of a Health Visiting / Family Nurse Partnership in isolation has been rejected as it will not enable the development of an innovative, integrated and efficient service to meet the needs of children, young people and their families.

13.0 IMPLEMENTATION DATE

13.1 It is intended that the process to provide a direct award would be undertaken following Executive approval with the new contract to commence in April 2017 for a period of five months.

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

14.1 None.

REPORT TO: Executive Board

DATE: 15 September 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: Supported Accommodation (Vulnerable Adults) Tender

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 This report gives an update to Executive Board on the implementation of the vulnerable adults support accommodation services following completion of the tender exercise.

2.0 RECOMMENDATION: That Executive Board notes the content of the report.

3.0 SUPPORTING INFORMATION

3.1 The Invitation to Tender to deliver supported accommodation services for adults with learning disabilities, autism, physical disabilities, mental health issues or acquired brain injury was advertised in October 2015. The tender consisted of 7 geographic zones plus an option to be included in a framework agreement for future business.

3.2 Contracts were awarded to PossAbilities, Community Integrated Care and United Response for 3 years from June 2016 to May 2019 with an option to extend for a further 1 year subject to satisfactory performance.

3.3 Subsequently the contract for United Responses 3 zones was withdrawn due to the additional funding required for the provider to deliver the service. Therefore, the position as of June 2016 was as follows:

Zone	Provider
1	PossAbilities
2	PossAbilities
3	CIC
4	-
5	-
6	-
7	PossAbilities

3.4 A report was taken to the 16th June, 2016 Executive Board meeting,

requesting permission to award to the next ranked provider in each of the 3 zones. This resulted in Zone 5 being offered to Community Integrated Care and Zones 4 and 6 being offered to Clece Care.

3.5 Based on the advice available at the time Executive Board also agreed to a contingency arrangement whereby should Clece Care be unable to deliver services in Zones 4 and 6 the Council could offer these Zones to PossAbilities and Community Integrated Care despite this resulting in one provider being awarded a total of 4 services.

3.6 Following a meeting with Clece Care and subsequent review of their costs, they were unable to provide the service within the available budget.

3.7 Further advice was sought from Legal and Procurement about the process for awarding the zones, who advised that we are not able to award 4 Zones to one provider as this was not in line with the Council's initial intention.

3.8 It was agreed a further procurement opportunity would be offered to those providers who got through to Stage II of the original tender. A further evaluation was completed.

3.9 Following the evaluation, Zone 6 was awarded to Community Integrated Care, and Zone 4 was awarded to Making Space.

The following table gives details of the full award:

Zone	Agency	Ranking	Contract Value
4 - WA7 4	Making Space	2	£2,112,042
6 - WA7 5	Community Integrated Care	1	£1,810,035
		TOTAL	£3,922,077

3.10 The final position is as follows:

Zone	Provider
1	PossAbilities
2	PossAbilities
3	CIC
4	Making Space
5	CIC
6	CIC
7	PossAbilities

4.0 POLICY IMPLICATIONS

4.1 The method of procurement has complied with the Public Contract Regulations, 2015 and the Council's own Procurement Standing Orders.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The financial implications are highlighted in 3.5 and 3.7 above and are allocated within the Directorate's budget. The tender process has given service providers the opportunity to ensure hourly rates are compliant with the Living Wage increases and that Sleeping Night Rates are in line with recent case law requiring payment of National Minimum Wage. By testing the market the Council has been able to ensure that the purchase of quality care represents value for money.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Appropriate accommodation for some young people through the transition planning stage is essential, with a particular focus on young people in care.

6.2 Employment, Learning & Skills in Halton

Halton's adult accommodation model works in partnership with other agencies to promote employment and skills, working towards greater independence of individuals.

6.3 A Healthy Halton

Individuals with additional needs or vulnerability can have disproportionate health related issues or life-long conditions. The current and future modelling will continue to promote health equalities

6.4 A Safer Halton

All providers will comply with Halton's Safeguarding Practice and Procedures and will ensure that individuals are aware how to stay safe, how to report incidents and to promote safe community inclusion.

6.5 Halton's Urban Renewal

None identified

7.0 RISK ANALYSIS

7.1 There is potential for a challenge by unsuccessful organisations, however this risk has been mitigated by the robust procurement process and giving an opportunity for resubmission of costs to ensure compliance with Living Wage and National Minimum Wage.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 All successful providers will be required to demonstrate that they embrace and comply with the Equality Act, and services will be monitored to ensure this is the case.

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

None identified under the meaning of the Act.

REPORT TO:	Executive Board
DATE:	15 September 2016
REPORTING OFFICER:	Strategic Director – Enterprise, Community & Resources
PORTFOLIO:	Transportation
SUBJECT:	Mersey Gateway Bridge Project – Progress Update
WARDS:	All

1.0 PURPOSE OF THE REPORT

1.1 To provide an update on progress with the Mersey Gateway Bridge Project (the Project) and the performance of the Mersey Gateway Crossings Board Limited (the MGCB) for the period January to June 2016, against the criteria set out in the MGCB Governance Agreement**.**

2.0 RECOMMENDATION: That

1) **progress with the Mersey Gateway Project as set out in the report, be noted; and**

2) **performance of the MGCB Ltd in monitoring the Project Company's (MER) performance as set out in the report, be noted.**

3.0 SUPPORTING INFORMATION

3.1 Background

3.1.2 The MGCB is a special purpose vehicle established by Halton Borough Council (the Council) with the delegated authority to deliver the Project and to administer and oversee the construction, maintenance and tolling of the new crossing including the tolling of the existing Silver Jubilee Bridge (SJB).

3.1.3 The MGCB's terms of reference and delegated authority are expressed in a Governance Agreement with the Council, set to last for sixty years. The MGCB is commissioned to deliver the Project on behalf of the Council and operate as a commercial (though not-for-profit) organisation on an arm's length basis.

3.1.4 The MGCB is working closely with MER on a day to day basis to ensure that all aspects of their policies are adhered to ranging from PR and Communications, environment, traffic management to local employment and skills.

3.2 Construction Progress (Construction sections shown in Appendix 1)

3.2.1 Summary of recent events:

Main Crossing approaches:

- All piers are complete for the North Approach Viaduct (NAV) except for pier head at P10.
- Pier construction for the South Approach Viaduct (SAV) is ongoing including piers P17 and P18 adjacent to the Manchester Ship Canal.
- The Mobile Scaffold System (MSS) box section of the NAV deck has been completed up to span 6 of the total 11 spans.
- Completion of NAV deck slab infill sections is ongoing independent of MSS works.
- Assembly of the NAV wing traveller is complete and construction of the deck cantilevers is continuing within span 1.
- Preassembly works for the second MSS for the SAV is ongoing with first launch (to span P19-P18) expected early September 2016.

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Main Crossing Cable Stayed Bridge:

- Hammerheads of South and North Pylon have been completed.
- Pier table in the Central Pylon has been completed.
- South Upper Pylon has been completed up to 14th lift (approx. 82% of total pylon height)
- North Upper Pylon has been completed up to the 13th lift (approx. 72% of total pylon height).
- Construction of the deck starter segments, at the South and North Pylons is ongoing.

Landside works:

- Section 1
    - Complete construction of deck for new Ditton Junction Bridge;
    - Continue highway and utilities works at and adjacent to Ditton Junction including 2300 sewer and Mersey Valley Sludge Pumped (MVSP) diversions;
    - Demolish existing Ditton Junction bridges and divert all SJB traffic through roundabout;
    - Complete removal of highway embankment at Ditton Junction;

- Section 2

    - Complete remediation of contaminated ground and removal and disposal of contaminated ground at the former Sammy Evans and Fallon's scrapyards;
    - Strengthening of ground under embankment near bridges through Soil Mixing techniques on-going;
    - Removal of existing Watkinson Way South carriageway and embankment on-going;
    - Construction of deck and supports (including foundations in former Royal Café area) for Widnes and Victoria Viaduct ongoing;
    - Construction of new highway embankment at Gussion site and between Widnes and Victoria Viaduct and the NAV on-going.

- Section 4

    - Pier column construction for Astmoor and Bridgewater Viaduct ongoing;
    - Erection of temporary propping and landing of deck beams for Astmoor and Bridgewater Viaduct ongoing;
    - Construction of deck for Astmoor and Bridgewater Viaduct ongoing;
    - New highway construction works at Bridgewater Junction ongoing.

- Sections 5, 6 & 7

    - Continue renovation and modification of existing expressway bridges;
    - Continue new highway construction works at Lodge Lane Junction under total closure of Central Expressway;
    - Erect new Lodge Lane North footbridge and reopen new northbound link from Weston Point Junction to Central Expressway;
    - Complete demolition of existing Lodge Lane Junction bridge;
    - Continue highway construction works at Weston Point Junction;

- Section 8

    - Complete highway construction works at M56 Junction 12 north roundabout, including commissioning installation of new traffic signals installation;
    - New highway construction works on Weston Point Expressway north of the new M56 Junction 12 north roundabout ongoing.

3.2.2 Given the scale and nature of the Project, from time-to-time it is necessary to modify the planned methods of construction. In particular, the variable ground conditions encountered and challenging tidal effects in the estuary have led to revisions and adaptations to the techniques and working practices. This can be clearly seen in the different methodology used in the construction of the Central Pylon Cofferdam compared to that of the North and South Pylon Cofferdams

and the procurement and construction of a second MSS. Merseylink also introduced additional resources and increased working hours following consultation with the appropriate regulators.

3.2.3 PR and communications is vital to ensure drivers in and around Halton are aware of traffic management changes. The Project website is a vital tool used to communicate changes and utilises innovative interactive maps which highlight works across the Project route. Weekly traffic updates are issued to local press and in instances of works which may cause significant change or disruption, specific detailed press releases are issued along with letters to affected residents and, where appropriate, public meetings are conducted.

3.2.4 MER uses dedicated computer software called Freshdesk to electronically capture all complaints and enquiries. MER must respond to all such complaints within 10 working days or must be formally acknowledged if a full response is expected to take longer to answer. The MGCB monitors compliance of this on a monthly basis.

3.2.5 The Project remains on programme for the main bridge and approach roads to be commissioned and trafficked in autumn 2017, as set out in the Project Agreement.

3.3 Compensation Event[1] – Specifically defined in the Project Agreement and Demand Management Participation Agreement.

3.3.1 None to report at this stage.

3.4 Relief Event[2] – Specifically defined in Project Agreement and Demand Management Participation Agreement.

3.4.1 None to report at this stage.

3.5 Health and Safety

3.5.1 MER acknowledges the importance of Health and Safety (H&S).It is a key Project priority and acts as a key driver in their site inductions for new starters and visitors. To date, **3,989** workplace safety inductions have taken place with attendees including site workers, consultants and sub-contractors. MER has also introduced random on site drug and alcohol testing. Those with positive test results are dealt with by the Health and Safety manager in line with MER's Drug and Alcohol policy.

3.5.2 As an exemplar of good practice, on returning to work following the 2 week 2015 Christmas close down, all MER employees, attended a

[1] A breach by the Board/Council of its obligations (could result in financial penalty)
[2] Failure by any Statutory Undertaker, Utility Company or Local Authority or other like body to carry out the works or provide services (could provide Merseylink with vindication for failures under the contract)

'Return to Work' seminar, known as Safety Stand Downs (SSD) to remind staff of the importance of H&S awareness at work.

3.5.3 MER has held a number of SSD presentations. These were split by Main Bridge and Landside so that each main work area could focus on their specific safety issues. Main Bridge SSDs were attended by a total of **400** staff and Landside SSDs were attended by a total of **415** staff.

3.5.4 From the start of the Project to June 2016 figures show **140** accident book entries with no notifiable events and no major injuries. Number of near misses and learning events[3] reported to date is **86**. There has been only 2 RIDDOR[4] incidents following which HSE reports were completed with preventative measures identified. Both of these incidents were service (underground cable) strikes and resulted in a 'Permit to Dig Authoriser' being recruited. Furthermore changes were made to the site working procedures. Since implementation there have only been very minor underground service difficulties.

3.5.5 The MGCB's most recent H&S Audit took place on 6th March. The audit focussed on compliance with the MER H&S procedures and the associated records. A site visit/inspection was also conducted.

3.5.6 Compliance with the H&S procedures was, in the main, confirmed and the site inspection showed good controls in place to manage H&S on the site in the area visited (being Section 4). Some improvements with respect to fire and first aid do need to be implemented.

3.5.7 The MGCB had scheduled the next H&S Audit for July 2016 and the findings will be included in the Executive Board Report for the period July to December 2016.

3.6 Key Performance Indicators (KPI)

3.6.1 In general the MGCB does not measure MER's construction phase performance save for a number of KPI's associated with the PA's Employment and Skills Delivery Plan.

3.6.2 Throughout the lifetime of the Project, the majority of KPI's are associated with the Demand Participation Agreement (DMPA) which is being delivered through the Project's operational phase by Emovis (DMPA Co, formerly Sanef).

3.6.3 The KPIs are set out in Schedule 1 of the agreement and will be used to determine the performance of the Revenue Collection Services and any additional measures specified in the Roadside Tolling Equipment Specification. They will also measure Safety Performance.

[3] Accidents resulting in the over-seven-day incapacitation of a worker
[4] Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

3.6.4 MER is required to report data in connection with current national indicators during the contract period and these are known as Statutory Authority Performance Indicators.

3.6.5 Although not monitored as a KPI, the MER Monthly Progress report, submitted to the MGCB, is an effective method of monitoring progress as the report incorporates Design and Construction, Service, Management, Monthly Payment and Data Reports. Also included in the Monthly Report are all accidents, incidents, enquires, complaints and traffic management data. This report is monitored by the MGCB and issues requiring further consideration are logged in the minutes of the Monthly Progress meeting.

3.6.6 There are currently **825** people working on the Project across sites in Runcorn and Widnes. They include **34** people engaged by the MGCB, **251** people employed by the three partners (Kier, Samsung, FCC) in the MER construction joint venture (CJV) including **105** people recruited directly for the Project and **503** people supplied by labour suppliers or sub-contractors working on different elements of work across the site.

3.6.7 MER's Time Bank scheme, which aims to help local groups and organisations by providing professional services for community projects, has saved the local community approximately £100,000 having supplied consultation, labour and other services to around 25 successful applicants.

3.6.8 The Mersey Gateway Visitors Centre in Widnes at the Catalyst Science and Discovery Centre opened in February 2015 and so far has had **9,510** visitors. The Mersey Gateway Information Centre in Runcorn opened in February 2016 and so far has had **3,165** visitors.

3.7 Risk

3.7.1 Current progress on the actions and risks accepted by the Council and the MGCB at Financial Close is as follows:

- The procurement of the necessary enforcement powers for the collection of tolls on the new bridge and on the SJB. The period for representations to the Secretary of State (SoS) closed on 14th May 2015 by which time three objections had been received. All three were from individuals who reside in Halton and none related directly to the content of the proposed Modification Order placed before the SoS but rather to imposition of tolls. An attempt to provide the objectors with sufficient comfort to withdraw their objections proved to be unsuccessful. The SoS made a decision on how to proceed with the application on 11 June 2015. The SoS decided that this would be by written representation. The Council would submit representations relating to all three objections by 9 July 2015: they

were delivered to the SoS on 26 June 2015. The SoS forwarded these to the objectors on 30 June 2015. By the required date of 21 July 2015 the SoS received only 1 communication from an objector which did not require further response from the MGCB.

Update: The Modification Order was approved by DfT at the end of May. However, as the provisions of the Modification Order include a new "Power of Entry", approval by Home Office Ministers is now required. This is a provision to the effect that, if there is no Road User Charging Scheme in place and Halton reverts to using the tolling powers in the 2011 Order, some of the enforcement powers relating to road user charging including a power to enter vehicles would be available. DLA provided DfT with the "Powers of Entry Gateway" forms on 2 June and they have been passed to the Home Office. The Home Office is currently processing the approval following which DfT will arrange for a notice of making if the Order to be published in the London Gazette and the MGCB will arrange for publication in a local newspaper.

- Bye-laws – An initial draft of the byelaws has been agreed with Merseylink and the Council's legal team. Therefore, following advice from DfT, the MGCB has carried out an informal consultation with a small number of key third parties. This process will close at the end of July and to date the MGCB has received feedback from Cheshire Police, Cheshire Fire and Rescue and HBC Highways. The draft byelaws will be updated to reflect third party comments and the revised byelaws will be sent to the Council's legal team and DfT for approval. The MGCB is also compiling a report for Council.

3.7.2 Risk Register

3.7.2.1 The MGCB has developed a comprehensive Risk Register to identify those risks associated with the Project, to ensure that the retained and contractual risks are effectively managed and any potential impact is mitigated.

3.7.2.2 The Risk Register is a standing item on the agenda of both the MGCB's Audit Committee, whose membership includes the Council's Head of Internal Audit, and the monthly Board of Directors meeting, whose membership includes Cllr Polhill and Cllr Wharton as the duly appointed Council Non-executive Directors.

3.7.2.3 As reported to full Council (Dec 2013) under the Project Agreement MER take the risk of any cost or programme overrun but the Council is exposed to some cost risk during construction (specifically associated with sharing the cost of dealing with contamination in exceptional circumstances). The DMPA Co is responsible for the collection risk associated with the tolls.

3.7.2.4 The principle risk retained by the Council and DfT relates to toll revenue which is a function of the toll charge and the volume of traffic using the bridges.

3.7.2.5 Although appearing numerous, the risks identified in the Risk Register predominately relate to contractual risks associated with any major infrastructure project.

3.7.2.6 The Risk Register is available for inspection by Members at the MGCB's offices.

3.8 Business Plan

3.8.1 Under the Governance Agreement there is a requirement for the MGCB to produce an Annual Business Plan, the requirements of this plan predominately relate to the Project during the operational period.

3.8.2 The MGCB has produced and supplied to the Council a business plan which is more suited to the operations of the MGCB during the construction period.

3.8.3 The Business Plan is available for inspection by Members at the MGCB's offices.

4.0 POLICY IMPLICATIONS

4.1 The Project is a key priority for the Council which will deliver benefits locally and across the wider region.

5.0 FINANCIAL IMPLICATIONS

5.1 All substantive implications are reported in the Mersey Gateway Financial Reports to the MGCB.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

6.1.2 The Project provides an opportunity to improve accessibility to services, education and employment for all.

6.2 Employment, Learning and Skills in Halton

6.2.1 Over **800** jobs have been created for the Project so far and the Project ensures the local community continues to have access to all job opportunities through the Employment and Skills Working Group. In the longer term, several thousand jobs are forecast to be created in the sub-region due to the wider economic impact of the Project.

6.3 A Healthy Halton

6.3.1 The Project provides an opportunity to improve accessibility to services, education and employment for all, including improved cycling and walking facilities.

6.3.2 Improve local air quality and enhance the general urban environment.

6.4 A Safer Halton

6.4.1 The Project will provide much needed environmental improvements to the immediate areas. Removal of cross river congestion will enhance response times for emergency services.

6.4.2 The new crossing will improve safety and reduce the cost of accidents currently found with the high collision SJB route by up to £39 million. The narrow lane widths of 3.05m on the SJB will be redesigned to deal with local traffic, and offer new routes for cyclists, pedestrians and those using public transport.

6.5 Halton's Urban Renewal

6.5.1 The Project is a priority project in the Urban Renewal Programme.

7.0 RISK ANALYSIS

7.1 The Project structure supported by the proposed delegation and decision authority will reduce the risk of delay and improve the quality of the Project control.

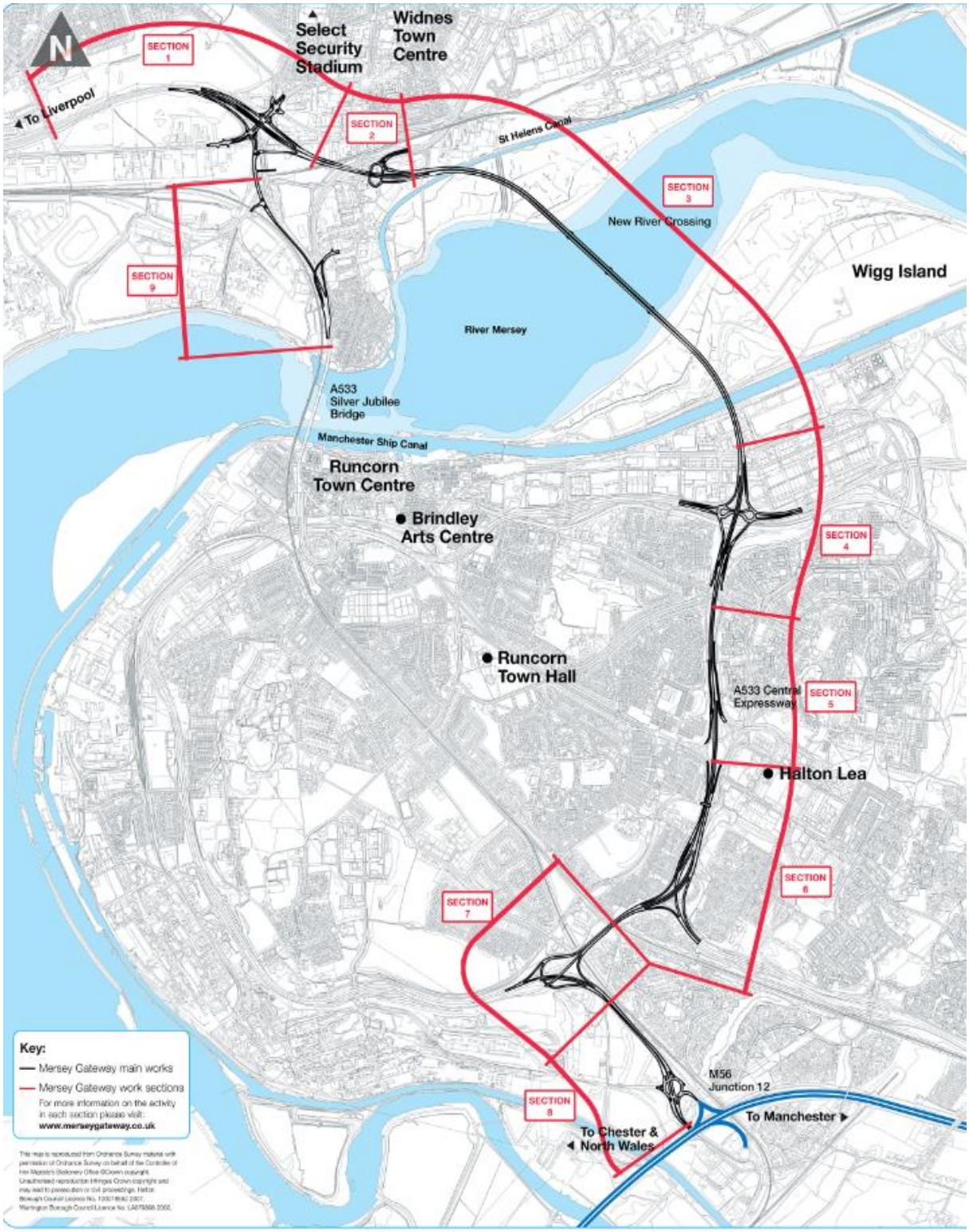
8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The Project provides an opportunity to improve accessibility to services, education and employment for all.

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

9.1 None under the meaning of the Act.

Appendix 1 - Construction sections



REPORT TO: Executive Board

DATE: 15 September 2016

REPORTING OFFICER: Strategic Director – Enterprise, Community & Resources

PORTFOLIO: Transportation

SUBJECT: Street Lighting Highway Electrical Term Maintenance Contract

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To seek approval from Executive Board to extend the current term maintenance contract for a period of one year from 1st November 2016 to 31st October 2017, and to notify the Board that the anticipated expenditure will be in excess of £1.0m.

2.0 **RECOMMENDATION: That Executive Board**

1) agree to the extension of the Street Lighting Term Maintenance Contract under Procurement Standing Order 1.15 for a period of 1 year from 1st November 2016 to 31st October 2017; and

2) It be recorded that the expenditure is anticipated to be in excess of £1.0m per annum.

3.0 **SUPPORTING INFORMATION**

3.1 In November 2010, Tarmac commenced a term maintenance contract to maintain all highway electrical equipment within the Borough. It was initially for a period of 5 years but included options for up to five one year extensions. One extension has already been utilised. The Council's highway electrical assets covered by this contract includes the following equipment: -

- Over 20,000 conventional lighting columns plus 400 lighting columns for HHT
- 98 high mast lighting columns
- 1,400 illuminated traffic signs
- 450 illuminated bollards
- 18 Zebra crossings

3.2 The normal expenditure covered by this contract has usually been around £0.5m each year. However, due to capital funding being

secured to install LED lanterns, which will be carried out through this contract, this will increase the work carried out through the contract and, consequently, it is anticipated that the expenditure will now exceed £1.0m for the next extension period. In the longer term, as a result of installing LED lanterns, there will be a reduction in street lighting maintenance costs.

3.3 There is no statutory duty to provide street lighting. The power to provide street lighting is set out in Section 97 Highways Act 1980 (see below).

> **Highways Act 1980**
> *97 Lighting of highways.*
>
> *(1) The Minister and every local highway authority may provide lighting for the purposes of any highway or proposed highway for which they are or will be the highway authority, and may for that purpose—*
>
> *(a) contract with any persons for the supply of gas, electricity or other means of lighting; and*
>
> *(b) construct and maintain such lamps, posts and other works as they consider necessary.*
>
> *(2) A highway authority may alter or remove any works constructed by them under this section or vested in them under Part III of the Local Government Act 1966 or section 270 below.*
>
> *(3) A highway authority shall pay compensation to any person who sustains damage by reason of the execution of works under this section.*
>
> *(4) Section 45 of the Public Health Act 1961 (attachment of street lamps to buildings) and section 81 of that Act (summary recovery of damages for negligence) apply to a highway authority who are not a council of a kind therein mentioned as they apply to such a council.*

However, if street lighting is provided under this Act, then it needs to be maintained in a serviceable condition, hence the need for the current maintenance contract.

4.0 BUSINESS CASE FOR EXTENSION OF CONTRACTS

4.1 Value for money

Value for money will continue to be assured through regular contract monitoring by the Street Lighting Team.

4.2 Transparency

The Contract will be recorded in the Council's Contract Register

accessible via the internet together with the publication of all spend in excess of £500.

4.3 **Propriety and Scrutiny**
The extension of the contract referred to in this report will be compliant with Halton Borough Council's Procurement Standing Orders. Compliance with anti-corruption practices will be adhered to and the contract within the subject of this report will be terminated if there is any occurrence of corruption by any organisations or their staff.

4.4 **Accountability**
The contract will be performance managed and monitored by the Street Lighting Team.

5.0 POLICY IMPLICATIONS

5.1 There are no policy implications.

6.0 FINANCIAL IMPLICATIONS

6.1 The total financial cost to the authority of the contract and the recommended extension will be met from existing capital and revenue budgets, which have been approved previously, but there will be a need for future revenue allocations after 31st March 2017.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 **Children & Young People in Halton**
There are no direct implications for this priority.

7.2 **Employment, Learning & Skills in Halton**
There are no direct implications for this priority.

7.3 **A Healthy Halton**
There are no direct implications for this priority.

7.4 **A Safer Halton**
Street lighting can contribute to road safety and a reduction in accidents. It can also help reduce crime and anti-social behaviour which affects how safe people feel during the hours of darkness.

7.5 **Halton's Urban Renewal**
Street lighting is often part of Urban Renewal schemes and does have a positive impact on improving the environment and needs to be maintained once it is installed.

8.0 RISK ANALYSIS

8.1 Street lighting is not a statutory function and there is no legal

requirement for roads to be lit, but once it is installed it must be maintained. There are no risks associated with this report as the funds for maintenance of all highway electrical equipment have been secured for the current financial year and therefore a risk assessment is not required. There will be a need for future revenue allocations to be approved for maintenance works after 31st March 2017.

9.0 EQUALITY AND 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 under the meaning of the Act.

REPORT TO: Executive Board

DATE: 15 September 2016

REPORTING OFFICER: Strategic Director Enterprise, Community & Resources

SUBJECT: Surface Treatment Term Maintenance Contract

WARDS: Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of the report is to notify members that the Operational Director, Policy Planning and Transportation has given approval to proceed with a procurement process with regards the provision of a Surface Treatment Term Maintenance contract for carriageway and footway surface dressing and micro asphalt across the borough.

2.0 RECOMMENDATION: That Members note that a procurement process will be entered into via The Chest with the purpose of securing a Surface Treatment Term Maintenance contract for carriageway and footway surface dressing and micro asphalt across the Borough.

3.0 SUPPORTING INFORMATION

3.1 The existing 10 year term contract for Surface Treatment of the Highway comes to an end on 31st March 2017. This contract provides Halton Borough Council as the Highway Authority with the ability to complete proactive preventative maintenance of the Highway utilising Surface Dressing, Slurry Surfacing, Micro Asphalt, Overspray preservation and other proprietary treatments. These treatments aim to seal and prevent the ingress of water and moisture into the bituminous surfacing each being used depending on the existing condition of the surfacing. During the winter freeze thaw period these treatments then help to prevent potholes forming ensuring a well maintained surface for all forms of traffic. There is, therefore, a need to make arrangements to secure a new term maintenance contract during the remainder of this financial year.

3.2 It is proposed that the new arrangements are set up for a 5 year period with the potential for up to five 1 year extensions, subject to satisfactory performance. The anticipated tender date is circa 4th October 2016 with the anticipated commencement date being 1st April 2017.

3.3 Based on previous expenditure, it is anticipated that the annual value of the contracts in total is likely to be in the region of £600k thus making the value of a five year contract in the order £3m. This figure is above the

OJEU threshold; as such the contract is subject to European procurement rules and will be tendered accordingly. The open procedure will be used whereby expressions of interest are first obtained and then assessed.

3.4 The tender submissions will be evaluated on both price and quality, this being on a 30% price, 70% quality ratio and the most economically advantageous tender will be reported to this Board for acceptance.

3.5 The cost of the works that will be let through this contract will be met from annually approved budget allocations for Highways maintenance.

4.0 POLICY IMPLICATIONS

4.1 The method of procurement fits with the Council's procurement policy, the tender process being carried out in conjunction with the Procurement Centre of Excellence, using 'The Chest' procurement portal.

5.0 OTHER IMPLICATIONS

5.1 The above contract will ensure that we continue to deliver the maintenance of the Highway network in a cost effective manner ensuring the Highway Authority fulfils its statutory duties.

5.2 This contract can adapt to any changes in responsibility for the management and maintenance of the Key Route Network that may result from the Devolution Agreement.

5.3 Our partners within Liverpool City Region (Liverpool Procurement Hub) will have the facility to draw down on the contract.

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

Properly maintained footways and carriageways should encourage more people to walk and cycle, and hence develop healthier lifestyles

6.4 **A Safer Halton**

Ongoing and effective maintenance of our highways should reduce the risks of trips and claims against the council, as well as the potential for other accidents.

6.5 **Halton's Urban Renewal**

Adequately maintained highways improve the public realm and the reputation of the borough, thereby making it potentially more attractive to investors and to those who may wish to live here.

7.0 RISK ANALYSIS

Failure to enter into this contract would mean that surface treatment works would need to be procured on an ad-hoc basis, leading to increased procurement costs and would give no price certainty for planning future programmes of works.

8.0 EQUALITY AND DIVERSITY ISSUES

None

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

None under the meaning of the Act.

REPORT TO: Executive Board

DATE: 15 September 2016

REPORTING OFFICER: Operational Director – Finance

PORTFOLIO: Resources

SUBJECT: 2016/17 Quarter 1 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 June 2016.

2.0 RECOMMENDED: That;

1) **All spending continues to be limited to the absolutely essential;**

2) **Strategic Directors take steps to ensure overall spending by year-end is within their total operational budget; and**

3) **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 June 2016, along with individual statements for each Department. In overall terms revenue expenditure is £0.2m above the budget profile. Whilst the budget profile is only a guide to expected spending, historically spend is lower in the first quarter of the year and accelerates towards the year-end. Therefore there is a significant risk that the Council may overspend its budget for the year.

3.2 Given the adverse variance position and continuing budget pressures Directorates should continue to limit all spending to absolutely essential items only, to ensure that each Directorate's total spending by year-end is within its total operational budget.

3.3 The main budget pressures facing the Council continue to be within the Children & Families Department, in particular out-of-borough residential placements and out-of-borough fostering. Latest available information shows that children in care numbers have been increasing steadily since November 2015. To help manage these pressures over the past two years, £2.3m of additional budget resources have been provided. Despite

this and based upon current service demands, spending is forecast to be £2.5m over budget by year-end.

3.4 Out-of-borough placements have had to be sourced at a higher cost dependent upon the needs of the child, as it is not always possible to place them within the Borough. The annual average cost of placing a child in residential care is £88,000 therefore even a slight upturn in demand can have a significant impact upon the budgetary position.

3.5 The Community and Environment Department continues to experience shortfalls in various sources of income. The total shortfall in income at the end of quarter 1 is £154,000 and relates to a variety of income sources including, sales, fees & charges and catering fees. It is expected that the shortfall will continue to be a budget pressure for the remainder of the financial year.

3.6 Total spending on employees is £192,000 below budget profile at the end of the quarter. This is mainly due to posts being held vacant within a number of Departments. In recent years the managed underspend on staffing budgets has been significant and has helped to offset overspends in other areas of the Council's budget. However, as vacant posts have been removed as budget savings, there are now fewer vacant posts and hence the managed underspend is significantly lower. As a result it will be more difficult to offset areas of budget overspend in 2016/17 and beyond.

3.7 As a result of the four days unpaid leave terms and conditions saving not being in place prior to April 2016, the full budget saving for the year will not be realised, with a shortfall of approximately £125,000.

3.8 Included within the employees budget is a staff turnover savings target of 3.0% 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 in most Departments with the exception of Community & Environment, Economy, Enterprise & Property, Legal & Democratic Services and Children & Families.

3.9 Expenditure on general supplies and services is £58,000 below the budget to date of £2.4m. This position is relatively marginal compared to previous years and therefore it is important to ensure spending continues to be limited to only essential items.

3.10 Spending within the Complex Care Pool, which has budgeted gross expenditure of over £48m, is currently in line with budget and this is expected to be the case for the remainder of the financial year.

3.11 The council tax collection rate for the first quarter of 28.5% is marginally lower (0.1%) than at this stage last year. However, the collection rate for business rates of 29.4% is up by 0.5% from last year. The forecast retained element of business rates is in line with the estimate used when setting the 2016/17 budget. However, forecasting retained business rates through to the end of the financial year remains difficult due to the number of appeals outstanding with the Valuation Office Agency.

Capital Spending

3.12 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. Widnes Market Refurbishment
2. Halton Recovery & Wellbeing Hub
3. RSL Adaptations (Joint Funding)
4. Disabled Facilities Grant
5. Police Station Site
6. Travellers' Site Warrington Road
7. Madeline McKenna Residential Home
8. Fire Compartmentation
9. Fairfield Primary School
10. Hale Primary School
11. Capital Repairs – Schools
12. Equality Act Improvement Works
13. Peelhouse Lane Cemetery
14. Peelhouse Lane Cemetery Enabling Works
15. Runcorn Cemetery Extension
16. Open Spaces Schemes
17. Children's Playground Equipment
18. The Glen Play Area
19. Runcorn Hill Park
20. Land Acquisitions – Mersey Gateway
21. Development Costs – Mersey Gateway
22. Widnes Waterfront
23. S106 Schemes
24. STEPS Programme
25. Hale Road Bus Priority Route

3.13 Capital spending at 30 June 2016 totalled £13.538m, which is 99% of planned spending at this stage. This represents 15% of the total Capital Programme of £88.386m.

Balance Sheet

3.14 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 AND OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

6.0 RISK ANALYSIS

6.1 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.

6.2 In preparing the 2016/17 budget, a register of significant financial risks was prepared which has been updated as at 30 June 2016.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

APPENDIX 1

Summary of Revenue Spending to 30 June 2016

Directorate / Department	Annual Budget £'000	Budget to Date £'000	Expenditure to Date £'000	Variance to Date (overspend) £'000
Community & Environment	19,030	2,615	2,675	(60)
Economy, Enterprise & Property	1,232	-515	-533	18
Finance	4,104	219	135	84
ICT & Support Services	2	-154	-272	118
Legal & Democratic Services	602	147	142	5
Planning & Transportation	8,190	1,722	1,684	38
Policy, People, Performance & Efficiency	0	-320	-323	3
Enterprise, Community & Resources	**33,160**	**3,714**	**3,508**	**206**
Adult Social Care, Prevention & Assessment	25,722	4,826	4,792	34
Children & Families	19,861	4,925	5,551	(626)
Commissioning & Complex Care	10,030	2,533	2,517	16
Education, Inclusion & Provision	8,923	1,310	1,293	17
Public Health & Public Protection	458	2,167	2,121	46
People	**64,994**	**15,761**	**16,274**	**(513)**
Corporate & Democracy	**306**	**-1,987**	**-2,094**	**107**
Net Total	**98,460**	**17,488**	**17,688**	**(200)**

ENTERPRISE, COMMUNITY & RESOURCES DIRECTORATE
Community & Environment

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	13,736	3,492	3,525	**(33)**
Other Premises	2,075	855	842	**13**
Supplies & Services	1,727	489	467	**22**
Book Fund	170	56	55	**1**
Hired & Contracted Services	1,186	214	201	**13**
Food Provisions	687	172	168	**4**
School Meals Food	2,059	324	316	**8**
Transport	59	17	16	**1**
Other Agency Costs	557	128	59	**69**
Waste Disposal Contracts	5,119	468	477	**(9)**
Grants To Voluntary Organisations	254	100	97	**3**
Grant To Norton Priory	172	86	87	**(1)**
Transfers To Reserves	133	0	0	**0**
Capital Financing	96	22	20	**2**
Total Expenditure	**28,030**	**6,423**	**6,330**	**93**
Income				
Sales Income	-2,414	-578	-540	**(38)**
School Meals Sales	-2,179	-476	-488	**12**
Fees & Charges Income	-5,188	-1,575	-1,493	**(82)**
Rents Income	-267	-199	-200	**1**
Government Grant Income	-1,186	-1	-1	**0**
Reimbursements & Other Grant Income	-643	-205	-206	**1**
Schools SLA Income	-83	-82	-80	**(2)**
Internal Fees Income	-140	-18	-16	**(2)**
School Meals Other Income	-2,350	-1,526	-1,539	**13**
Meals On Wheels	-245	-61	-39	**(22)**
Catering Fees	-187	-47	-13	**(34)**
Capital Salaries	-53	0	0	**0**
Transfers From Reserves	-75	-67	-67	**0**
Total Income	**-15,010**	**-4,835**	**-4,682**	**(153)**
Net Operational Expenditure	**13,020**	**1,588**	**1,648**	**(60)**
Recharges				
Premises Support	1,916	311	311	**0**
Transport Recharges	2,051	376	376	**0**
Departmental Support Services	9	0	0	**0**
Central Support Services	2,483	480	480	**0**
HBC Support Costs Income	-449	-140	-140	**0**
Net Total Recharges	**6,010**	**1,027**	**1,027**	**0**
Net Department Expenditure	**19,030**	**2,615**	**2,675**	**(60)**

Economy, Enterprise & Property

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	4,715	1,054	1,084	(30)
Repairs & Maintenance	2,557	347	345	2
Premises	41	39	39	0
Energy & Water Costs	690	128	118	10
NNDR	552	508	504	4
Rents	353	170	170	0
Economic Regeneration Activities	50	1	1	0
Supplies & Services	1,922	219	207	12
Grants to Non Voluntary Organisations	269	36	36	0
Total Expenditure	**11,149**	**2,502**	**2,504**	**(2)**
Income				
Fees & Charges	-252	-56	-59	3
Rent – Markets	-777	-185	-190	5
Rent – Industrial Estates	-41	-41	-54	13
Rent – Investment Properties	-871	-228	-233	5
Transfer to /from Reserves	-1,760	-916	-916	0
Government Grant – Income	-1,831	-233	-233	0
Reimbursements & Other Income	-70	-17	-20	3
Recharges to Capital	-242	-17	-8	(9)
Schools Sla Income	-496	-451	-451	0
Total Income	**-6,340**	**-2,144**	**-2,164**	**20**
Net Operational Expenditure	**4,809**	**358**	**340**	**18**
Recharges				
Premises	1,916	470	470	0
Transport	19	5	5	0
Central Support Services	2,022	535	535	0
Repairs & Maintenance Recharge Income	-2,703	-676	-676	0
Accommodation Recharge Income	-2,897	-724	-724	0
Central Support Services Income	-1,934	-483	-483	0
Net Total Recharges	**-3,577**	**-873**	**-873**	**0**
Net Department Expenditure	**1,232**	**-515**	**-533**	**18**

Finance

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	6,642	1,660	1,653	7
Supplies & Services	356	159	151	8
Other Premises	69	50	46	4
Insurances	1,456	707	707	0
Concessionary Travel	2,120	530	539	(9)
Rent Allowances	53,100	11,212	11,212	0
Non HRA Rebates	77	10	10	0
Discretionary Housing Payments	387	34	34	0
Local Welfare Payments	150	31	31	0
Total Expenditure	**64,357**	**14,393**	**14,383**	**10**
Income				
Fees & Charges	-292	-41	-31	(10)
SLA to Schools	-796	-796	-801	5
NNDR Administration Grant	-166	0	0	0
Hsg Ben Administration Grant	-731	-160	-160	0
Council Tax Admin Grant	-232	-232	-233	1
Rent Allowances	-52,700	-11,506	-11,506	0
Clerical Error Recoveries	-398	-139	-139	0
Non HRA Rent Rebates	-77	-9	-9	0
Discretionary Housing Payments Grant	-387	-130	-130	0
Reimbursements & Other Grants	-313	-78	-156	78
Liability Orders	-421	-251	-251	0
Transfer from Reserves	-410	0	0	0
Total Income	**-56,923**	**-13,342**	**-13,416**	**84**
Net Operational Expenditure	**7,434**	**1,051**	**967**	**84**
Recharges				
Premises	340	85	85	0
Transport	8	2	2	0
Central Support Services	2,511	628	628	0
Support Services Income	-6,189	-1,547	-1,547	0
Net Total Recharges	**-3,330**	**-832**	**-832**	**0**
Net Department Expenditure	**4,104**	**219**	**135**	**84**

ICT & Support Services

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	5,440	1,359	1,253	106
Supplies & Services	773	158	150	8
Computer Repairs & Software	615	245	247	(2)
Communications Costs	385	130	130	0
Other Premises	32	5	5	0
Other Transport	6	1	2	(1)
Capital Financing	356	106	106	0
Transfers to Reserves	29	0	0	0
Total Expenditure	**7,636**	**2,004**	**1,893**	**111**
Income				
Fees & Charges	-848	-105	-107	2
SLA to Schools	-514	-484	-489	5
Total Income	**-1,362**	**-589**	**-596**	**7**
Net Operational Expenditure	**6,274**	**1,415**	**1,297**	**118**
Recharges				
Premises	353	88	88	0
Transport	8	2	2	0
Central Support Services	626	156	156	0
Support Service Income	-7,259	-1,815	-1,815	0
Net Total Recharges	**-6,272**	**-1,569**	**-1,569**	**0**
Net Department Expenditure	**2**	**-154**	**-272**	**118**

Legal & Democratic Services

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	1,725	512	530	(18)
Supplies & Services	444	112	110	2
Civic Catering & Functions	27	1	1	0
Mayoral Allowances	22	0	0	0
Legal Expenses	223	41	39	2
Total Expenditure	**2,441**	**666**	**680**	**(14)**
Income				
Land Charges	-103	-26	-21	(5)
License Income	-256	-49	-47	(2)
Schools SLA's	-66	-66	-89	23
Government Grants	-34	-34	-34	0
Other Income	-28	-10	-13	3
Transfers from Reserves	-15	0	0	0
Total Income	**-502**	**-185**	**-204**	**19**
Net Operational Expenditure	**1,939**	**481**	**476**	**5**
Recharges				
Premises Support	158	40	40	0
Transport Recharges	11	3	3	0
Central Support Recharges	361	90	90	0
Support Recharges Income	-1,867	-467	-467	0
Net Total Recharges	**-1,337**	**-334**	**-334**	**0**
Net Department Expenditure	**602**	**147**	**142**	**5**

Planning & Transportation

Policy, People, Performance & Efficiency

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	4,271	1,068	1,043	25
Other Premises	213	61	58	3
Contracted Service	241	44	41	3
Supplies & Services	197	57	56	1
Street Lighting	1,901	105	103	2
Highways Maintenance	2,254	416	416	0
Bridges	99	1	1	0
Fleet Transport	1,424	238	238	0
Lease Car Contracts	316	78	78	0
Bus Support – Hopper Tickets	184	57	57	0
Bus Support	502	161	161	0
Out of Borough Transport	51	0	0	0
Finance Charges	145	78	78	0
Grants to Voluntary Organisations	68	34	34	0
NRA Levy	61	15	15	0
Total Expenditure	**11,927**	**2,413**	**2,379**	**34**
Income				
Sales	-415	-69	-71	2
Planning Fees	-541	-104	-104	0
Building Control Fees	-205	-40	-40	0
Other Fees & Charges	-461	-155	-155	0
Rents	-8	0	0	0
Grants & Reimbursements	-498	-98	-98	0
Government Grant Income	-7	0	0	0
Efficiency Savings	-60	0	0	0
Schools SLAs	-41	-41	-43	2
Capital Salaries	-312	0	0	0
Transfers from Reserves	-100	0	0	0
Total Income	**-2,648**	**-507**	**-511**	**4**
Net Operational Expenditure	**9,279**	**1,906**	**1,868**	**38**
Recharges				
Premises Recharges	858	215	215	0
Transport Recharges	512	106	106	0
Central Recharges	1,584	396	396	0
Borrow to Save Cost	240	0	0	0
Transport Recharge Income	-3,358	-726	-726	0
Central Recharge Income	-925	-175	-175	0
Net Total Recharges	**-1,089**	**-184**	**-184**	**0**
Net Department Expenditure	**8,190**	**1,722**	**1,684**	**38**

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	1,717	423	418	5
Employee Training	133	21	21	0
Supplies & Services	122	29	33	(4)
Total Expenditure	**1,972**	**473**	**472**	**1**
Income				
Fees & Charges	-88	-62	-63	1
Reimbursements & Other Grants	-10	-3	-4	1
School SLA's	-408	-386	-386	0
Transfers from Reserves	-98	0	0	0
Total Income	**-604**	**-451**	**-453**	**2**
Net Operational Expenditure	**1,368**	**22**	**19**	**3**
Recharges				
Premises Support	67	17	17	0
Central Support Recharges	265	66	66	0
Support Recharges Income	-1,700	-425	-425	0
Net Total Recharges	**-1,368**	**-342**	**-342**	**0**
Net Department Expenditure	**0**	**-320**	**-323**	**3**

PEOPLE DIRECTORATE

Adult Social Care, Prevention & Assessment

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	7,694	1,833	1,805	28
Other Premises	80	14	15	(1)
Supplies & Services	342	117	113	4
Aids & Adaptations	113	9	9	0
Transport	18	2	3	(1)
Food Provision	28	4	4	0
Other Agency	23	3	0	3
Transfer to Reserves	2,224	0	0	0
Contribution to Complex Care Pool	17,761	2,937	2,934	3
Total Expenditure	**28,283**	**4,919**	**4,883**	**36**
Income				
Fees & Charges	-306	-77	-75	(2)
Reimbursements & Grant Income	-209	-81	-80	(1)
Transfer from Reserves	-2,464	-18	-18	0
Capital Salaries	-111	-28	-28	0
Government Grant Income	-86	-49	-49	0
Total Income	**-3,176**	**-253**	**-250**	**(3)**
Net Operational Expenditure	**25,107**	**4,666**	**4,633**	**33**
Recharges				
Premises Support	389	93	93	0
Central Support Services	1,874	441	441	0
Internal Recharge Income	-1,677	-381	-381	0
Transport Recharges	29	7	6	1
Net Total Recharges	**615**	**160**	**159**	**1**
Net Department Expenditure	**25,722**	**4,826**	**4,792**	**34**

Children & Families

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	8,637	2,266	2,300	(34)
Premises	276	94	90	4
Supplies & Services	887	300	317	(17)
Transport	6	1	14	(13)
Direct Payments/Individual Budgets	161	30	100	(70)
Commissioned Services	317	39	39	0
Out of Borough Residential Placements	3,387	929	1,183	(254)
Out of Borough Adoption	80	25	25	0
Out of Borough Fostering	414	76	290	(214)
In House Adoption	242	66	86	(20)
Special Guardianship	1,092	269	310	(41)
In House Foster Carer Payments	1,950	456	447	9
Care Leavers	140	46	24	22
Family Support	82	14	17	(3)
Agency Related Expenditure	89	0	0	0
Capital Financing	6	0	0	0
Total Expenditure	**17,766**	**4,611**	**5,242**	**(631)**
Income				
Adoption Placements	-44	0	0	0
Fees & Charges	-123	-16	-18	2
Dedicated School's Grant	-77	-25	-25	0
Reimbursements & Other Grant Income	-220	-210	-213	3
Government Grants	-62	-62	-62	0
Transfer from Reserves	-33	-33	-33	0
Total Income	**-559**	**-346**	**-351**	**5**
Net Operational Expenditure	**17,207**	**4,265**	**4,891**	**(626)**
Recharges				
Premises Support Costs	434	108	108	0
Transport Support Costs	42	13	13	0
Central Support Service Costs	2,178	539	539	0
Net Total Recharges	**2,654**	**660**	**660**	**0**
Net Department Expenditure	**19,861**	**4,925**	**5,551**	**(626)**

Commissioning & Complex Care

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	6,418	1,576	1,524	52
Other Premises	243	71	81	(10)
Supplies & Services	342	86	86	0
Other Agency Costs	618	66	66	0
Transport	187	47	37	10
Carer's Breaks	429	93	91	2
Contracts & SLAs	151	23	21	2
Emergency Duty Team	94	23	22	1
Payments To Providers	3,149	482	482	0
Total Expenditure	**11,631**	**2,467**	**2,410**	**57**
Income				
Sales & Rents Income	-198	-99	-102	3
Fees & Charges Income	-290	-41	-35	(6)
Reimbursements & Other Grant Income	-492	0	0	0
CCG Contribution To Service	-340	-75	-53	(22)
Transfer From Reserves	-1,351	0	0	0
Total Income	**-2,671**	**-215**	**-190**	**-25**
Net Operational Expenditure	**8,960**	**2,252**	**2,220**	**32**
Recharges				
Premises Support	236	59	59	0
Transport	393	98	114	(16)
Central Support Services	1,090	264	264	0
Internal Recharge Income	-649	-140	-140	0
Net Total Recharges	**1,070**	**281**	**297**	**(16)**
Net Department Expenditure	**10,030**	**2,533**	**2,517**	**16**

Education, Inclusion & Provision

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	6,355	1,461	1,416	45
Premises	442	17	13	4
Supplies & Services	2,996	563	539	24
Transport	5	2	2	0
School Transport	934	109	184	(75)
Commissioned Services	2,647	538	528	10
Agency Related Expenditure	1,474	464	462	2
Independent School Fees	2,463	824	824	0
Inter Authority Special Needs	175	0	0	0
Pupil Premium Grant	191	1	1	0
Nursery Education Payments	2,980	1,053	1,053	0
Schools Contingency	469	100	100	0
Special Education Needs Contingency	2,016	500	500	0
Capital Finance	3	0	0	0
Early Years Contingency	50	0	0	0
Total Expenditure	**23,200**	**5,632**	**5,622**	**10**
Income				
Fees & Charges	-351	-4	-5	1
Government Grant	-569	-545	-545	0
Reimbursements & Other Income	-1,112	-81	-78	(3)
Schools SLA Income	-252	-222	-233	11
Transfer to / from Reserves	-781	-506	-506	0
Dedicated Schools Grant	-12,938	-3,398	-3,398	0
Inter Authority Income	-578	-91	-91	0
Sales Income	-38	-2	0	(2)
Rent	-102	0	0	0
Total Income	**-16,721**	**-4,849**	**-4,856**	**7**
Net Operational Expenditure	**6,479**	**783**	**766**	**17**
Recharges				
Central Support Services Costs	1,982	455	455	0
Premises Support Costs	288	71	71	0
Transport Support Costs	253	1	1	0
HBC Support Costs Income	-79	0	0	0
Net Total Recharges	**2,444**	**527**	**527**	**0**
Net Department Expenditure	**8,923**	**1,310**	**1,293**	**17**

Public Health & Public Protection

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	3,385	818	779	39
Supplies & Services	273	27	26	1
Other Agency	21	21	16	5
Contracts & SLA's	7,556	1,324	1,322	2
Total Expenditure	**11,235**	**2,190**	**2,143**	**47**
Income				
Other Fees & Charges	-57	-16	-14	(2)
Sales Income	-44	-44	-44	0
Reimbursements & Grant Income	-166	-121	-121	0
Government Grant	-10,718	0	0	0
Transfer from Reserves	-500	0	0	0
Total Income	**-11,485**	**-181**	**-179**	**(2)**
Net Operational Expenditure	**-250**	**2,009**	**1,964**	**45**
Recharges				
Premises Support	162	40	40	0
Central Support Services	592	113	113	0
Transport Recharges	18	5	4	1
Support Income	-64	0	0	0
Net Total Recharges	**708**	**158**	**157**	**0**
Net Department Expenditure	**458**	**2,167**	**2,121**	**46**

Corporate & Democracy

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	338	84	76	8
Other Premises	86	22	78	(56)
Contracted Services	63	7	5	2
Supplies & Services	144	65	63	2
Mersey Gateway Crossings Board Ltd	776	314	288	26
Members Allowances	785	208	208	0
Interest Payable	2,047	512	363	149
Bank Charges	78	14	14	0
Audit Fees	142	30	30	0
Contingency	1,000	0	0	0
Capital Financing	1,752	553	497	56
Contribution to Reserves	751	0	0	0
Precepts & Levies	181	0	0	0
Corporate Property Savings Target	-670	-167	0	(167)
Total Expenditure	**7,473**	**1,642**	**1,622**	**20**
Income				
Interest Receivable	-436	-109	-165	56
Other Fees & Charges	-110	-12	-14	2
Grants & Reimbursements	-1,075	-494	-523	29
Government Grant Income	-5,257	-3,272	-3,272	0
Transfer from Reserves	-1,081	0	0	0
Total Income	**-7,959**	**-3,887**	**-3,974**	**87**
Net Operational Expenditure	**-486**	**-2,245**	**-2,352**	**107**
Recharges				
Premises Recharges	5	1	1	0
Central Recharges	1,157	350	350	0
Central Recharge Income	-370	-93	-93	0
Net Total Recharges	**792**	**258**	**258**	**0**
Net Department Expenditure	**306**	**-1,987**	**-2,094**	**107**

APPENDIX 2

Complex Care Pooled Budget

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

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Intermediate Care Services	4,196	505	424	81
End of Life	192	48	57	(9)
Sub Acute	1,727	5	4	1
Urgent Care Centres	815	50	47	3
Joint Equipment Store	615	115	100	15
Contracts & SLA's	987	316	288	28
Intermediate Care Beds	596	149	178	(29)
BCF Schemes	1754	424	424	0
Adult Care:				
Residential & Nursing Care	21,387	4,270	4,005	265
Domiciliary & Supported Living	9,678	2,075	2,327	(252)
Direct Payments	5,033	1,642	1,866	(224)
Day Care	434	65	58	7
Frailty Pathway	155	0	0	0
Contingency	518	0	0	0
Total Expenditure	48,087	9,664	9,778	(114)
Income				
Residential & Nursing Income	-5,059	-777	-914	137
Community Care Income	-1,840	-283	-235	(48)
Direct Payments Income	-253	-51	-83	32
BCF	-9,491	-2,373	-2,373	0
CCG Contribution to Pool	-12,846	-3,211	-3,211	0
Other CCG income	-114	-32	-28	(4)
ILF Grant	-723	0	0	0
Total Income	-30,326	-6,727	-6,844	117
Net Department Expenditure	**17,761**	**2,937**	**2,934**	**3**

APPENDIX 3

Capital Expenditure to 30 June 2016

Directorate/Department	Actual Expenditure to Date	2016/17 Cumulative Capital Allocation				Capital Allocation 2017/18	Capital Allocation 2018/19
		Quarter 1	Quarter 2	Quarter 3	Quarter 4		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Enterprise, Community & Resources Directorate							
Community and Environment							
Stadium Minor Works	15	15	175	225	280	30	30
Leisure Centres Refurbishment	267	267	275	275	275	0	0
Widnes Recreation Site	39	40	156	156	156	0	0
Norton Priory	1,737	1,737	2,000	2,300	2,628	529	0
Norton Priory Biomass Boiler	0	0	0	0	107	0	0
Open Spaces Schemes	21	21	80	150	200	0	0
Children's Playground Equipment	0	0	20	40	65	91	65
Upton Improvements	0	0	0	0	13	0	0
The Glen Play Area	12	20	95	100	100	4	0
Runcorn Hill Park	1	1	190	200	210	150	75
Crow Wood Play Area	0	0	3	6	9	0	0
Runcorn Cemetery Extension	0	0	0	0	0	9	0
Peelhouse Lane Cemetery	0	0	5	100	105	1,000	293
Peelhouse Lane Cemetery – Enabling Works	35	32	37	43	46	0	0
Landfill Tax Credit Schemes	0	0	5	10	340	340	340
Litter Bins	19	20	20	20	20	20	20
ICT & Support Services							
ICT Rolling Programme	301	275	550	825	1,100	1,100	1,100

Directorate/Department	Actual Expenditure to Date	2016/17 Cumulative Capital Allocation				Capital Allocation 2017/18	Capital Allocation 2018/19
		Quarter 1	Quarter 2	Quarter 3	Quarter 4		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Economy, Enterprise & Property							
Castlefields Regeneration	10	10	40	60	179	0	0
3MG	155	150	570	1,370	2,809	0	0
Widnes Waterfront	0	0	0	0	0	1,000	0
Johnsons Lane Infrastructure	0	0	302	302	302	0	0
Decontamination of Land	0	0	0	0	6	0	0
SciTech Daresbury – Tech Space	7,845	8,000	8,000	8,000	10,953	0	0
Former Crosville Site	229	203	1,000	1,800	2,618	0	0
Police Station Site	219	219	326	341	341	0	0
Travellers' Site Warrington Road	0	0	0	48	48	0	0
Signage at The Hive	0	0	2	95	100	0	0
Advertising Screen at The Hive	0	0	0	0	100	0	0
Widnes Town Centre Initiative	0	0	5	11	16	0	0
Widnes Market Refurbishment	0	0	5	918	1,052	370	10
Widnes Land Purchases	0	0	0	0	235	0	0
Equality Act Improvement Works	0	0	20	100	150	450	300
Mersey Gateway							
Land Acquisitions	100	100	759	4,690	4,880	2,241	3,863
Development Costs	498	498	1,234	1,956	2,819	2,649	0
Loan Interest During Construction	758	758	1,705	2,557	3,416	2,011	0
Construction Costs	0	0	0	0	35,000	67,500	0
Mersey Gateway Liquidity Fund	0	0	0	0	0	10,000	0

Directorate/Department	Actual Expenditure to Date	2016/17 Cumulative Capital Allocation				Capital Allocation 2017/18	Capital Allocation 2018/19
		Quarter 1	Quarter 2	Quarter 3	Quarter 4		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Other							
Risk Management	0	0	25	100	125	120	120
Fleet Replacements	110	110	1,060	2,010	2,959	624	556
Planning & Transportation							
Bridge & Highway Maintenance	134	130	1,230	2,330	3,433	3,231	1,546
Integrated Transport & Network Management	64	65	300	535	736	908	0
Street Lighting – Structural Maintenance & Upgrades	158	160	400	600	2,751	1,700	200
STEPS Programme	0	0	200	400	651	0	0
S106 Schemes	0	0	85	170	256	0	0
Peelhouse Lane Cemetery - Highways	0	0	0	50	101	0	0
Hale Road Bus Priority Route	0	0	50	100	150	0	0
Total Enterprise Community & Resources	**12,727**	**12,831**	**20,929**	**32,993**	**81,840**	**96,077**	**8,518**

Directorate/Department	Actual Expenditure to Date	2016/17 Cumulative Capital Allocation				Capital Allocation 2017/18	Capital Allocation 2018/19
		Quarter 1	Quarter 2	Quarter 3	Quarter 4		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
People Directorate							
Commissioning & Complex Care							
ALD Bungalows	0	0	100	200	299	100	0
Grangeway Court	172	172	343	343	343	0	0
Community Capacity Grant	0	0	0	0	57	0	0
Social care capital grant	0	0	0	0	356	0	0
Complex Pool							
Disabled Facilities Grant	114	140	225	338	788	0	0
Stairlifts (Adaptations Initiative)	86	75	113	135	157	0	0
RSL Adaptations (Joint Funding)	62	50	80	110	140	0	0
Madeline McKenna Residential Home	0	0	450	450	450	0	0
Prevention & Assessment							
Community Meals Oven	0	0	0	0	10	0	0
Lifeline Telecare Upgrade	11	11	20	100	100	0	0
Public Health & Public Protection							
Halton Recovery & Wellbeing Hub	0	0	45	45	45	0	0

Directorate/Department	Actual Expenditure to Date	2016/17 Cumulative Capital Allocation				Capital Allocation 2017/18	Capital Allocation 2018/19
		Quarter 1	Quarter 2	Quarter 3	Quarter 4		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Schools Related							
Asset Management Data	1	1	1	3	7	0	0
Fire Compartmentation	25	25	37	37	37	2	0
Capital Repairs	75	75	450	600	735	0	0
Asbestos Management	1	1	3	10	20	0	0
Schools Access Initiative	2	2	20	70	80	0	0
Education Programme (General)	4	4	15	50	110	0	0
Basic Need Projects	0	0	0	0	848	71	0
School Modernisation Projects	21	21	200	400	506	0	0
Early Education for 2 Year Olds	1	1	1	10	52	0	0
Universal Infant School Meals	0	0	0	0	2	0	0
Halebank	20	20	20	20	20	0	0
St Edwards Catholic Primary	0	0	20	27	27	0	0
Hale Primary	27	27	98	108	118	0	0
Fairfield Primary School	189	189	500	750	1,194	841	0
Weston Point Primary	0	0	0	0	45	0	0
Total People Directorate	**811**	**814**	**2,741**	**3,806**	**6,546**	**1,014**	**0**
TOTAL CAPITAL PROGRAMME	**13,538**	**13,645**	**23,670**	**36,799**	**88,386**	**97,091**	**8,518**
Slippage (20%)					-10,684	-3,918	-1,704
						10,684	3,918
TOTAL	**13,538**	**13,645**	**23,670**	**36,799**	**77,702**	**103,857**	**10,732**

REPORT TO:	Executive Board
DATE:	15 September 2016
REPORTING OFFICER:	Strategic Director – Enterprise, Community and Resources
SUBJECT:	Discretionary Non-Domestic Rate Relief
PORTFOLIO:	Resources
WARD(S):	Borough-wide

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to consider an application for discretionary non-domestic rate relief, under the amended provisions of the Local Government Finance Act 1988.

2.0 RECOMMENDATION: That under the provisions of Section 47 of the Local Government Finance Act 1988, the application for 15% discretionary rate relief from Loose be granted for the period of three years commencing 1st April 2016.

3.0 SUPPORTING INFORMATION

3.1 Under the amended provisions of the Local Government Finance Act 1988, the Council is able to grant discretionary rate relief to any business ratepayer. This relief had previously only been available to organisations that were a charity, a community amateur sports club or a not for profit organisation. A summary of the application is presented below and the associated financial implications are shown in the Appendix.

3.2 From 1st April 2013, there have been significant changes in the funding of non-domestic rate reliefs and exemptions, following the introduction of the Business Rates Retention Scheme. The Council is now responsible for funding 49% of any award of mandatory or discretionary rate relief granted, with the Government meeting the remaining 51%. Previously, the Government fully funded all mandatory relief awards.

Loose Studio
2 Lacey Street, Widnes

3.3 Loose is a local registered charity whose objective is to remove barriers to participation in music, arts and life. The Loose Studio is for community benefit and is also used by other not for profit support groups and organisations. The organisation is run by volunteers.

3.4 The organisation's premises at 2 Lacey Street, Widnes are used as an arts and music centre for adults with mental health issues, young people, people of the community who are unemployed, local theatre & music groups, dance classes and for local fund raising events. The premises are also used by MIND, Just Chill (referred support group for disadvantaged young people) and Fresh Start.

3.5 As a registered charity the organisation has already been awarded 80% mandatory rate relief in respect of the above property. The annual cost of the mandatory rate relief to the Council is £2,240.48

3.6 Retail rate relief was awarded in 2014/15 and 2015/16 which offset the remaining balance due in respect of business rates, however, this relief has now ceased.

3.7 A new application has therefore been received from Loose seeking top-up discretionary rate relief from 1st April 2016 in respect of the above premises. Since 1st April 2016 the maximum top-up award granted by the Council is 15%. The annual cost of such an award to the Council in this instance would be £420.09.

4.0 POLICY IMPLICATIONS

4.1 The Board is required by the regulations to consider each application on its own merit. Any recommendations provided are given for guidance only, are consistent with Council policy and, wherever possible, previous decisions.

5.0 FINANCIAL IMPLICATIONS

5.1 It should be noted that 49% of any discretionary rate relief granted to organisations receiving mandatory rate relief must be met by the Council. Any awards of mandatory rate relief will also be funded at the same percentage (49%) by the Council. The Appendix presents the potential costs to the Council.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**
Loose offers community support to children through the promotion of arts and music.

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

6.3 **A Healthy Halton**
The organisation provides an arts and music centre for adults with mental health issues and also dance classes for all age groups.

6.4 **A Safer Halton**
None

6.5 **Halton's Urban Renewal**
None.

7.0 RISK ANALYSIS

7.1 There are no key risks associated with the proposed action.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The applicants offer their services to all sections of the community, without any prejudice.

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

9.1	Document	Place of Inspection	Contact Officer
	Application forms and supporting evidence	Kingsway House, Caldwell Road, Widnes	Janet Sinnott, Business Rates Manager

APPENDIX

Ratepayer	Address	Annual Rates 2016/17 £	Actual Rates Liability 2016/17 £	Mandatory Rate Relief Awarded	Annual Cost of Mandatory Rate Relief to HBC £	Actual Rates Payable 2016/17 £	Disc. Rate Relief Claimed	Annual Cost of Disc.Rate Relief to HBC 2016/17 £	Actual Cost of Disc. Rate Relief to HBC 2016/17 £
Loose	2 Lacey Street, Widnes	5,715.50	5,715.50	80%	2,240.48	1,143.10	15%	420.09	420.09

REPORT TO: Executive Board

DATE: 15 September 2016

REPORTING OFFICER: Operational Director – Finance

PORTFOLIO: Resources

SUBJECT: 100% Business Rate Retention - Consultation

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To outline the consultations on business rates reform recently published by Government covering 100% business rates retention and a call for evidence on relative needs and redistribution. To provide details on the calculation of 'No Detriment' of funding to council members of the Liverpool City Region Area during the piloting of 100% business rate retention.

2.0 RECOMMENDED: That

1) **the Operational Director, Finance, in consultation with the Portfolio Holder Resources, take the necessary steps to accept the four-year funding settlement offer by 14 October 2016; and**

2) **the Operational Director, Finance, in liaison with the Portfolio Holder Resources contribute and agree to the Liverpool City Region response on the consultation titled "Self-Sufficient Local Government: 100% Business Rate Retention" and the call for evidence titled "Fair Funding Review: Call for Evidence on Needs and Distribution.**

3.0 BACKGROUND

3.1 Since April 2013 councils have retained 50% of the business rates they collect. The remaining 50%, or central share, is paid over to Government and is then redistributed to councils in the form of revenue support grant and other specific grants.

3.2 The 50% which is retained by councils, or local share, is partly redistributed between councils through a system of tariffs and top-ups. This redistribution is intended to ensure that areas do not lose out just because their retained business rates are low compared to their assessed needs. Halton currently receives a top-up grant of approximately £7.6m pa.

3.3 The current system also includes a safety net mechanism, which protects councils who see their annual business rates income fall by more than 7.5% below a baseline level. This is funded by a levy charged against those councils who see excess growth in their business rates.

3.4 On 5 July 2016 the Department for Communities and Local Government (DCLG) published a consultation paper regarding the implementation of a new system of 100% business rates retention for local government by the end of this Parliament in 2020. The consultation paper asks questions about the principles underlying the system and requires responses by 26 September 2016. A more detailed technical consultation is planned during Autumn 2016.

3.5 Halton is working with the other LCR councils to prepare a combined LCR response to the 100% Business Rates Retention consultation, as the implications for each of the six councils are very similar.

3.6 Alongside the consultation on 100% Business Rates Retention, the Government also announced a Fair Funding Review of councils' relative needs and resources, with responses due by 26 September 2016.

3.7 The outcome of the Fair Funding Review will establish the funding baseline for each council, which reflects their specific needs and the business rates income required to meet these. It will also determine the level of top-up grant to be received, where a council's retained business rates are less than the baseline level. This is a vital feature of the system for Halton and all of the LCR councils, therefore a combined LCR response will be provided to the Fair Funding Review.

3.8 The Liverpool City Region has already agreed to be a pilot area for 100% Business Rates Retention. Following this consultation and the technical consultation during Autumn 2016, legislation will be introduced in early 2017 to provide the framework for the business rates reforms. The piloting of 100% Business Rates Retention will begin from April 2017.

4.0 Business Rate Retention Pilot Area

4.1 On 16 June 2016 the proposal for Liverpool City Region including Halton to be a pilot area for 100% Business Rate Retention was presented to the Executive Board. Included within the report was information on the option for councils to take up the option of a four year grant settlement providing councils produced and published an efficiency plan. The intention being to provide councils with some degree of financial certainty. Should the national economic position deteriorate and the Government need to make additional austerity measures, they are providing some assurances (although not an absolute guarantee) that they will not reduce each council's grant allocations below this minimum level.

4.2 It was considered at this time, following discussions with DCLG, that as a result of being a member of a pilot area the Council would not be required to sign up to the four year grant settlement offer as during the pilot period DCLG guaranteed that no council would be financially no worse off.

4.3 DCLG have now issued a paper titled "Calculating No Detriment" outlining the principles of each council of the pilot areas being without detriment to the resources

that would have been available to individual councils in the pilot areas under the current local government finance regime. The principle calculation is to compare the difference between A and B where:

A is the sum of the councils retained business rates under the 50% scheme plus the sum of any grants/payments that would have been paid to the council if they had not rolled-into the 100% pilot; and

B is the retained business rates income actually retained under the pilot, including grants and other payments.

4.4 Whilst the above guarantees the council will be no worse off as a result of being within the pilot area it doesn't provide absolute certainty of the council being no worse off if it had signed up to the 4 year settlement offer or if it hadn't. Therefore it is considered prudent for the Council to sign up to the 4 year offer and publish an efficiency report by 14 October 2016.

5.0 KEY PROPOSALS FROM THE CONSULTATION / FAIR FUNDING REVIEW

5.1 The consultation paper stresses that the Government expects the new system to have strong similarities to the existing system and in particular will include mechanisms for the redistribution of business rates between councils, in a similar way to the existing tariffs and top-ups.

5.2 There will however also be some significant changes. The levy on growth referred to in para 3.3 will cease, which currently funds the safety net mechanism. It is suggested Councils will have scope to reduce the business rates multiplier (rate in the pound) and the potential for combined authorities to charge an Infrastructure Levy of up to 2p in the £ supplement on business rates growth with the approval of the Local Enterprise Partnership (LEP) and the new system will reflect the roles of Combined Authorities and Devolution Deals.

5.3 In advance of the consultation the Government has set up technical working groups which have considered in the following themes:

- Devolution of Responsibilities
- Operation of the system, including how growth is rewarded and risk is shared.
- Local Tax Flexibilities
- Accountability and accounting in a reformed system.
- Assessment of council's needs and redistribution of resources.

Devolution of Responsibilities

5.4 Government identify with the introduction of 100% business rate retention it will give councils an additional £12.5bn of revenue from business rates to spend on local services. The reforms will be fiscally neutral and to ensure this, councils will gain new responsibilities and some existing government grants will be phased out.

5.5 The consultation identifies a number of responsibilities, currently funded from government grant which are considered as a possible fit for being funded through retained business rates. The list includes:

- Revenue Support Grant (RSG)
- Public Health Grant
- Independent Living Fund
- Early Years (currently funded from Dedicated Schools Grant)
- Youth Justice
- Local Council Tax/Housing Benefit Pension Administration Subsidy
- Attendance Allowance

5.6 The consultation also considers responsibilities which have been, or will be devolved at a combined authority level and seeks views on these being funded by retained business rates.

5.7 There are a number of risks to funding these responsibilities from retained business rates, a future decrease in local business rates (to any safety net level) will result in less funding being available than would have been under the grant being provided from Whitehall departments. In addition, the extent to which a responsibility is suitable to be financed by retained business rates is subjective. For example, Localised Support for Council Tax Funding was introduced in April 2013 and funded from 50% business rate retention but this was closely linked to the economic prosperity of the national and local economy. A downturn in the economy could lead to an increased demand in services whilst at the same time reduction in business rates income.

Operation of the System – Rewarding Growth and Sharing Risk

5.8 The consultation seeks views on how a reformed system provides stronger incentives to boost growth and reward councils that take bold decisions to further increase growth. In addition the system design also needs to ensure that councils are adequately protected from business rates volatility and shocks in business rates income. Working alongside these aims is to have a system which is simple to understand and operate.

5.9 In order to help manage growth and risk Government have shared the view that there must be fixed reset periods within the system to reconsider relative need and the value of tariff and top-ups. The fixed period could be frequently (approx. every 5

years) or infrequently (approx. every 20 years),the more regular the reset will minimise the risk in the system and provide more certainty whilst an infrequent reset will reward any growth over a longer period.

5.10 To balance revenue with relative needs, Government are of the view there needs to continue to be a form of redistribution within the system. In order to achieve this, the proposal is for the system of tariffs and top/ups to remain, fixed for the period between resets. Under the current 50% retention system, the Council are in receipt of a top-up of approximately £7.6m per financial year.

5.11 Responses to the consultation are also being sought on the view that a directly elected Mayor should have the opportunity for an enhanced role in achieving growth under the 100% rate retention system. This could be achieved by the mayoral area deciding how any growth is distributed across the area, or further still by each mayoral area having an area-wide baseline and single tariff/top-up and developing governance arrangements on how resources are distributed.

5.12 Increasing the retained element of business rates from 50% to 100% will increase the risk inherent within the system. Income from business rates is at risk for broadly two reasons:

- Changes to rateable values of hereditaments following successful appeals by ratepayers.
- Physical changes to property, including building closures as a result of business failure.

5.13 To protect against the risk in the current system the Council makes an annual provision within the accounts for outstanding appeals by ratepayers, as at 31 March 2016 the provision stood at £10.2m, the share attributable to the Council of £5m. Additionally, the current system provides a safety net against significant losses, calculated to be more than 7.5% loss to retained rates as measured against the baseline funding level.

5.14 To help manage the risks within the system further there are a number of suggestions proposed in the consultation with the aim of providing more certainty to the medium term finances for councils. These include accounting for appeals at a regional or national level, which would help share the risk. This could be achieved by moving some of the higher risk hereditaments from a local list to a central risk managed by Combined Authorities or Central Government; these could include hereditaments such as power stations, oil refineries and national airports.

5.15 The consultation makes clear that the new system will continue to need to help insulate authorities from shocks. Currently this works at a national levy with the safety net being funded from a levy on excessive growth in business rates retained. Prior to the consultation Government confirmed the levy will be scrapped and all growth will remain with the local authority. There are two alternatives proposed to funding the

continued operation of the safety net, the first being to manage it on a geographical level and working together to manage risk and reward or for it to continue on a national level with all councils collectively contributing.

Local Tax Flexibilities

5.16 A key part of the reforms to make local authorities more self-sufficient and better able to drive local growth is the devolving of tax-setting powers. Under the new system, councils will have the ability to tailor their own business rates to fit the local economic environment. New powers include:

- The ability to reduce the business rates tax rate (the multiplier)
- The ability for Combined Authority Mayors to levy a supplement on business rate bills to fund new infrastructure projects, provided they have the support of the business community through the Local Enterprise Partnership.

5.17 The decision to reduce the multiplier is down to each relevant council to exercise such a power. The costs of reducing the multiplier would also be the responsibility of each relevant Council. There would be no impact on the rate of tariffs and top-us paid and received as a result of such a decision. The view of Government is councils should continue to use their existing local discount powers for targeted relief and that the new power should be used as a structural power across their area.

5.18 The consultation document is seeking views on the power of Combined Authority Mayors to levy a 2p in the pound supplement on business rate bills to fund new infrastructure projects. The approval of a majority of the business members of the LEP Board will be required in order for an infrastructure levy to be raised.

Accountability and Accounting

5.19 The Accountability and Accounting working group is considering how reforms may change the balance of local and central accountability, including in relation to the additional responsibilities that Councils will take on. It seeks views on the current method of accounting for business rates and depending on the design of the scheme, whether this may need to change.

Assessment of Council's Needs and Redistribution of Resources

5.20 In April 2013 at the commencement of 50% business rate retention Government carried out an assessment of the relative level of needs and resources of councils across England. It is argued by many that too much time has passed since the last fundamental review of the approach to assessing a council's relative needs, and the costs it can be expected to incur in delivering services. This is especially relevant to Halton given the additional service pressures and costs as a result of the aging population and increase in number of children in care.

5.21 The consultation asks for views on the methods Government should undertake in collecting and measuring data required to develop a formulae to assess and compare needs and resources. Going further it also requests views on whether need should continue to be measured at individual local authority level or at larger geographical areas.

6.0 POLICY IMPLICATIONS

6.1 None.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 There are no direct implications however, the funding for the Council's budget supports the delivery and achievement of all of the Council's priorities.

8.0 RISK ANALYSIS

8.1 The introduction of 100% business rate retention will bring additional risks to Local Government in that councils will have full responsibility in the resources it generates to fund existing and future services.

8.2 Throughout the document a number of risks have been identified as a result of the proposals included both within the running of the business rate retention pilot and consultation/review documents. The Council together with the Liverpool City Region will aim to mitigate these risks through responses to the proposals and dialogue with Central Government. Being a member of a pilot area will provide an advantage in that during the period of the pilot the Council will be given the opportunity to comment on issues as they arise. Government have also given the guarantee that during the period of the pilot Halton's funding will be no worse than that which would have been received, the position will be strengthened further by agreeing to the four year settlement offer.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 None.

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

Document	Place of Inspection	Contact Officer
Business Rate Reform Consultations and Fair Funding Review Paper	Kingsway House	Steve Baker

REPORT TO: Executive Board

DATE: 15 September 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO Physical Environment

SUBJECT: Brennan Lodge Supported Housing Scheme

WARDS: Borough-wide

1.0 PURPOSE OF REPORT

1.1 The purpose of the report is to inform the Executive Board that the contract with the Salvation Army, who were commissioned to deliver services at Brennan Lodge supported housing scheme for single homeless people, has been terminated.

2.0 RECOMMENDATION: That the Board

1) **Note the report;**

2) **Note that the contract with the Salvation Army has been terminated; and**

3) **Note that a re-procurement process has commenced, the outcome of which will be reported to the Executive Board.**

3.0 SUPPORTING INFORMATION

3.1 Background information

3.1.1 The service was originally commissioned to provide a single homeless service in Widnes, as the majority of supported accommodation for this client group was sited in Runcorn.

3.1.2 Halton Housing Trust is the housing provider, and the property developed in partnership with the Council to ensure the service met our requirements.

3.1.3 The service was procured in 2014/15 and was originally due to open in April 2015. Delays in the building work and handover of the property however, resulted in the service opening in July 2015.

3.1.4 The Salvation Army were commissioned to deliver the service following a robust procurement process, and following contract award they joined the steering group responsible for the property

development. This ensured The Salvation Army was fully involved in the later stages of the development together with the Council and Halton Housing Trust.

3.1.5 Since the official opening of the Scheme in July 2015, the Housing Solutions Team was involved with residents and staff. The designated officer provides a weekly outreach support and advice service to residents and conducts regular case reviews with staff, to ensure that the required move on process is fully promoted.

3.1.6 Late August 2015, a number of procedural issues were identified within the scheme, with HBC staff reporting unacceptable levels of conduct and lack of support for residents. An issue occurred early September 2015, involving a young person going missing and the scheme staff failing to activate the missing from home policy.

3.1.7 It was evident at an early stage that the staff were not fully equipped to deal effectively with young people. During the review visit the level of discussions confirmed the lack of support and monitoring of young people within the scheme.

3.1.8 A multi-agency meeting was held on 19th September 2015, involving CSC Commissioners / Principal Managers and Police to discuss the above issues. Due to the safeguarding concerns highlighted, it was considered necessary to suspend the service and transfer all the young people from the scheme, all of whom were placed in alternative supported housing schemes or facilitated back home.

3.1.9 Salvation Army management were notified of the above action and agreed to work with HBC to complete and implement the devised action plan. The Salvation Army management agreed to implement further safeguarding measures, which included additional staffing within the scheme and an additional scheme manager to reinforce procedural practice and level of commitment to the service.

3.1.10 Since the scheme opened there has been complaints received, both internally and externally, which prompted a planned visit to Brennan Lodge. The service audit visits were undertaken by Principal Manager (Homelessness) and Quality Assurance Officer to complete an audit review of procedural practice, service provision and support within the scheme. The purpose was to ensure that staff were fully equipped and trained to manage, support and safeguard vulnerable residents accommodated. Unfortunately, during the number of visits completed, it was evident that the lack of action instigated by the scheme manager and continuance of errors was not considered acceptable. Due to the ongoing issues and areas of concern identified within the scheme, an action plan was devised for the relevant officers to update and complete.

3.1.11 A number of meetings and visits have been completed during the last 10 months. As part of the review process, further discussion meetings were held with the Salvation Army management team to outline the areas of concern, offering recommendations of best practice, including training and support available.

3.1.12 During each service audit review, the Salvation Army management have been asked if they could confidently manage the service at full capacity. On each occasion they stated they were not in a position to manage the service at full capacity and reinforced the findings of audit reports. The management team expressed their own concerns and requested additional time to implement the required actions before considering lifting the suspension.

3.1.13 The service audit review completed June 2016 confirmed that there had been slight improvements, however, repeated errors still existed within the procedural practice and case file management that had not been addressed previously.

3.1.14 The service is a 39 bed scheme, which has accommodated less than 40% during the last eight months, thus reaffirmed the concerns around service management and ability to provide an efficient service at full capacity. Furthermore, officers were not confident in removing the suspension or referral restrictions.

3.1.15 The level of involvement from HBC officers has not only proven time consuming, but difficult to manage. Due to the ongoing issues and concerns around resident welfare and lack of procedural practice, this has placed additional pressure on the review officers to undertake regular reviews to minimise the risks.

3.1.16 The following options were considered:

	Option	Detail / Risk
1	Fully lift suspension	This option would see an increase in referrals into the service, with agreed targets for occupancy levels and the expectation that the service would be up to full occupancy within a month. Although there has been some improvement in the quality of service being delivered by the Salvation Army, this has only been minimal progress and achieved when the service was running at low occupancy levels. Officers have concerns about their ability to manage at full capacity
2	Continue with partial	This is not considered a viable option as the service has been subject to a

	suspension	suspension/partial suspension for 8 months. HBC continues to pay the full contract value during the suspension period but this cannot continue as it does not represent a value for money service. Any reduction in funding will impact TSA who will already be incurring void losses from current occupancy levels.
3	Terminate contract with The Salvation Army	This would see TSA given 3 months notice of intention to end the contract. During this time, officers from Housing Solutions and Commissioning will work with TSA and other support providers to move people in a safe and managed way, either into settled move on accommodation (with floating support where required) or into an alternative single homeless service at Halton Lodge (YMCA)

3.1.17 Given the issues outlined above, Option 3 represented the best method of ensuring a safe, efficient and cost effective service.

3.1.18 The preferred option was to terminate the contract and retender this service to ensure there is sufficiency provision in Halton, with a geographical balance of single homelessness services within Widnes and Runcorn. If the service was not re-commissioned, it could prove detrimental and costly to the Local Authority. Consequently, there would be an increase in Bed and Breakfast placements and clients being placed out of Borough, which is considered inappropriate.

3.1.19 The Local Authority has now served formal notice to the Salvation Army, giving three months' notice to terminate the contractual agreement. Both staff and residents have been notified of the situation and provisions underway to address both the financial void implications and decant process.

3.1.20 An implementation plan has been developed to move people out of Brennan Lodge in a safe and structured way, and will link into other services, including the single homeless service at Halton Lodge (YMCA Building) and the Plus Dane/ SHAP floating support service for those who have secured move on properties but still require an element of housing support.

3.1.21 Nationally and Locally trends indicate a gradual increase in homelessness, which is predicted to continue. The increased levels in

both homelessness and prevention is contributed by legislative changes, welfare reform, universal credit etc., thus placing additional pressures on homelessness services and temporary/permanent accommodation provision.

3.1.22 Homeless Statistics Table:

	2011/12	2012/13	2013/14	2014/15	2015/16
Presentations	154	166	197	247	277
Acceptances	64	86	32	49	34
Homeless Prevention	492	431	777	798	989
Advice & Assistance Prevention	1665	2079	1781	1857	2057
B&B	0	0	0	0	0

3.1.23 As indicated within the table above, the gradual increase will place additional pressure upon the Local Authority to ensure additional accommodation resource is available to discharge legal duty.

4.0 POLICY IMPLICATIONS

4.1 None

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 Payment is still being made at the full contract value despite the service operating at reduced capacity for eight months. It is not financially viable for the Council for this to continue.

5.2 In addition, there are financial implications for The Salvation Army who will be incurring void loss costs together with additional staffing costs for the temporary manager. It is unclear if this is financially sustainable for provider, but it The Salvation Army has been informed these additional costs will not to be met by Halton Borough Council.

5.3 There is also a potential implication for the Council's Bed and Breakfast budget if the service is not re-procured.

5.4 The present contract value for the service is £656,709, which needs to be considered as part of the retendering process.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

The termination of the Salvation Army contract will have short term implications for the Councils priorities. The supported accommodation provision is a valued requirement, which allows the Local Authority to administer and comply with statutory homelessness legislation.

The procurement process will run parallel to the Salvation Army contract notice period. However, there will be a short period when the scheme will be empty, prior to the new contract being awarded. This will reduce the level of accommodation provision available within the Borough, which may result in the use of bed and breakfast accommodation.

6.1 Children & Young People in Halton

The Local Authority has a statutory duty towards vulnerable young people presenting as homeless and ensure they are fully supported to access all housing and support options and services available,

Children's services commission an emergency bed for 16/17 year olds, which was located within the Brennan Lodge Scheme. This provision has now ceased, thus reducing the level of temporary provision available for young people presenting as homeless.

Discussions are underway with another accommodation provider within the Borough. A full risk assessment will be undertaken to determine the appropriateness and safety of the accommodation to meet the needs of vulnerable young people.

The lack of temporary accommodation resource will place additional pressures on the relevant services and accommodation providers within the Borough.

6.2 Employment, Learning & Skills in Halton

The Housing and Support Gateway service will ensure appropriate referrals are made into housing support and accommodation services to meet any identified employment and training needs.

6.3 A Healthy Halton

The Authority will continue to provide services to support vulnerable people to access accommodation, health and care services.

6.4 A Safer Halton

The procurement process will determine the new contract provider; meanwhile, the appropriate referrals will continue to be made into housing support and accommodation services to keep vulnerable people safe in the community.

6.5 **Halton's Urban Renewal**

None identified.

7.0 RISK ANALYSIS

7.1 This has been included in the options appraisal at Section 3.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 It has not been appropriate, at this stage, to complete a Equality Impact Assessment (EIA), however should the decision be to recommend the contract be terminated this will be undertaken.

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

None under the meaning of the Act.

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