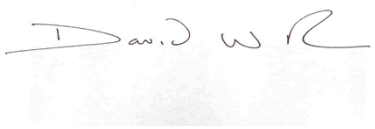
Public Document Pack

Health and Wellbeing Board

Wednesday, 19 January 2022 2.00 p.m.
Halton Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 23 March 2022

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

Part I

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 6 October 2021 at the Bridge Suite - Halton Stadium, Widnes

Present: Councillors Wright (Chair), J. Lowe, T. McInerney, Woolfall and S. Patel, R. Foster, D. Nolan, L. Gardner, D. Wilson, L. Thompson, P. Jones, C.Lyons, D. Parr, I. Onyia, K. Parker, S. Semoff, K. Roberts and G. Ferguson

Apologies for Absence: M. Larking, D. Merrill and S. Wallace Bonner

Also in attendance: Councillor P. Lloyd Jones

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB11 MINUTES OF LAST MEETING

The Minutes of the meeting held on 7 July 2021 having been circulated were signed as a correct record.

HWB12 PUBLIC HEALTH RESPONSE TO COVID-19 CORONAVIRUS

The Board received an update on the most recent Covid-19 coronavirus figures for Halton and how the Halton Outbreak Support Team were working successfully to identify and manage local outbreaks. The presentation also outlined the most recent information on testing and vaccination for people in Halton.

The Board discussed the importance of Lateral Flow Testing and the availability and distribution of testing kits.

RESOLVED: That the Board note the presentation.

HWB13 BETTER CARE (POOLED) FUND

The Board received a report of the Director of Adult Social Services, which provided an overview of the work carried out in order to ensure that the Better Care (Pooled) Fund (BCF) was balanced at the end of the financial year 2020/21. As a result of the pandemic, although there were significant challenges across the system during 2020/21, under the direction of the Pooled Budget Manager, work was

undertaken by colleagues across the Council and the Clinical Commissioning Group, to review the BCF schemes within the pooled budget. The work identified areas for savings and introduced new ways of working/reconfigured services within the Borough to relieve pressures across the system, including financial pressures. Examples of the work undertaken was outlined in the report.

The Board noted that as a consequence of the work undertaken during the previous 12-18 months, at the end of the financial year 2020/21 the BCF budget was £157k under budget. After deducting the overspend for the previous financial year, this left an underspend positon of 40k.

RESOLVED: That the report be noted.

HWB14 ONE HALTON ICP POSTION STATEMENT

The Board considered a report which provided a position statement in relation to:

- The development of Cheshire & Merseyside Health and Care Partnership as an Integrated Care System (ICS); and
- One Halton and the development of the One Halton Integrated Care Partnership (ICP).

The ICS guidance had been published on 2 September and as part of the new ICS arrangements, ICS Leaders should confirm their proposed place-based partnership arrangements for 2022/23, including their boundaries, leadership and membership by 1 April 2022.

In addition, the report also provided detailed information on the One Halton Integrated Partnership meetings held on 18 August and 15 September and the Workshops held on 18 August and 17 September.

RESOLVED: That the report be noted.

HWB15 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) SUMMARY

The Board were updated on the Joint Strategic Needs Assessment which analysed the health needs of the population to inform and guide commissioning of health, wellbeing and social care services within local authority areas. The JSNA underpined the health and wellbeing strategy and commissioning plans. A copy of the summary document for the Halton JSNA 2021 had been previously

circulated to the Board.

In 2012 the first executive summary of the JSNA mapped across the life course was presented. This approach had continued to receive good feedback from various partnerships and stakeholders. As a consequence the revised annual summary had used broadly the same approach, updating data and information since the previous version.

The Board received an update on the latest published whole year data JSNA summary, which was for the period 2019/20. The update provided the Board with the highlights of the 2021 JSNA, those areas which had remained difficult to improve, those that had worsened and the developments for the JSNA going forward. It was also noted that the JSNA could not take into account the impacts of the Covid-19 pandemic as much of the data was for the period 2019-2020.

The Board discussed the availability of NHS dentists in the Halton area and it was agreed that a report would be brought to a future meeting. In addition a report would also be brought to a future meeting on the outcomes of a recent Halton Healthwatch survey.

RESOLVED: That the report be noted and the draft summary document be approved for publication.

HWB16 COVID VACCINE UPDATE

The Board considered a report of the Director of Public Health, which provided an update on the Covid vaccination programme for Halton. As of 13 September:

- 90.48% of eligible people in Halton have had their first dose of vaccination and 82.51% of eligible people have had their second dose of vaccine;
- Around 50% of 16/17 year olds were vaccinated;
- the 12-15 year olds vaccination programme had also began;
- the booster vaccine had began to be rolled out to those in high risk groups; and
- the flu vaccine programme had also begun.

RESOLVED: That the Health and Wellbeing Board note the content of the report.

HWB17 MARMOT REVIEW AND THE MARMOT COMMUNITY PROGRAMME

The Board considered a report of the Director of Public Health, which provided an update on the Marmot Review including next steps following publication of 'Health Equity in England: The Marmot Review 10 years on' document in 2020; and informed the Board about the Marmot Community Review project.

The Board was advised that Cheshire and Merseyside (through CHAMPS and Cheshire and Merseyside Health Care Partnership) were working to achieve Marmot Community Status. Areas that were awarded the status of Marmot Community were those that could provide evidence that the six goals as set out in Sir Michael's Marmot's report from 2010 were addressed. As part of the next steps:

- the Marmot national team were looking to gain feedback from the nine local areas across Merseyside and Cheshire to develop action plans to tackle inequalities across local areas and to ensure local perspectives are incorporated into the national review report due to be published in 2022;
- the feedback would be provided by individual local area workshops. The Halton one would take place October/November 2021. Board members would be invited to the workshop;
- following the workshop, a Marmot Communities working group would be established with representation from all partners across Halton already working to tackle inequalities;
- the working group would establish a local work programme for the Marmot Community programme; and
- feedback from the programme would be provided to the Board.

RESOLVED: That the Board notes the content of the report and supports the Marmot Community programme workshop.

Meeting ended at 3.25 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 19th January 2022

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Public Health response to COVID-19 Coronavirus

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

To update the Board on the public health response to COVID-19 Coronavirus with a presentation covering the most recent data; latest update on Halton outbreak support team activity, Testing and Vaccination.

2.0 RECOMMENDATION: That the Board note the presentation.

3.0 SUPPORTING INFORMATION

3.1 The public health response is dynamic and in order to provide the most up to date information a presentation will be provided. The presentation will cover the most recent COVID-19 coronavirus figures for Halton. It will include an update on the work done by the Halton outbreak support team and its collaboration with others to successfully identify and manage local outbreaks and the presentation will also detail the most recent information on testing and vaccination for people in Halton.

4.0 POLICY IMPLICATIONS

4.1 There are no specific implications in respect of Council policy.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There is ring fenced allocated funding for outbreak response.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**

The outbreak response will protect the health of children and young people in Halton.

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

N/A

6.3 **A Healthy Halton**

All issues outlined in the presentation focus directly on this priority.

6.4 **A Safer Halton**

The outbreak response will protect the safety of people in Halton.

6.5 **Halton's Urban Renewal**

None identified at present

7.0 RISK ANALYSIS

7.1 The outbreak response team will reduce the risk to local people from an outbreak.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no equality or diversity issues as a result of the actions outlined in the presentation, however among people already diagnosed with COVID-19, people who were 80 or older were likely to die than those under 40. Risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those from minority ethnic groups, in particular those of Black and Asian heritage

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

None

REPORT TO:	Health & Wellbeing Board
DATE:	19January 2022
REPORTING OFFICER:	Programme Director – Integration & Collaboration (Bridgewater Community Healthcare NHS Foundation Trust) / Head of Primary Care (NHS England and NHS Improvement North West (Cheshire & Merseyside)
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Presentation on Dental Services in Halton
WARDS:	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present an update on dental services in the borough of Halton by the lead commissioner (NHS England and NHS Improvement) and by the provider of specialised dental care (to people of all ages), with disabilities and special needs which make it impossible for them to access treatment from an NHS family dentist

2.0 RECOMMENDATION: That the Board note the presentation and its contents

3.0 SUPPORTING INFORMATION

The presentation is designed to provide Health & Wellbeing Board members with an update from the lead commissioner on the current approach to dental services in Halton, current challenges and developments in response to COVID-19

A local provider of specialist dental services in Halton will then set out its own response and actions taken during the COVID-19 outbreak, and share its emerging work on a new Dental Network strategy, setting out its mission to be person focussed, helping to improve the health & wellbeing of every patient treated. This is being developed to embed the principles and maximise the opportunities of collaboration described in the White Paper.

4.0 POLICY IMPLICATIONS

The NHS Long Term Plan and the White Paper, Integrating Care: Next steps to building strong and effective integrated care systems across England published February 2021.

5.0 FINANCIAL IMPLICATIONS

None identified

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES ***(click here for list of priorities)***

6.1 **Children and Young People in Halton**
Commissioned dental services supports the Council priorities for Children and Young People

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

6.3 **A Healthy Halton**
Commissioned and provided dental services supports the Councils priorities for a Healthy Halton

6.4 **A Safer Halton**
None identified

6.5 **Halton's Urban Renewal**
None identified

7.0 RISK ANALYSIS
None identified

8.0 EQUALITY AND DIVERSITY ISSUES
Commissioned and planned dental services support equality and diversity and a targeted approach is being undertaken to support the more vulnerable of the population

REPORT TO: Health & Wellbeing Board

DATE: 19 January 2022

REPORTING OFFICER: Director of Social Services

PORTFOLIO: Adult Social Care
Health & Wellbeing

SUBJECT: Vaccinations in Care Homes

WARD(S): Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide the Board with details of the Government legislation published on the need to vaccinate people working or deployed in care homes.

2.0 RECOMMENDATION: That the Board note the contents of the report.

3.0 SUPPORTING INFORMATION

3.1 Background

Adult Care Homes are a “high risk” environment for Covid-19 infection, because of the age and frailty of residents and the close living and working conditions, which make transmission between residents and staff more likely.

Mitigations in the form of infection prevention and control measures have recently been strengthened through the introduction of new legislation.

In order to now ensure that care homes are as safe as possible for the staff working in them and the people they care for, the Government has decided that the best way to do this is to regulate that all persons entering Care Quality Commission registered care homes must be fully vaccinated, in order to enter the indoor premises of a home.

The Board will note that there will be some exemptions from the vaccination regulations. This includes relatives and friends visiting residents within homes, those that are medically exempt from vaccination and those emergency services who are required to attend a care home in the event of an emergency.

The implications of implementing the regulations are that those staff who are not fully vaccinated or refuse to be vaccinated who work within care homes, or are required to visit care homes as part of their role cannot continue to be employed in that role.

3.2 Whilst this legislation is expected to reduce the health risks to care home residents and staff, the restrictions on staff deployment introduce a number of consequential risks which threaten the operation of local health and care systems. This report considers

these consequential risks and the immediate actions needed to prepare for workforce reductions that are expected to arise as a result of the legislation.

3.3 There are an estimated 942 staff working within Halton Care Homes. The chart below shows the total numbers of staff within the independent sector fully vaccinated and those now receiving the booster vaccination and the flu vaccination. It also identifies the number of staff who potentially meet the medical exemption criteria. The cut off for the validity of temporary self-certified medical exemption letters has now been extended from 24th December 2021 until 31st March 2022.

3.4

	Independent sector	HBC owned care homes
Total Number of Staff	616	216
Total Staff undertaken Vaccination 1	611	212
% Total Staff undertaken Vaccination 1	100%	99%
Total Staff undertaken Vaccination 2	608	212
% Total Staff undertaken Vaccination 2	99%	99%
Total Staff undertaken Booster Vaccination	220	47
% Total Staff undertaken Booster Vaccination	36%	45%
Total Staff undertaken Flu Vaccination	72	33
% Total Staff undertaken Flu Vaccination	12%	14%
Number of staff refusing COVID vaccine	2	0
Number of staff exempt	5	4

3.5 HBC has been proactive in trying to overcome vaccine hesitancy and have consistently used the capacity tracker data to identify and contact homes with low vaccine uptake amongst staff.

Work is on-going in the other homes and plans are in place to minimise risk to service Delivery within those homes. HBC will continue to review the business contingency plans for Council run care homes and the numbers vaccinated will be monitored weekly.

Commissioners are urgently establishing with providers the potential impact on care provision for a range of scenarios, based on best case, worst case and most likely case staff reductions.

Providers have been asked to review their plans on the basis of their individual current and projected staff vaccination uptake levels and to share the results with

commissioners so that they can jointly assess the potential impact on continuity of care and future bed capacity.

HBC will then use this intelligence to develop strategies for both increasing uptake and simultaneously preparing for major adjustments in the workforce and care market.

HBC will continue to use all means available to encourage higher levels of uptake and to ensure that providers accurately and regularly report the vaccination status of their staff.

3.6 An initial Impact Assessment was undertaken against 5 identified risk areas which has been updated:

- **Employment -** Although the initial figures indicated that there may have been a high number of care home workers at risk of losing their positions the reality was that there were 8 people in the independent sector.
- **Workforce –** Homes have been able to recruit and retain new staff, however, they report that staffing remains the biggest risk to the sector with low rates of responses to advertised vacancies.
- **Commissioning risk –** There are a couple of homes that have contracted their bed capacity in order to operate safe staffing levels due to their staffing shortages due to both recruitment issues and the ongoing isolation requirements.
- **Continuity of Care –** It was anticipated that the scale of the workforce risk and reliance upon agency staff would impact on the care levels within the care homes. However, there is a reluctance of care homes to engage agency staff due to the increased care costs and the increased risks as the booster vaccinations are not mandatory. This has an impact on the permanent staff within the home covering rotas and potential burn out.
- **Viability –** Throughout the pandemic care homes had been operating with high under occupancy numbers and therefore reduced income. It was anticipated that the scale of the workforce challenge would make it impossible for them to be financially viable. Although there has undoubtedly been a financial impact on the sector the predicted provider failure has not emerged in Halton.

3.7 Work has commenced looking at internal policy for the extension to mandatory vaccination across health and social care. In house services have high levels of vaccination (above 90%) and work continues to improve this further. External services have high rates in supported living (circa 905+) with lower rates (circa 75%) in domiciliary care however this is increasing since the announcement.

4.0 POLICY IMPLICATIONS

4.1 Associated changes in Human Resource and Care Home processes have been required to support the introduction of this legislation and has continued to be developed in the light of further requirements.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 These issues have the potential to severely impact the Halton care market, there will undoubtedly be resulting financial implications. Further work is being carried out to fully understand these.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton**
The availability of an effective Care Home market in Halton is directly linked to this priority.

6.4 **A Safer Halton**
None Identified.

6.5 **Halton's Urban Renewal**
None Identified.

7.0 RISK ANALYSIS

7.1 None identified.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

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

9.1

Document	Place of Inspection	Contact Officer
Not Applicable		

REPORT TO:	Health and Wellbeing Board
DATE:	19th January 2022
REPORTING OFFICERS:	HBC Strategic Director, People & Chief Commissioner, NHS Halton CCG
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Update on One Halton Place Based Partnership
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 To provide an update on One Halton Place Based Partnership development with Cheshire Merseyside Integrated Care Board (ICB) and Integrated Care Partnership (ICP) context.

2.0 RECOMMENDED: That the report be noted.

3.0 SUPPORTING INFORMATION

3.1 The Health and Wellbeing Board received a comprehensive report in October 2021 setting out the requirements for the formation of Integrated Care Systems regionally (for Halton that is Cheshire & Merseyside) and an Integrated Care Partnership at Place level (locally this is One Halton Place Based Partnership) detailed in NHS Reforms set out in the White Paper, Integration & Innovation published in February 2021; this paper builds on the NHS long term plan. These are the most significant changes to health arrangements in a decade which aim to improve outcomes and reduce inequalities. 'Thriving Places' is a useful resource for further reading, a user friendly document providing the context and requirements for place based partnerships: -

https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf

3.2 **ICS new target date 1st July 2022**

To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for new statutory arrangements to take effect and Integrated Care Boards (ICBs) to be legally and operationally established. This replaces the previous target date of 1 April 2022. This new target date will provide some extra

flexibility to prepare for the new statutory arrangements and manage the immediate priorities in the pandemic response, while maintaining our momentum towards more effective system working.

3.3 The ICB (Cheshire & Merseyside), the accountable statutory body for the system is progressing through the gearing up stages of establishing the ICB, developing the Constitution, the Board membership, working with the nine places in the footprint to support the development on place based partnerships to manage due diligence for the disbanding of the Clinical Commissioning Groups and preparing for the staff and functions to transfer to the ICB under the new arrangements. There is significant focus on workforce to support the people and arrangements

Recruitment to Senior Executive roles has commenced, the ICB has appointed a Designate Chief Executive, Graham Urwin who has connected with Halton Borough Council Chief Executive and the CCG Accountable Officer. Recruitment for the remaining three Executive roles was conducted just before Christmas and there are four further Executive posts out to recruitment currently. The ICB will then move to recruit place Directors, one of which will be the senior executive position for Halton.

3.4 As One Halton becomes the statutory body for health & care arrangements (at place level) there is greater emphasis in the new arrangements on integration and collaboration, tackling wider determinants of health and enabling increased third sector and community involvement.

3.5 One Halton conducted a self-assessment in October 2021 to gather a current position on the (place based) partnership, to aid a development plan for embedding One Halton as the place based partnership and meeting assurance requirements. The assessment considered activity against four domains: -

1 Ambition and vision
2 Leadership and culture
3 Design and delivery
4 Governance

Each domain had several descriptors to assess against with the assessment categories being emerging, evolving, established and thriving. The outcome of One Halton's assessment was: -

Descriptor	**Assessment Level**
Ambition & Vision	
Clarity of Purpose & Vision	Established
Objectives & Priorities	Evolving
Population health management to address health inequalities	Evolving

Leadership & Culture	
Place Based Leadership	Evolving
Partnership Working	Evolving
Culture / OD / Values & Behaviours	Evolving
Responding to the voice of our communities / public & patient engagement	Evolving
Design & Delivery	
Financial Framework	Evolving
Planning & Delivery of Integrated Services	Evolving
Digital	Emerging
Estates & Assets	Emerging
Governance	
Governance	Established

Overall, One Halton is assessed as an **evolving** place and is on a trajectory to be **established** by April 2022 with an ambition to achieve **thriving** by the end of the year with a Joint Committee structure of the ICB and the Local Authority. This will be an iterative process building on the existing One Halton model, expanding on the strengths of inclusivity recognising the democratic and statutory roles, governance and oversight of both HBC and the ICB.

3.6 There is a large and complex range of programmes and activities to be progressed in Halton to support the transition as detailed in the October report and become a thriving place base partnership. A Programme Management Office (PMO) is being established. The Senior Programme Manager, Nicola Goodwin commenced in post in mid-December 2021 with a Project Manager joining the team at the end of January 2022. The team will be further developed in the coming months.

The team will support One Halton to function as a partnership, steer One Halton through assurance to becoming a statutory body, support System Leaders to fulfil integrated & collaborative approaches in the One Halton framework and interact with Cheshire & Merseyside ICS and the other eight place based partnerships in the ICS footprint.

The immediate priorities are to development an overarching Organisational Development plan that supports One Halton through the assurance process with Cheshire & Merseyside (ICB) and support system leaders and stakeholders with the three strands of support from **Advancing Quality Alliance (Aqua), Local Government Association (LGA**) and **Hill Dickinsons LLP** which will develop the governance and work programme for One Halton.

3.7 **Hill Dickinsons LLP** – this work was commissioned to support One Halton integrated arrangements and future governance. Hill Dickinsons LLP has supported One Halton thus far with the structure of the governance arrangements; the guidance sets out five potential models for place based partnerships. One Halton has endorsed a Committee of the ICB at Place (Halton) with delegated authority to make joint decisions about the use of resources with a Sub-Committee structure. Further propositions and maturity within the system will facilitate further integration by the means of a joint committee between partner organisations. The relevant statutory bodies will need to agree to delegate defined decision making functions to the joint committee in accordance with their scheme of delegation. A budget can be defined by statutory bodies relevant to the resources delegated to the committee. Proposed legislation will allow setting up of Joint Committees (currently only possible as part of S75)

Hill Dickinsons LLP has provided a review of the existing Section 75, Joint Working Arrangements (JWA). System leaders need to consider Hill Dickinsons LLP report (December 21) which concluded the current JWA provides aligned rather than pooled funding and a revised Section 75 agreement should be negotiated. There needs to be clarity on the aims of the S75 partnership and what will be commissioned under the arrangement – in the current agreement this is by defined by client groups. A revised S75 should also incorporate non-financial contributions for example other goods, services or accommodation that support service delivery from the partners involved and an information sharing protocol re-visited.

Overall, there is further progress required to ensure the recommended steps to satisfy governance and place based arrangements are in place. The PMO will be supporting system leaders and the local partnerships to progress this.

3.8 **Advancing Quality Alliance (AQuA)** has supported both the Health and Wellbeing Board and One Halton previously. The offer is to support the wider population health management and will include but not limited to three strands of activity; Start Well, Living Well & Ageing Well. This work is being led by Public Health and will be delivered between January and March 2022 to provide a clear plan and ambitious programmes for delivery. It will support Halton system leaders to have clarity about the work they are doing; facilitate the development of a clear strategic direction; support partners to re-commit to the work and share learning and experience of other systems working in this way.

Aqua's approach will examine the breadth of activity/delivery already in place and identify opportunities for key areas of work and alignment to

other work streams such as Marmot to develop one plan for improving outcomes for Halton's residents.

3.9 **Local Government Association** – this is a peer support offer to the Health and Wellbeing Board (HWB) and its members. Halton Health and Wellbeing Board is part of the Cheshire & Merseyside Care Partnership and this support offer will develop the approach hence, it is essential the Board and its Members are supported to understand the system change and responsibilities. The LGA work will focus on:-

- It's about Halton Health and Wellbeing Board knowing and understanding its role in the wider system architecture
- building consensus and clarity on the distinct leadership role and responsibilities of the HWB
- reviewing the structure and format of the HWBB & One Halton Place Based Partnership Board and to be more decision-focused and impactful in driving delivery of better outcomes and reducing health inequalities for the people of Halton
- establishing greater collaboration between members and wider partners so it represents, reflects and drives forward local plans and priorities for the population it serves

LGA have provided two experts to work with the HWB. The peers have held, or currently hold senior positions and come as 'critical friends' to provide constructive challenge, a safe space for open and frank conversations and to help determine collective next steps.

There will be two LGA facilitated workshops in the coming months and it is imperative Board Members harness this approach. The HWB reflecting on the partnership and embracing this significant system change will be key to One Halton meeting assurance requirements around governance. Ultimately, the assurance process will impact on what is delivered at scale and what is delegated to Halton from Cheshire & Merseyside Integrated Care Board.

3.10 The PMO will provide update reports to the Health and Wellbeing Board and is available to support members and system leaders through the transition period and the agreed One Halton delivery programmes.

There is still much work to do however, Halton has a track record of strong effective partnership working which will enable the transition to One Halton Place Based Partnership.

4.0 **POLICY IMPLICATIONS**

White Paper, *Integrating Care: Next steps to building strong and effective integrated care systems across England* published February 2021. Once legislation is passed, a new NHS Framework will be shared which is likely to have impact on a number of policies and will need to be reviewed in due course.

5.0 FINANCIAL IMPLICATIONS

Anticipated, but not yet known. Cheshire & Merseyside ICB need to agree services to be delivered at scale and provision delegated to One Halton to enable us to fully understand the resource and financial impacts.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

6.1 Children and Young People in Halton

One Halton supports the Health & Wellbeing Boards priority of improving levels of early child development. The One Halton programme work has commissioned Aqua to work with Halton's stakeholders in developing a strategic and transformational approach to start well, live well and age well. This work stream is being led by the Interim Director of Public Health and will inform future system delivery plans.

6.2 Employment, Learning and Skills in Halton

One Halton shares the Council's priorities for employment, learning and skills in Halton. The workforce that supports the health & care system is significant in Halton and there will be a focussed work stream in the transition arrangements to ensure current staff are supported and there is planning and investment to develop skills and the future workforce.

6.3 A Healthy Halton

One Halton is a key stakeholder locally supporting the Council & Health and Wellbeing Boards priorities for supporting improved health outcomes and reducing health inequalities for Halton's population.

6.4 A Safer Halton

One Halton supports the Council's priorities to create a safer Halton. Health and wellbeing are pivotal characteristics of resilient communities; a whole system approach to place will intrinsically contribute to building a safer Halton.

6.5 Halton's Urban Renewal

The NHS reforms to Integrated Care Systems and Place Based Partnerships seek to engender a whole place collaborative approach.

As arrangements progress there will be a work stream around assets to understand the estate that supports delivery in Halton.

It is also imperative to plan appropriately for healthy communities utilising Public Health ensuring evidence led approach to meet the future needs of Halton's population. One Halton should be linked into future regeneration schemes and developments in the Borough to ensure appropriate planning and system partner involvement. There are recent examples of joint working with the delivery of a Hospital Hub in Shopping City (opening April 2022) and the development of the Town Deal for Runcorn Old Town.

7.0 **RISK ANALYSIS**

This will require further work to be shared in future reports as and when One Halton understands the services and activity that will be delivered at scale (Cheshire & Merseyside footprint) and those delegated to place (One Halton).

8.0 **EQUALITY AND DIVERSITY ISSUES**

In developing One Halton, all services will continue to require equality impact assessments for any fundamental changes to service delivery to ensure equality and access to services is considered.

The One Halton Board and its sub-committees also has membership of Halton's Third Sector organisations and will actively work alongside them to consider equality and diversity issues. Many of Halton's voluntary sector organisations exist to support vulnerable, disadvantaged or disenfranchised cohorts of the community and have a reach often beyond public service delivery.

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

None under the meaning of the Act.

Cheshire and Merseyside
Health and Care Partnership

Brief for Development Advisory Group – Wednesday 5th January, 2022

ICS development – new target date 1 July 2022

The Health and Care Bill, which intends to put Integrated Care Systems (ICSs) on a statutory footing and create Integrated Care Boards (ICBs), is currently being considered by Parliament.

To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for new statutory arrangements to take effect and Integrated Care Boards (ICBs) to be legally and operationally established. This replaces the previous target date of 1 April 2022.

This new target date will provide some extra flexibility to prepare for the new statutory arrangements and manage the immediate priorities in the pandemic response, while maintaining our momentum towards more effective system working.

Together with our CCGs, we are continuing to prepare for the closure of CCGs and the establishment of NHS Cheshire and Merseyside Integrated Care Board, working towards the new target date.

Please be assured that this short delay does not affect our priorities and what we are currently doing to achieve a smooth transition of staff and functions. We will continue to focus on the immediate demands of Covid, the ambitious booster programme and the operational issues that ensue. Our work towards organisational redesign will continue at pace. If anything, the extra time will allow for better engagement with our partners, our communities and, of course, our staff.

Key questions

What happens between 1 April and 1 July 2022?

The first quarter of 2022/23 will now be an extension of the preparatory period.

During this period:

- CCGs will remain in place as statutory organisations. They will retain all existing duties and functions and will conduct their business (collaboratively where appropriate), through existing governing bodies.
- Our CCG leaders will work with designate ICB leaders on key decisions which will affect the future ICB, notably commissioning and contracting.

- NHS England and Improvement will retain all direct commissioning responsibilities not already delegated to CCGs.

Will this slow progress on integration, which has accelerated during the pandemic?

Joint working arrangements have been in place at system level for some time, and there has already been significant progress in preparing for the proposed establishment of the statutory Integrated Care System, including recruitment of Graham Urwin as our ICB Designate Chief Executive.

Designate ICB leaders will continue to develop system level plans for 2022/23 and prepare for the formal establishment of ICBs in line with the guidance previously set out by NHS England and Improvement and this updated timeline.

What does the timing mean for establishing Integrated Care Partnerships?

The Department of Health and Social Care's (DHSC) guidance on establishing ICPs sets an expectation that all systems will have at least an interim ICP up and running at the point when the statutory arrangements come into effect and ICBs are formed. Local authority and designate ICB leaders will continue to work together to develop Cheshire and Merseyside ICP arrangements in line with the DHSC guidance, working to the revised target implementation date of 1 July 2022.

Is this going ahead without the legislation?

The establishment of statutory ICS arrangements is subject to the passage of the Health and Care Bill, which is currently being considered by Parliament. Some preparatory steps are necessary to enable the new arrangements to come into effect at the point of establishment if legislation is passed. This preparatory phase will now be extended to reflect the new target date.

Could the implementation date change?

The establishment of statutory Integrated Care Systems is subject to the passage of the Health and Care Bill. Working towards a target date of 1 July 2022 is intended to give systems a clear timescale for preparations and many positive steps have already been taken to prepare for the establishment of Integrated Care Boards if and when the Bill is enacted.

For more information

Visit: www.cheshireandmerseysidepartnership.co.uk/ics-development

Recruitment to senior roles

The recruitment processes are well underway for key leadership roles, non-executive directors and the Designate Chair. We will soon be in a position to confirm the appointment of our Medical Director, Associate Medical Director and Finance Director. Other senior roles are currently being advertised and we will soon begin appointing to the positions of our nine place leads.

We will keep you informed of progress and confirm appointments as they are made.

The delay to the target date provides an opportunity for us to refine our thinking on staffing structures at Place. We had planned to engage with staff on this around 14th January, but this will be delayed slightly and will start later this month. The slight delay reflects the fact that whilst we want to make sure we get this right, we do not wish to lose momentum and are keen to provide staff with the information they need, as soon as is practicable.

Covid-19 Update

Here is a reminder of the current restrictions in place, which are to remain until 28th January.

- Face covering compulsory in most public indoor venues, other than hospitality
- NHS Covid Pass mandatory in specific settings, using a negative test or full vaccination via the NHS Covid Pass
- People asked to work from home if they can
- Vaccines and testing remain our best lines of defence

Boris Johnson said in his briefing on Tuesday this week that he hopes England can "ride out" the current wave of Covid-19 without further restrictions, but he acknowledged parts of the NHS would feel "temporarily overwhelmed" amid a surge of Omicron cases. The weeks ahead would be challenging and some services may be disrupted by staff absences. Sickness absence in Cheshire and Merseyside is currently at around 10% but this does not reflect bank and agency staff who are also affected and their availability is reduced, adding to the pressure.

He said the health service was moving on to a "war footing" with plans to set up coronavirus surge hubs at hospitals across England in preparation for a potential wave of admissions.

Covid admissions in C&M are currently at around 100 per day and critical care availability is ok. However, hospital occupancy rates are at around 95% so safe discharge remains a key priority. The system is taking a balanced, pragmatic approach with situation under continuous review. The community, mental health and social care sectors are also greatly pressured and virtual wards and respiratory wards are being stepped up.

To reflect the Level 4 Incident status of Covid, the hospital and out-of-hospital cell structure has been stepped up with daily meetings to monitor the situation.

Vaccination and Boosters

Latest figures show that 71.3% of the Cheshire and Merseyside population have received at least one vaccine, with 75.7% of the eligible population having had a booster. As expected, demand for the vaccine and boosters significantly reduced over the Christmas period and it is important we continue to urge everyone who is eligible to get their jab. There is sufficient capacity in the system and we need to increase take up. Vaccination remains the best line of defence against Covid. Concerted communications efforts continue but we appreciate all help in getting these key messages out.

- Everybody should be vaccinated to protect themselves and their loved ones.
- Vaccination not only reduces the chances of infection, it reduces severity and transmissibility.
- Full vaccination status affects accessibility to many events, venues and travel opportunities.
- And it's never too late – even if people have so far declined the opportunity to be vaccinated, they will be welcome in vaccination centres and staff will be only too happy to administer first, second or third doses.

Confirmatory PCR tests to be temporarily suspended for positive lateral flow test results

From 11th January in England, people who receive positive lateral flow results for COVID-19 will be required to self-isolate immediately and won't be required to take a confirmatory PCR test. This is a temporary measure while COVID-19 rates remain high across the UK. Whilst levels of COVID-19 are high, the vast majority of people with positive LFD results can be confident that they have COVID-19.

This move frees up capacity in PCR testing, increasing speedy access to those who need it most, like front line health and care staff and other essential workers.

Under this new approach, anyone who receives a positive lateral flow device (LFD) test result should report their result on gov.uk and must self-isolate immediately but will not need to take a follow-up PCR test. After reporting a positive LFD test result, they will be contacted by NHS Test and Trace so that their contacts can be traced and must continue to self-isolate.

REPORT TO: Health & Wellbeing Board

DATE: 19th January 2022

REPORTING OFFICER: Director Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: Better Care Fund (BCF) 2020 – 21 Plan and BCF Planning Template for 2021/22

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To update the Health and Wellbeing Board on the Better Care Fund Plan 2020/21 and Planning Template for 2021/22, for retrospective approval following its submission in mid-November and successful regional assurance (subject to HWBB sign-off).

2.0 RECOMMENDATION: That

(1) The BCF Plan for 2020/21 and Planning Template for 2021/22 are approved.

3.0 SUPPORTING INFORMATION

3.1 **BCF Planning Guidance 2020/21**

As reported to the Board in January 2020, the guidance and templates from NHS England for the BCF Plan 2020/21 were postponed and were not published until September 2021. Systems were asked to prioritise continuity of provision, social care and system capacity and roll forward schemes from 2019/20, which is what Halton have done.

3.2 Halton's BCF Plan for 2020/21 is attached at Appendix 1 and confirms:

- How we've engaged with stakeholders;
- Governance arrangements including the new ways of working for One Halton;
- Approach to integration;
- Supporting Discharge from Hospital (National condition 4);
- Disabled Facilities Grant and wider services; and
- Equality and Health Inequalities.

BCF Planning Template for 2021/22 (Appendix 2)

3.3 This includes Halton's plans for 2021/22 encompassing:

- Expenditure Plan (tab 5a) and the integrated schemes that form part of the plan;
- Metrics (tab 6) including actuals for 20/21 and planned metrics for 21/22 with narrative to support this rationale; and
- Confirmation of planning requirements (tab 7)

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The Better Care Fund sits within the wider pooled budget arrangement and the financial context of the local health and social care environment. The pooling of resources and integrating processes and approach to the management of people with health and social care needs will support effective resource utilisation.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 A Healthy Halton

Developing integration further between Halton Borough Council and the NHS Halton Clinical Commissioning Group will have a direct impact on improving the health of people living in Halton. The plan that is developed is linked to the priorities identified for the borough by the Health and Wellbeing Board.

7.0 RISK ANALYSIS

7.1 Management of risks associated with service redesign and project implementation are through the governance structures outlined within the Joint Working Agreement.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified at this stage.

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

9.1 None under the meaning of the Act.

BETTER CARE FUND PLAN 2021/2022

HALTON

Contents

Background to the BCF Plan

This Better Care Fund Plan for 2021/2022 covers **Halton** Health and Wellbeing Board.

How have you gone about involving stakeholders?

Our Local Vision - In 2017 the Health and Wellbeing Board published a five-year One Halton Health and Wellbeing Strategy. The strategy was jointly developed after extensive consultation with a wide range of partners and stakeholders across the Borough, including HBC, NHS Halton CCG, GPs, voluntary sector, Community Health Services, Healthwatch, statutory partners, housing, local community groups, patients and the public. The purpose of the strategy is to improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill-health, promoting self-care and independence, arranging local, community-based support whenever possible and ensuring high-quality hospital services for those who need them. The strategy sets the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on prevention and early intervention.

With partners being fully involved with the development of the Health and Wellbeing Strategy, the BCF plan for 2021/22 runs parallel to this and all members of the Health and Wellbeing Board will approve the plan and the ambitions for the metrics, which for this current year the targets are aligned to the NHS Halton CCG agreed planning assumptions. The main trusts that we work alongside and that are members of the HWBB are:

- Bridgewater Community Healthcare NHS Foundation Trust
- Merseycare NHS Foundation Trust
- St Helens and Knowsley Teaching Hospital NHS Trust
- Warrington and Halton Hospital NHS Foundation Trust

In addition to the above acute trusts, Halton Borough Council and NHS Halton CCG, the Board also involves the following organisations within Halton:

- Cheshire Constabulary
- Cheshire Fire and Rescue Service
- Halton Children's Trust
- Halton Housing Trust
- Halton and St Helens Voluntary and Community Action
- Healthwatch Halton

In addition to the HWBB, work continues as part of two hospital system footprints to reduce key performance metrics, as detailed in the BCF Plan, including Admission Avoidance and Lengths of Stay. Contract meetings with the respective trusts take place on a regular basis.

1.0 Executive Summary

The BCF aligns to the wider integration landscape including One Halton which is a local system partnership where by all priority areas are shared and prioritised via a structured governance process. One Halton's vision is:

"Working together to improve the health and wellbeing of the people of Halton so they live longer, healthier and happier lives".

With the establishment of the One Halton Place Based Partnership (PBP), in line with the White Paper *Integrating Care: Next Steps to building strong and effective integrated care systems across England* published in February 2021, we are working together to transform services across the health and social care system to deliver sustainable change with maximum benefits to communities, residents and patients/users of services. This includes joint accountability and decision-making, improved commissioning and a move to integrated service delivery.

The Integrated approach for the BCF enables the local commissioners and providers to develop plans that support local placed-based delivery and system-wide strategic transformation. The development of the Cheshire and Merseyside Integrated Care System (CMICS) supports the place and programme developments and creates an opportunity to work on tactical, operational and strategic approaches.

The ***One Halton Plan – Longer, Happier and Healthier Lives, 2019 – 2024,*** identifies six priority areas where the opportunities are greatest to transform our healthcare delivery, these are:

- Children and Young People: Improved levels of early child development;
- Generally Well - increased levels of physical activity and healthy eating and reduction in harm from alcohol;
- Long-term conditions - reduction in levels of heart disease and stroke;
- Mental Health - (including LD and dementia) improved prevention, early detection and treatment;
- Cancer - reduced level of premature death;
- Older People - improved quality of life.

The priority areas take a life course approach and have a strategic fit with the NHS Long Term Plan and the C&M ICS. Work is ongoing with the wider system to ensure local transformation, commissioning intentions and provider redesign support opportunities to improve outcomes.

2.0 Governance

2.1 Current Governance Arrangements

Internal governance arrangements from 2019/2020 will continue for the majority of 2021/22, transferring into the new governance arrangements set out by the One Halton PBP. The current arrangements including the Better Care Development Group (BCDG) (formerly the Operational Commissioning Committee) meets on a monthly basis and the Executive Partnership Board (EPB) meets quarterly. As set out in the Joint Working Agreement, the role and function of the BCDG is:

• To be responsible for oversight of the management, monitoring and use of the Pooled Fund by the Pool Manager, through monthly reports from the Pool Manager, and for reporting to the Better Care Board and Parties in all matters relating to the Pooled Fund.

• To be responsible for the monitoring contractual relationships with Providers financed by the Pooled Fund through the implementation of a performance management framework and for reporting to the Executive Partnership Board in all matters relating to such monitoring, including those associated with the Better Care Fund.

• To develop and prepare the performance management framework.

• To be responsible for the implementation of the decisions of the Executive Partnership Board relating to the strategic objectives for the commissioning of the Services and for the operational delivery of those Services including those outlined in the Better Care Fund Plan.

• To prepare detailed planning proposals for the Services and present to the Executive Partnership Board for discussion and approval.

Halton BC and the NHS Halton CCG have in place a Section 75 Joint Working Agreement and as part of that undertake to share the risks jointly in Complex Care.

One of the main roles of the Executive Partnership Board is to ensure that any on-going risks associated with the process which might impact on the success of the agreement are identified and appropriate risk control measures established to mitigate against them. Halton BC and the NHS Halton CCG work together to ensure the appropriate and robust implementation of the BCF to maintain and enhance health and wellbeing in Halton. The 2021/2022 pooled fund arrangement for the BCF funds and the governance around this pool include appropriate risk sharing arrangements as outlined in the Joint Working Agreement. Sound financial systems and procedures, including a robust ledger and budgetary control systems are in place across both Halton BC and the NHS Halton CCG. Expertise in forecasting and budget-setting are key skills which the finance teams share. The Finance Teams from both organisations hold monthly meetings. Through the Executive Partnership Board and the Better Care Development Group, regular financial reports are presented to ensure that any financial risks are highlighted in a timely fashion and dealt with under the Joint Working Agreement. There are regular Executive to Executive meetings with the NHS Halton CCG, Acute Trusts and community providers where risk sharing issues are discussed. There is a

formal contract monitoring arrangement between the NHS Halton CCG and Trusts as appropriate. All providers have a Contract Review process in place which review and assess the risk of contract over performance. Both Halton BC and the NHS Halton CCG engages in this process and works with the relevant co-ordinating commissioner to mitigate the financial risks associated with contract variation and the overall financial viability of the Trusts.

2.2 New Governance Arrangements – One Halton Place Based Partnership

Work is underway on developing new arrangements in line with national and regional guidance on the emerging Place Based approach and ICS / ICB. These will incorporate the requirements of the BCF for 2022/23.

3.0 Overall Approach to Integration

We want people to live longer, healthier and happier lives. We are acutely aware that we are working within scarce resources. It is a well-known fact that over the next five years NHS Halton CCG, Halton BC and our partners face significant financial challenges. These financial challenges are driving us to do things differently and transform all aspects of health, social care and wellbeing in Halton, and by working together through the establishment of the Place Based Partnership, will strengthen our overall approach to integration across all key stakeholders within the borough. Through a range of contracts, both within the BCF and outside the Voluntary and Community Sector are engaged in supporting pathways of care.

Halton continuously analyses a wide range of data and evidence to identify where opportunities exist for the health and social care economy to change the configuration and delivery of services to provide better outcomes and value for money whilst ensuring that acute services only need to be used by people in acute need. Most of this analysis is available in the Joint Strategic Needs Assessment (JSNA), but additional sources of information are also used such as Right Care's Commissioning for value pack, Getting it Right First Time (GIRFT), primary care QoFF data, local intelligence from Aristotle, VENN capacity and demand data, local insight through patient engagement and local analysis of trend data. The analysis highlighted that our NeL activity, ambulance data, AEC activity are areas where significant pressures have been identified at both Acute providers. A&E attendances and hospital admissions for certain conditions, most notably respiratory, mental health and frailty were significant areas where opportunities for change existed. Opportunities also existed in improving cancer outcomes especially with regard to screening and length of time to start treatment. Other areas highlighted included prevention work around obesity, gastro, childhood accidents, health checks and child development. The use of hospital services by frail older people is also identified as a key opportunity in both providing alternative pathways of care and reducing length of stay where admission occurs.

By redesigning primary care access we aim to enable 7 day GP access to same day appointments, working with our Primary Care Networks (PCNs) we aim to prioritise our plans and reduce unwarranted variation. By integrating Acute and Community services in local integrated community hubs through the Place Based Integration (PBI) project, we aim to align clinical pathways enabling a seamless approach to patient care. Focusing on the vulnerable through Multi-Disciplinary Teams (MDT) will allow for significant efficiencies. The BCF will play a key role in these areas.

Building on these innovative solutions and experiences, the people of Halton will experience a fully integrated system that puts people at the heart of decision making about their care.

4.0 Supporting Discharge (National Condition 4)

The Halton population accesses elective and non-elective care at two main hospitals, St Helens and Knowsley NHS Teaching Hospital Trust and Warrington and Halton Hospitals NHS Foundation Trust. Both Trusts have processes in place for the early identification of discharge needs and monitoring the flow through the in-patient episode. Both have regular length of stay processes which the multi-disciplinary discharge teams are engaged in. This is supported by regular senior management input from Halton. Both trusts have commenced transfer to assess processes utilising community based services to continue the assessment of need (this includes supporting <15% of CHC assessments undertaken in an acute environment).

In 19/20 we reviewed Intermediate Care Services and planned to develop a new model of care. The pandemic delayed the implementation of this. However the changing models developed during the pandemic have enabled a speedier transition to the new models and incorporated both the 2 hour crisis response and a local frailty pilot. It is anticipated that the revised model will be commenced in December 2021 with full implementation by March 2022 (subject to recruitment).

All intermediate care and social care services are available and accessible 7 days a week with a programme of work commenced exploring 'trusted assessor' model for care homes. A single coordinating provider for domiciliary care in the borough will play a crucial role in expediting hospital discharge whilst the 'reablement first' approach will link directly to transfer to assess and hospital discharge.

Both hospital trusts use a discharge to assess (D2A) model. Increases in capacity in the discharge teams, continuing healthcare team and Intermediate Care will go some way to the management of long lengths of stay and preventing hospital admission.

Disabled Facilities Grant and Wider Services

Halton's Home Assistance Policy describes how we use our powers under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 to provide home adaptations for disabled people. The policy aims to ensure that residents with disabilities are provided with support to adapt their home so that it meets their needs and they are able to continue living safely and independently at home. The assistance offered through this policy is funded through the Disabled Facilities Grant (DFG) allocation.

The DFG is used as a means of financing a wide range of equipment and adaptations within and around the home to ease accessibility, aid independence and promote wellbeing. As a result of transformation the fund can be allocated in a variety of ways including grants, loans, equity release, subsidies (e.g. 50/50 funding agreements with registered social landlord or housing associations) or a combination of these. The Council works collaboratively with service users in a person-centred way to meet their care and support needs.

Halton have traditionally used mandatory grants for:

• External access - to get into and out of the home e.g. widening doors, ramps, rails
• Safety – e.g. improved lighting, a room made safe so a disabled person can be left for a period unattended
• Internal access – to make it easier to get into the living room
• Washing/bathing/cooking/sleeping - to provide/ improve access to the bedroom/kitchen/toilet/ washbasin/bath/shower e.g. by altering the layout, installing a stair lift, providing a downstairs WC or putting in an accessible shower
• Heating – improving/providing a heating system suitable to the disabled person's needs
• Ease of use – e.g. adapting heating or lighting controls to make them easier to use
• Facilitate caring - to enable the disabled person to care for someone else who lives in the property, such as a spouse/partner, child or other person
• Garden access – this was added in 2008 with the aim of providing access to and from a garden or to make a garden safe (in practice this may only cover a limited amount of larger gardens).

As part of the developments and transformation of the fund we now also use it to cover repairing, improving, extending, converting or adapting housing accommodation. This creates schemes that help disabled people in a more responsive and accessible way and can include:

• Providing a 'fast track' scheme for low level adaptations not requiring a full social care assessment or a means test or for those facing end of life.
• The effective utilisation of new technologies to support independence e.g. telehealthcare.
• Provision of relocation grants to help people to move to a more accessible home.
• Dealing with small repairs and heating problems, allowing people to live well in their home for longer and/or helping people to return to their home faster (e.g. hospital discharge)
• Issue of aids and equipment which allow people to maintain their independence for longer – including mobility aids and personal care equipment

The scope for use of the DFG is aligned to schemes and facilities which support prevention of more complex intervention, promotion of independence and delay transfers into care.

This grant and associated capital expenditure are also being used to improve the range of specialist accommodation available in the borough, notably in respect of Adults with LD/Autism, and also care home provision for older people.

5.0 Equality and Health Inequalities

The ***One Halton Plan – Longer, Happier and Healthier Lives 2019 – 2024,*** sets out how, as a system, we are aiming to work together to develop pro-active prevention, health promotion and identifying people at risk early, when physical and / or mental health issues become evident, will be at the core of all our developments, with the outcome of a measurable improvement in our population's general health and wellbeing.

The Local Authority and the CCG are working together to develop services centred around care homes, including medication and dementia screening and strengthening clinical nursing support for residents and staff alike.

Choice, partnership and control will continue to be developed based on integrated approaches to needs assessment. Bringing care out of acute settings and closer to home will be an essential part of providing health and social care over the next five years. We also use a Choice Protocol in both Trusts to proactively challenge people.

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.

The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.
1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

HM Government

NHS

Version 1.0

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Halton
Completed by:	Emma Sutton-Thompson
E-mail:	Emma.Sutton-Thompson@halton.gov.uk
Contact number:	0151 511 7398

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chairperson of HWBB
Name:	Councillor Marie Wright

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Wed 19/01/2022

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Marie	Wright	Marie.wright@halton.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	N/A	Leigh	Thompson	Leigh.Thompson@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	N/A	Andrew	Davies	Andrewdavies@nhs.net
	Local Authority Chief Executive	N/A	David	Parr	David.parr@halton.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	N/A	Sue	Wallace-Bonner	Susan.Wallace-bonner@halton.gov.uk
	Better Care Fund Lead Official	N/A	Damian	Nolan	Damian.nolan@halton.gov.uk
	LA Section 151 Officer	N/A	Ed	Dawson	Ed.dawson@halton.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	BCF Support	N/A	Emma	Sutton-Thompson	Emma.Sutton-Thompson@halton.gov.uk
	Regional Support	N/A	Ruth	Proudlove	ruth.proudlove@nhs.net

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Halton

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,994,703	£1,994,703	£0
Minimum CCG Contribution	£11,431,477	£11,431,477	£0
iBCF	£6,776,781	£6,776,781	£0
Additional LA Contribution	£639,130	£639,130	£0
Additional CCG Contribution	£0	£0	£0
Total	**£20,842,091**	**£20,842,091**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£3,248,502
Planned spend	£4,748,131

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£5,745,275
Planned spend	£6,198,267

Scheme Types

Assistive Technologies and Equipment	£823,000	(3.9%)
Care Act Implementation Related Duties	£0	(0.0%)
Carers Services	£470,894	(2.3%)
Community Based Schemes	£959,336	(4.6%)
DFG Related Schemes	£1,994,703	(9.6%)
Enablers for Integration	£0	(0.0%)
High Impact Change Model for Managing Transfer of C	£2,885,517	(13.8%)
Home Care or Domiciliary Care	£4,628,883	(22.2%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£809,741	(3.9%)
Bed based intermediate Care Services	£151,736	(0.7%)
Reablement in a persons own home	£1,893,425	(9.1%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£61,905	(0.3%)
Residential Placements	£5,103,917	(24.5%)
Other	£1,059,034	(5.1%)
Total	**£20,842,091**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1605 (1205.1)	1,605.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	12.5%	12.5%
	LOS 21+	7.1%	7.1%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	94.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	618	633

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Halton

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Halton	£1,994,703
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,994,703**

iBCF Contribution	Contribution
Halton	£6,776,781
Total iBCF Contribution	**£6,776,781**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Halton	£639,130	Winter Pressures Grant
Total Additional Local Authority Contribution	**£639,130**	

CCG Minimum Contribution	Contribution
NHS Halton CCG	£11,431,477
Total Minimum CCG Contribution	**£11,431,477**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£11,431,477**	

	2021-22
Total BCF Pooled Budget	**£20,842,091**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Halton

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,994,703	£1,994,703	£0
Minimum CCG Contribution	£11,431,477	£11,431,477	£0
iBCF	£6,776,781	£6,776,781	£0
Additional LA Contribution	£639,130	£639,130	£0
Additional CCG Contribution	£0	£0	£0
Total	**£20,842,091**	**£20,842,091**	**£0**

Please note:

Scheme Types categorised as 'Other' currently account for approx. 5% of the planned expenditure from the Mandatory Minimum. In order to reduce reporting ambiguity, we encourage limiting this to 5% if possible.
While this may be difficult to avoid sometimes, we advise speaking to your respective Better Care Manager for further guidance.

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£3,248,502	£4,748,131	£0
Adult Social Care services spend from the minimum CCG allocations	£5,745,275	£6,198,267	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Urgent Care/D2A	Integrated Discharge Team	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£454,913	Existing
2	Intermediate Care	Reablement/Rehab Services	Reablement in a persons own home	Reablement to support discharge -step down		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,589,441	Existing
3	Intermediate Care	Oak Meadow IC Beds	Residential Placements	Care home		Social Care		LA			Local Authority	Minimum CCG Contribution	£447,522	Existing
4	Falls Prevention	Falls Service	Prevention / Early Intervention	Risk Stratification		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£61,905	Existing
5	Early Supported Discharge Scheme	Stroke Outreach Pathway	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£169,171	Existing
6	Care Home Placement/Trusted Assessor	Maintaining Social Care	Residential Placements	Care home		Social Care		LA			Private Sector	Minimum CCG Contribution	£1,014,044	Existing
7	Domiciliary Care	Maintaining Social Care	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum CCG Contribution	£2,221,453	Existing

10	Integrated Services and Quality	Care Homes Liaison	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£150,000	Existing
11	DFG and Equipment Adaptations	Equipment Service	Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£783,000	Existing
12	DFG and Equipment Adaptations	DFG	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Private Sector	DFG	£1,994,703	Existing
13	Development Fund	New expanded Intermediate Care model which includes	Other		Purchase additional capacity and	Other	Contingency	Joint	50.0%	50.0%	Local Authority	Minimum CCG Contribution	£968,039	Existing
20	Care Home Schemes	Improving Care Home Provision and aligning Primary Care	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£204,828	Existing
21	Out of Hospital Care (OPAT)	Preventing DTOC, facilitating discharge	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£93,413	Existing
22	Intermediate Care - Bridgewater	Support to Intermediate Care Services	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Local Authority	Minimum CCG Contribution	£151,736	Existing
23	Elderly Day Unit (STHKT)	Support to Intermediate Care Services	High Impact Change Model for Managing Transfer	Early Discharge Planning		Community Health		CCG			NHS Acute Provider	Minimum CCG Contribution	£104,008	Existing
24	Community Respiratory Scheme	preventing DTOC, Facilitating discharge extending community	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£142,517	Existing
25	Respiratory Out of Hospital Team	Extending community provision	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£330,777	Existing
26	Rehab Post Discharge (STHKT)	Providing services in the community enabling timely discharge	High Impact Change Model for Managing Transfer	Early Discharge Planning		Community Health		CCG			NHS Acute Provider	Minimum CCG Contribution	£1,677,173	Existing
27	Specialist Rehab (STHKT)	Enabling discharge and reducing DTOC	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£196,643	Existing
29	Carers	Carers Centre	Carers Services	Other	Carer Support	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£364,754	Existing
29	Carers	Carers Breaks	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum CCG Contribution	£98,640	Existing
30	Halton Haven	Community based teams	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£200,000	New
31	Red Cross	Carers Services	Carers Services	Respite services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£7,500	New
7	Domiciliary Care	Maintaining Social Care	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£2,407,430	Existing
14	Reablement First	Reablement first on discharge from hospital	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	iBCF	£394,990	Existing
14	Transforming Domiciliary Care	Bed based service (spot purchase)	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Social Care		LA			Private Sector	iBCF	£201,015	Existing

14	Single handed care	Equipment Service	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	iBCF	£40,000	Existing
14	Care Homes	Maintaining Social Care	Residential Placements	Nursing home		Social Care		LA			Private Sector	iBCF	£177,000	Existing
14	Development Fund	Development Other	Other		new service developments including CRR	Other	Contingency	LA			Local Authority	iBCF	£90,995	Existing
6	Care Home Placements	Maintaining Social Care	Residential Placements	Care home		Social Care		LA			Private Sector	iBCF	£3,465,351	Existing
15	Winter Pressures	Increase capacity in OT and Social Work - enhance Reablement	Reablement in a persons own home	Rapid/Crisis Response - step up (2 hr response)		Community Health		LA			NHS Acute Provider	Additional LA Contribution	£303,984	Existing
16	Development Fund	Development Other	Community Based Schemes	Integrated neighbourhood services		Other	Contingency	LA			Local Authority	Additional LA Contribution	£335,146	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Halton

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	1605 (1205.1)		1,605.0	The BCF contributes to this metric. Work is ongoing in the borough to bolster the community wardens to support care homes with fall, introducing the falls car into Widnes from 1st December (work in progress on Runcorn) and respiratory car early December and increasing the staffing and doctors hours in the UTCs and	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	12.5%	12.5%	The plan is for Halton to maintain the current performance, based on locally set trajectories. However, these are superseded by regional trajectories for winter, based on hospital trusts. Work continues across both hospital trusts that Halton work alongside to meet these regional trajectories. The BCF in Halton contributes to ensuring rapid Discharge to Assess and Home First is achieved. This is supported by block purchasing of 1,000 additional hours for Domiciliary Care, bedbases at	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	7.1%	7.1%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	94.0%	April 19 to August 21 data shows that 94% of Halton patients were discharged to their normal place of residence, this is top quartile performance and 2nd highest in Cheshire and Merseyside, the plan is to maintain this level of performance into 21-22. This will be achieved through systems and processes in place at	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	636	643	618	633	The rate of admissions to residential and nursing care as at 30th September 2021 was 203, however we are expecting this to increase due to a delay in data due to the pandemic. Development of the Intermediate Care and Frailty Service and the increasing capacity in care and support in the community will support this area.
	Numerator	151	153	149	157	
	Denominator	23,735	23,812	24,105	24,797	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.2%	45.7%	84.0%	This is an annual collection only, data will not be available for 21-2 until June 2022. Development of the Intermediate Care and Frailty Service and the increasing capacity in care and support in the community will support this area.
	Numerator	81	32	84	
	Denominator	101	70	100	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Halton

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	N/A		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	N/A		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	HBC Home Assistance Policy		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes	N/A		
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes	N/A		
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes	N/A		

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes	N/A		
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes	N/A		

REPORT TO: Health & Wellbeing Board

DATE: January 19th 2022

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health & Wellbeing

SUBJECT: The procurement of a new Integrated Specialist Adult Community Substance Misuse Service for Halton

1.0 PURPOSE OF THE REPORT

1.1 To inform the Board of the decision to award a contract to the provider who, through an open procurement exercise have been assessed as being the most economically advantageous and effective organisation to deliver an Integrated Specialist Adult Community Substance Misuse Service for Halton and to receive a brief update on performance to date.

2.0 RECOMMENDATION THAT THE BOARD:

1) **Note the outcome of the formal open procurement exercise for the provision of an Integrated Specialist Adult Community Substance Misuse Service for Halton and the award of a contract to CGL.**
2) **Note the brief update on the current service performance.**

3.0 SUPPORTING INFORMATION

3.1 Halton Borough Council is responsible for commissioning services to support local people with substance (drugs and alcohol) misuse problems. The aim is to improve health and social care outcomes, reduce the harm from addiction to legal and illicit substances, promote recovery and reduce health inequalities for local people.

3.2 Supporting people living with addictions is a mandatory element of the Public Health Grant and as such, the provision of local services is a key local requirement. The Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy identify the local problems caused by the use of substances, and reducing the harm caused by alcohol in particular remains a key local, regional and national priority.

3.3 The substance misuse service aims to bring together local partners to support Halton to meet the key objectives and priorities to educate and inform local people and to prevent and tackle substance misuse wherever it occurs. Whilst levels of risk are high locally, a lower proportion of Halton young people appear to be starting to take drugs than their peers regionally and nationally with levels of those drinking alcohol falling and broadly similar to regional levels. Slightly more adults in Halton say they drink alcohol than across Merseyside or England.

3.4 There is a significant relationship between drug related hospital admissions and deprivation. Certain vulnerable groups are also more likely to have problems with drug and alcohol misuse including military veterans, homeless people and offenders. Drug use is a significant issue amongst those who commit criminal offences. Hospital admissions for alcohol, both generally and for those under the age of 18, remain higher than the regional and local averages.

3.5 The Commissioners have sought the provision of a high quality service that is both effective in improving universal outcomes through the use of evidence based interventions delivered by skilled practitioners, and also safeguards local people at risk of harm.

3.6 A procurement exercise was undertaken and completed in October 2021. Despite significant interest, only one application was received for consideration. The application was from the incumbent provider, **CGL (Change Grow, Live)**. The application was assessed on the basis of both cost (30%) and quality (70%). The application from CGL exceeded the minimum standards expected and met all aspects of the proposed contract and specification.

3.7 The expectation is that the service will combine a balance of advice/guidance and promotional/prevention activity as well as direct evidenced based interventions for those that require clinical support. Such an approach will enhance the availability of local services that are joined up, supportive and affordable to meet the identified needs of the population of the area they serve.

3.8 As well as providing an outstanding application, throughout the last 18 months CGL have proven themselves as a supportive and successful organisation in terms of helping some of our most vulnerable residents. The impact of the pandemic on service users, staff and partners has been immense, and our local teams have found new ways to continue to support some of our most vulnerable residents.

3.9 Despite the challenges faced from the pandemic, CGL has continued to perform highly across all domains. In particular, the service has continued to perform above both Public Health England and National averages. This is a testament to all of the teams engaged in supporting the substance misuse agenda and their commitment, focus and motivation despite the challenges faced over the last 18 months.

3.10 **New Treatment Journeys -** During Quarter 2, the team assessed 171 individuals for support. This was an increase from the previous three quarters (Q3, 150; Q4, 149. Q1 170). The primary substance of choice was alcohol, followed by alcohol and non-opiates combined.

Substance of choice	Total Q2	Total Q1&Q2
Alcohol	109	**189**
Opiates	23	**53**
Non-Opiates	28	**55**
Alcohol/Non-Opiates	11	**46**

3.11 The team are continuing to offer both face to face and telephone assessments, following feedback from staff and service users about the benefits of assessment via telephone. This included some individuals feeling more comfortable at home, being able to engage more within the assessment process.

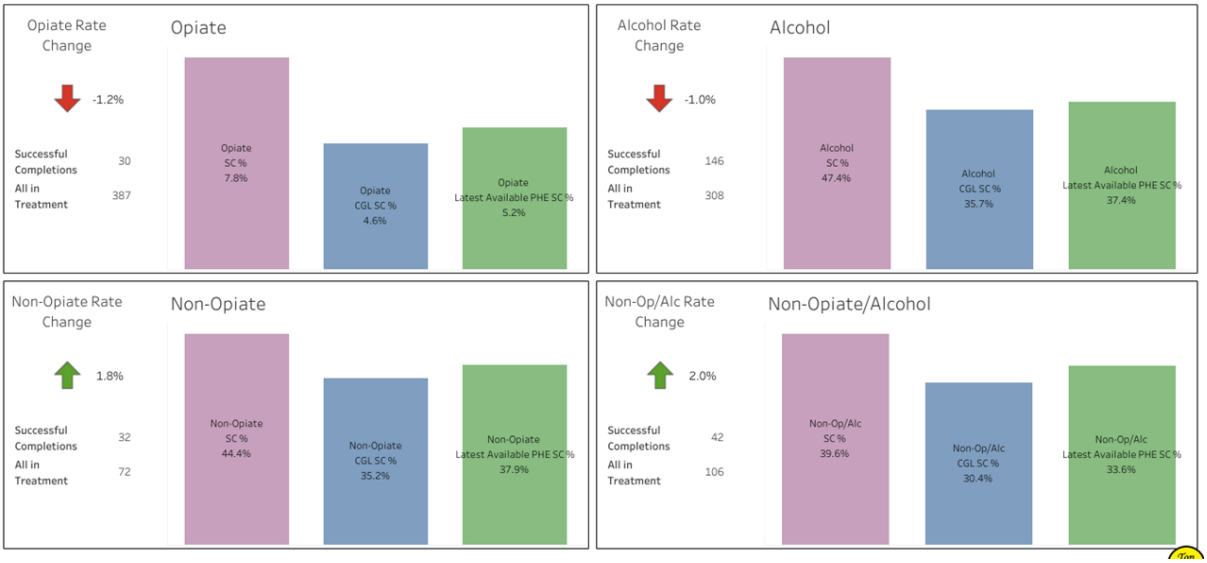
Current Caseload (Q2 Jul – Sep 21)

Structured Treatment Numbers in Treatment - Primary Alcohol	Total Q2
Structured Treatment Core (Specialist Service)	**233**
Total	**233**
Structured Treatment Numbers in Treatment - Primary Drugs	**Total Q1**
Structured Treatment Core (Specialist Service)	**389**
Structured Treatment Shared Care	**0**
Opiates	**297**
Alcohol/Non Opiates	**55**

Non Opiates	**37**
Total	**389**

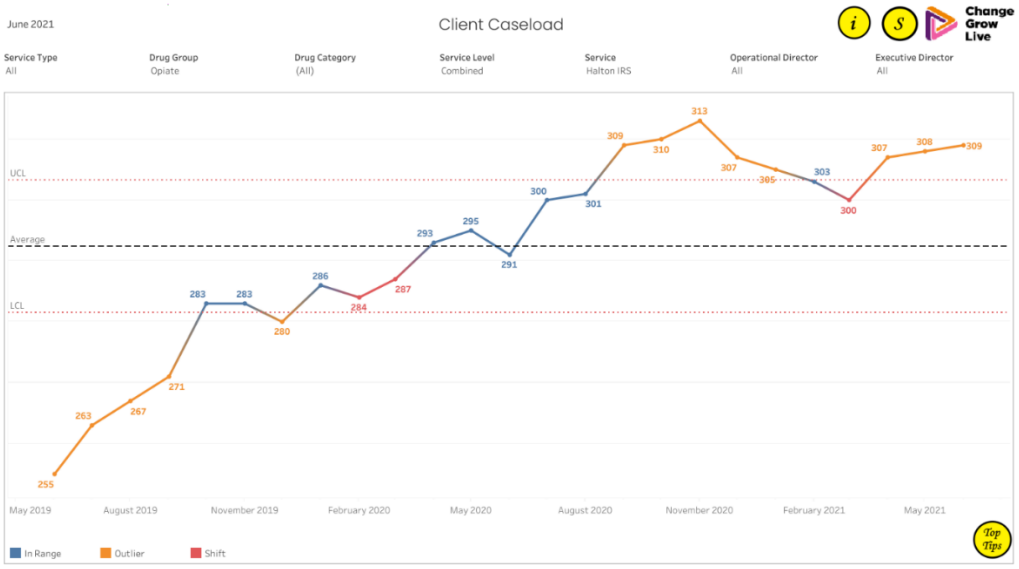
Active in Recovery Support (post structured treatment)	**Total Q1**
Alcohol	**47**
Drug	**67**
Total	**114**

3.12 **Completed Treatment Journeys -** At the end of quarter 2, CGL Halton successful completion rate across all four cohort domains (Alcohol / Opiate / Non-Opiate / Non Opiate & Alcohol) remains above both CGL nation average and PHE average. This is a great achievement given the pandemic situation. All individuals successfully discharged from the service are provided with the opportunity to remain in our recovery support element of treatment, providing relapse prevention and ongoing support in continuing to build recovery capital to maintain positive changes made.



3.13 **Opiate Caseload -** As can be seen from the graph below, caseloads for opiate clients have increased since May 2019 from **255 - 309** in May 2021. The service saw the highest number on opiate caseload at **313** in November 2020, (an increase of **58** clients compared to 2019). This is consistent with increased attempts at rapid re-engagement for those who disengage, in addition to optimisation of opiate substitute prescribing, which has seen an improved engagement in services.

3.14



Tackling the impact of substance misuse on our communities remains a priority for Halton and the proposals put forward by CGL as part of their application mean they can build on the success of the past and continue to grow and develop local services to reduce local inequalities and improve the health and wellbeing of local people.

4.0 POLICY IMPLICATIONS

4.1 The provision and performance of a substance misuse service is in line with the priorities set out in the local Health & Wellbeing Strategy and is a core condition of the Public Health grant.

5.0 FINANCIAL IMPLICATIONS

5.1 Financial provision for the Service is contained within the Public Health ring fenced grant. A contract will be awarded for **three (3) years** with **two one year optional extensions**. TUPE regulations will apply for affected staff, and measures will be put in place to review contract values on an annual basis in line with available resources.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**
The service contributes to the delivery of the objectives of the Halton Children's Plan.

6.2 **Employment, Learning and Skills in Halton**
The service contributes to supporting local residents affected by substance misuse to regain control of their lives and access opportunities to improve their employment, learning and skills in a recovery focused environment.

6.3 **A Healthy Halton**
Specialist Community Substance Misuse Service are important in promoting the health and wellbeing of all service users and their families and reducing inequalities through targeted intervention for vulnerable and disadvantaged individuals. The service contributes to the delivery of the objectives of the Health and Wellbeing Board.

6.4 **A Safer Halton**
The service contributes to a Safer Halton by supporting local people in reducing risk taking behaviour, such as alcohol, drugs, etc. Community services also play an important role in reducing crime and anti-social behaviour

6.5 **Halton's Urban Renewal**
N/A.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 All contractors 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.

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

Document	Place of Inspection	Contact Officer
None under the meaning of the Act		

REPORT TO: Halton Health and Wellbeing Board

DATE: 19th January 2021

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Marmot Workshop Report

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

To provide an update on the Marmot Workshop held on November 25th 2021 and set out next steps.

2.0 RECOMMENDATION: That the Board note the contents of the report.

3.0 SUPPORTING INFORMATION

3.1 Health inequalities are avoidable, unfair and systematic differences in health between different groups of people.

3.2 Health inequalities are experienced between different groups of people and are often analysed across four main categories: socio-economic factors (for example, income); geography (for example, region); specific characteristics (for example, ethnicity or sexuality) and socially excluded groups (people who are asylum seekers or experiencing homeless). The effects of inequality are multiplied for those who have more than one type of disadvantage.

3.3 'Health Equity in England: The Marmot Review 10 years on' found significant widening of health inequalities across England in the ten years since the publication of the original Marmot Review.

3.4 Cheshire and Merseyside (through CHAMPS and Cheshire & Merseyside Health Care Partnership) is now working to achieve Marmot Community status. This means true integration across of number of sectors in order to undertake collaborative action to achieve six common goals, as set out in Sir Michael Marmot's original report from 2010:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives

- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

3.5 The Marmot national team have held workshops across the nine local areas in Merseyside and Cheshire to identify key areas for combined action to tackle inequalities across local areas and to ensure local perspectives are incorporated into the national review report due to be published in 2022.

3.6 The Marmot community programme workshop for Halton took place on 25th November 2021. Whilst it was an online meeting it was well attended with over 50 participants from a range of settings including voluntary sector, primary and secondary healthcare and local authority and local representation from council members and officers who work at grassroots level.

The workshop considered the following areas:

- Changes to a set list of existing of indicators
- What are the key local priorities related to health inequalities in Halton
- What actions are working to reduce health inequalities in Halton? What
- should we be doing more of?
- What isn't working? Do we need to stop doing anything?

3.7 Feedback has been themed and will link to existing work on inequalities and the One Halton Plan as well as feed into the regional Marmot Community programme.

3.8 Two themes dominated the discussions, Children and Families and the role of Employment. Sub themes were identified that overlapped or linked to one or both of these topics which included poverty, the role of transport, housing, physical activity and mental health. Three other themes identified included substance and alcohol misuse, the role of aspiration and resilience as well as a need to focus on the needs of older adults. In addition to the thematic areas identified a lot of the workshop looked at indicators that the Marmot Team were looking to expand as well as discussion on ways of working and the approach to inequalities in general, this covered the need to be more preventative, some of the funding models, need for a balance between talking to the community and moving to deliver outcomes that are beneficial for local people whilst ensuring these are properly evaluated.

3.9 NEXT Steps:

The Marmot Team will independently produce a set of indicators and a report which pulls together the outcomes of the workshops across the nine places as well as help shape a regional Marmot Community programme and national review.

3.10 In Halton the thematic areas will feed into the One Halton Strategy Transformation group and will build into work on Starting Well, Living Well and Ageing Well.

4.0 POLICY IMPLICATIONS

4.1 The Marmot report recognises that the partners within the Health and Wellbeing Board are crucial to delivering reductions in health inequalities at a local level through improving inequalities in the social determinants of health. The workshop has enabled the identification of key challenges as well as work areas for focus. Information gathered from this workshop will also help shape a regional Marmot Community programme.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton. The review will highlights key topics for children.

6.2 Employment, Learning & Skills in Halton

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

6.3 A Healthy Halton

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

6.4 A Safer Halton

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

There are also close links between partnerships on areas such as scams, alcohol and domestic violence.

6.5 Halton's Urban Renewal

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

7.0 RISK ANALYSIS

7.1 Developing the programme plan does not present any obvious risk however, there may be risks associated with the resultant recommendations. These will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None