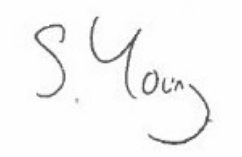
Public Document Pack

Health and Wellbeing Board

Wednesday, 11 October 2023 2.00 p.m.
Karalius Suite - Halton Stadium, Widnes



Chief Executive

Please contact Kim Butler on 0151 5117496 or e-mail kim.butler@halton.gov.uk for further information.

The next meeting of the Committee is on Wednesday, 17 January 2024

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, 5 July 2023 at Karalius Suite - Halton Stadium, Widnes

Present: Councillor Wright (Chair)
Councillor J. Lowe
Councillor T. McInerney
Councillor Woolfall
I. Onyia, Public Health
W. Longshaw, St. Helens & Knowsley Hospitals
A. Leo, NHS ICB – Halton Place
S. Josepil, NHS ICB – Halton Place
J. Hogan, Bridgewater Community NHS Foundation Trust
D. Nolan, Adult Social Care, Halton Borough Council
S. Drennan, Halton Borough Council (Care Homes)
L. Olsen, Halton Housing Trust
A. Doble, Public Health
T. McPhee, Mersey Care
L. Gardner, Warrington & Halton Hospitals
T. Knight, Primary Care, Cheshire & Merseyside
S. Yeoman, Halton & St. Helens Voluntary Action

Action

HWB1 MINUTES OF LAST MEETING

The Minutes of the meeting held on 22 March 2023, having been circulated, were signed as a correct record.

HWB2 CARE HOMES - PRESENTATION

The Board received a report and presentation from the Clinical Development Lead for Care Homes which provided a progress update of the work to date within the Care Home Sector.

Nationally, Nursing Homes across the country required further investment to drive up the standards of care, and to ensure professionals recognised and received recognition for the work undertaken within care homes. To help do this, the Clinical Lead Development Officer was created and funded via the Cheshire and Merseyside Local Action Board. The aim of the post aim was to enhance quality within the Care Home Sector focussing on Nursing Care Homes

The presentation outlined:

- The role of the Clinical Development Lead Officer;
- Work undertaken to date;
- The work plan for the remainder of the 12 month project;
- Case studies to evidence the positive outcomes of the work undertaken to date; and
- Future developments.

RESOLVED: That the presentation be received.

HWB3 UPDATE ON ONE HALTON PLACE BASED PARTNERSHIP - PRESENTATION

The Board received a presentation from the Place Director – Halton, which provided an update on the One Halton Place Based Partnership.

The new arrangements for the Integrated Care Systems (ICS) came into effect on 1 July 2023 and the aim was to improve outcomes and reduce health inequalities. Locally, the One Halton Partnership Board was the vehicle for delivery of national priorities, local priorities and Halton's Joint Health and Wellbeing Strategy. Membership of the Board included representatives from Local Authorities, NHS/Foundation Trusts and Primary Care.

The key priorities of the Board were to:

- Improve population health and healthcare;
- Tackle unequal outcomes and access;
- Enhance productivity and value for money; and
- Support broader social and economic development.

The presentation set out the context and provided an overview of progress and the current position. It also outlined how Halton compared to the rest of the North West and how the challenges in Halton would be addressed.

RESOLVED: That the presentation be noted.

HWB4 GENERAL PRACTICE ACCESS - PRESENTATION

The Board received a presentation from the Place Director – Halton, which provided an overview on the current position in relation to access to General Practice (GP) Services in Halton and the National Delivery Plan for recovering access to Primary Care, NHS England.

Access to GP services is one of the key enablers in supporting residents health and wellbeing.

The presentation outlined the following key points:

- Between April 2022 and March 2023, there had been a 29% increase in GP appointments;
- In March 2023, across the 9 Cheshire and Merseyside Places, Halton had the:
    - second highest number of appointments provided face-to-face;
    - second lowest of appointments provided by telephone;
    - joint third highest % of appointments provided by a GP; and
    - third highest % of appointments provided on the same day.
- Between April 2022 and March 2023, "Did Not Attend" appointments had increased;
- The 4 key areas to alleviate pressure and address the increasing demands on Primary Care:
    - Empowering patients;
    - Implementing modern General Practice access;
    - building capacity; and
    - cutting bureaucracy.

The Board discussed the above points and shared experiences of local issues regarding difficulties that residents in Halton had received. It was suggested that Healthwatch Halton and the Voluntary Sector would be able to gather together some intelligence from local communities about access to GP appointments.

RESOLVED: that the presentation be noted.

HWB5 HALTON & WARRINGTON COMMUNITY DIAGNOSTIC CENTRE - PRESENTATION

The Board received a report and presentation from the Director of Strategy and Partnerships, Warrington and Halton Hospitals (WHH) which provided an update on the WHH Foundation Trust's Plan for the provision of a Community Diagnostic Centre (CDC) in Halton.

It was noted that the Plan would be delivered in 3 phases:

1) Phase 1 - Warrington and Halton Diagnostics Centre at Nightingale building, Halton Hospital site. All works

completed and services fully operational with effect from 26 June 2023;

2) Phase 2 – Warrington and Halton Diagnostics Centre at Halton Health Hub, Runcorn Shopping City. Planned to be operational in late November 2023; and

3) Phase 3 – Warrington and Halton Diagnostics Centre at Captain Sir Tom Moore building, Halton Hospital site. Planned to be fully operational in Summer 2024.

RESOLVED: that the Board:

1) note the report and presentation; and

2) support the WHH Trust's plan for the development of the CDC at the Halton site.

HWB6 COMMISSIONING OF PRIMARY CARE DENTAL SERVICES

The Board received an update report from the Head of Primary Care (Cheshire and Merseyside) on the Commissioning of Primary Care Dental Services.

The report outlined that currently there was 13 dental practices and 2 Urgent Care Plus providers offering urgent dental care for patients that did not have a regular dentist. Despite ongoing challenges, there was increased activity across Cheshire and Merseyside. Commissioners were keen to explore the use of Dental Care Professionals i.e. Dental Therapists and Dental Nurses as these could free up Dental Performer time and support access for new patients.

The report also described the development of a Dental Improvement Plan which was approved by ICB System Primary Care Board in June 2023. An important part of the Plan was to develop access sessions for new patients across 60 practices in the ICB.

Commissioners were seeking an additional 30,000 appointments across Cheshire and Merseyside and would link with Local Authorities to identify suitable organisations who work with vulnerable people e.g. the homeless and asylum seekers. In addition to this, a number of Foundation Dentists would work across Cheshire and Merseyside from September this year.

The Board acknowledged that the update was

encouraging and Public Health asked to be part of future conversations about how children's dental health could be improved.

The Head of Primary Care agreed to:

- Circulate a copy of the Dental Improvement Plan to the Board;
- Confirm the number of practices that carry out NHS work; and
- Provide further updates to the Board in due course.

Head of Primary Care

RESOLVED: that the report be noted.

HWB7 PUBLIC HEALTH ANNUAL REPORT 2022-23

The Board received a report and presentation from the Director of Public Health, which provided an update on the development of Halton's Public Health Annual Report (PHAR).

Each year a theme would be chosen for the PHAR and for this year the focus would be on health improvement and prevention work to support the Halton community with their health in the different stages of their lives, as well as coping with pressures, such as the recent pandemic and the rising cost of living.

The report would use 4 key life stages as a guide to the issues including the following sections:

1) Start – looking at children's health and giving children and young people the best possible start to their lives;
2) Strong – acknowledges busy lives and a range of pressures, needing services to be flexible and accessible;
3) Live – providing community and work based services that allow people with busy working lives to take action for their health as well as get help when it is needed; and
4) Well – living healthy and independent lives as we age, reducing impact poor health can have on our health and social care system as well as for individuals.

The Plan also contained some free local offers e.g. mental health for men, free blood pressure checks, free help to stop smoking etc. It was suggested that the offers be promoted via Halton Housing Trust (HHT) via their magazine that was sent out to tenants. HHT also agreed to promote

and signpost a range of health services, discussed at the meeting, to their tenants during home visits.

RESOLVED: That the theme and development of the PHAR be noted. *Halton Housing Trust*

HWB8 TERMS OF REFERENCE REFRESH

The Board considered a draft version of some updated Terms of Reference which took into account several changes that had occurred since the last refresh in 2019.

In November 2022, the Department of Health and Social Care set out new guidance for all Health and Wellbeing Board in light of the changes to the NHS, in particular, the establishment of the Integrated Care Boards (ICB) and Integrated Care Systems (ICS). The guidance was to support the ICB and ICP (Integrated Care Partnership) Leaders, Local Authorities and Health and Wellbeing Boards to understand how they should work together to ensure effective system and place-based working and to determine how best to deliver holistic care and prevention activities in the communities.

The Board previously received guidance that set out the functions of the Health and Wellbeing Board in relation to the new strategic partners and the revised Terms of Reference reflected these.

Members of the Board were invited to make any comments or suggestions before the end of July 2023. A final version of the document would be presented to the Board at the next meeting.

RESOLVED: that the Board:

1) note the refreshed draft Terms of Reference; and

2) feedback any comments by the end of July 2023. *Health & Wellbeing Board*

HWB9 BETTER CARE FUND (BCF) 2022-23 YEAR-END RETURN

The Board received a report from the Executive Director of Adult Social Services, which provided an update on the Better Care Fund 2022/23 Year-End return, following its submission on 26 May 2023. The update provided the Board with information on the four national conditions which had been met, progress on the four national metrics, income and expenditure actual, year-end feedback and adult social

care fee rates.

RESOLVED: The Better Care Fund Year-End return for 2022/23 be noted for information.

Meeting ended at 3.50 p.m.

REPORT TO: Health & Wellbeing Board

DATE: 11 October 2023

REPORTING OFFICER: Executive Director - Adult Services

PORTFOLIO: Adult Social Care

SUBJECT: Halton Borough Council and NHS Cheshire & Merseyside: Joint Working Agreement (Better Care (Pooled) Fund)

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To present a brief overview of the updated two year Joint Working Agreement (JWA) between Halton Borough Council (HBC) and NHS Cheshire & Merseyside (CM), taking effect from 1st April 2023 to 31st March 2025, and which replaces the previous one year JWA which was approved by both organisations in March 2023.

2.0 RECOMMENDATION

RECOMMENDED: That the Board note the contents of the report.

3.0 SUPPORTING INFORMATION

3.1 Introduction/Background

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

Since it's original development, the JWA and associated Pooled Budget has gone through a number of changes, including the inclusion of the Better Care Fund in 2015 and the separating out of the Continuing Healthcare and Community Care budget elements in 2020.

3.2 Joint Working Agreement (JWA) & Governance Arrangements

Following approval in March 2023 of the one year JWA, national guidance was issued in respect to the requirements regarding the Better Care Fund Plan and that is was intended to be a two year plan (2023/25). Also further discussions took place between HBC and NHS CM regarding the governance arrangments in respect to the pooled budget arrangements which resulted in agreement to formally remove management of the Pooled Budget etc. from the One Halton Partnership governance arrangments.

In the main, this change has resulted in the establishment of a Joint Senior

Leadership Team (JSLT) between HBC Adult Social Care and NHS CM.

The JSLT is responsible for the direction, oversight, monitoring of the BCF Plan and associated Pooled Budget. The JSLT is supported in this duty via the Better Care Commissioning Advisory Group (BCCAG). The BCCAG reviews in detail information pertaining to BCF Plan, impact of the Pool Budget, quality, performance, activity and finances, and make recommendations to the JSLT on remedial action plans or future use of the Pool as appropriate.

The new governance arrangements along with links to the two year Better Care Fund Plan has been reflected in the new JWA.

3.3 **Benefits of Joint Working**

By working together collaboratively and in partnership we are able to achieve and sustain good health and wellbeing for the people of Halton and are able to provide a range of options to support people in their lives by jointly designing and delivering services around the needs of local people rather than focusing on the boundaries of our individual organisations. This aids in our ability to be ensure that services are sustainable, particularly with the continued challenges that we are presented with.

If we didn't undertake this approach then it has the potential to have a negative impact on the Health & Social Care system within the Borough, for example:-

- A lack of cohesive approach could lead to fragmentation of service delivery and lack of ownership.
- No clear picture of the demand and capacity on services shared by system leaders, which could lead to our inability to develop robust plans for the future service needs of local people.
- Lack of choice/information for service users and possible duplication of provision.

This would have the potential to ultimately lead to a lack of confidence in the system and our inability to deliver high quality services in order to ensure that service users receive the outcomes that they want.

4.0 **POLICY IMPLICATIONS**

4.1 None identified.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The Better Care (Pooled) Fund budget for 2023/24 is circa. £30m.

5.2 With effect from 1st April 2023, the pooled budget will include:-

- Better Care Fund and Improved Better Care Fund (iBCF)
    - Includes spend in areas such as Intermediate Care Services, Carers, Equipment Services, Care Homes, Domiciliary Care,

Telecare, Supported Discharge, Community Respiratory and Rehabilitation Services

- Hospital Discharge Funding
- Disabled Facility Grant

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**
Those people who are in receipt of long term care whether that is funding from Health or Social Care are those people in our communities with some of the most clinically complex and severe on going needs, so it is essential we have effective mechanisms in place to ensure that people we provide services to receive appropriate outcomes.

The integrated system and pooled budget arrangements will continue to ensure that the resources available to both Health and Social Care are effectively used in the delivery of personalised, responsive and holistic care to those who are most in need.

6.4 **A Safer Halton**
None identified.

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

7.0 **RISK ANALYSIS**

7.1 The JWA complies with the financial standing orders of HBC and NHS CM and the regulatory and monitoring arrangements contained within.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with this report.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 There are no environmental or climate implications as a direct result of this report.

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

10.1

Document	**Place of Inspection**	**Contact Officer**
Joint Working Agreement – HBC	Copy available on request	Sue Wallace Bonner Susan.Wallace-

& NHS Cheshire & Merseyside 1.4.23 -31.3.25		Bonner@halton.gov.uk Tel: 0151 511 8825

REPORT TO: Health and Wellbeing Board

DATE: 11 October 2023

REPORTING OFFICER: Director of Public Health.

PORTFOLIO: Health and Wellbeing

SUBJECT: Joint Strategic Needs Assessment Summary

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide members of the Board with an update on the Joint Strategic Needs Assessment.

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

3.0 SUPPORTING INFORMATION

3.1 Background to the JSNA summary document

Joint strategic needs assessments (JSNAs) analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNA underpins the health and well-being strategy and commissioning plans. The main goal of a JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.

In 2012 the first executive summary of the JSNA mapped across the life course (the approach advocated by the Marmot Review on tackle health inequalities) was presented.

This approach has continued to receive good feedback from various partnerships and stakeholders. As a consequence the revised annual summary has used broadly the same approach, updating data and information since the previous version.

The 2022-2027 Health and Wellbeing Strategy also uses these broad life course stages with the addition of the wider determinants of health as the basis of its priority setting.

3.2 Local development of the JSNA

The JSNA continues to be hosted on the Halton Borough Council website.

The JSNA is developed as a series of chapters, on a rolling programme with an annual summary and a selection of health profiles.

Since resuming the JSNA work post Covid-19 pandemic suspension the work has focussed on a number of general topics and updating the core JSNA products as well as statutory requirements. These include:

- Inequalities in life expectancy
- Cheshire & Merseyside cancer health needs assessment
- Pharmaceutical Needs Assessment
- Drugs JSNA
- GP JSNA profiles
- Poverty and Cost of Living JSNA
- Ward profiles
- Understanding the drivers for healthy life expectancy

The JSNA annual summary document is split into sections on:

- Population
- Health Inequalities: life expectancy and healthy life expectancy
- Wider determinants of health
- Starting Well: focus of children and young people
- Living Well: focus on adults of working age and those with long-term health conditions
- Ageing Well: focus on older People (65 and over)

This summary document is attached as Appendix 1.

3.4 **Key changes since the previous summary**

Despite the continuing challenges the borough faces many of the health indicators show year on year improvements. So whilst the borough's health continues to be, generally, worse than the England average, these improvements show that we are moving in the right direction – we are doing the right things for the right people, who are then able to engage with services, making the most of them to bring about positive changes for themselves, their families and their communities.

Note: The latest available published whole year data in the 2023 JSNA summary is 2021/22. Due to methodological changes post Covid-19 pandemic a substantial number of indicators have been restarted with no trend data available.

Some highlights include:

- Average life expectancy for both men and women has improved.
- The levels of children achieving a good level of development by age 5 have fallen and are lower than pre-pandemic levels. This is the same across the North West and England averages. Halton's level remains statistically lower than the North West and England average
- Child immunisations and flu vaccination uptake continue to perform well. For example, uptake of MMR is similar to the North West and England and uptake of flu vaccination amongst those aged 65 and over is better
- Uptake of NHS Health Checks has continued to improve and is better than the North West and England averages
- Smoking prevalence amongst adults continues to fall and is now similar to the England average. Inequalities continue e.g. between those in routine & manual occupations and amongst those with mental illness compared to the overall prevalence.
- The percentage of working age people with no formal qualifications remains the same.
- There has been a fall in the employment gap between those with a long-term condition and the overall employment rate
- Unemployment levels are lower than the North West and England rates

However, some areas do remain difficult to improve and others have worsened since the previous reporting period:

- Both male and female life expectancy, at birth and at age 65, have improved but remain statistically worse than England.
- Internal differences in life expectancy remain substantial and have increased since the previous reporting period by over 2 years. There is now a 11.7 year gap between life expectancy at birth amongst men living in the most deprived 10% of Halton compared to the least deprived. For females the gap is 9.6 years.
- There has been an increase in the levels of children living in poverty. The levels of both child poverty and older people living in poverty are statistically higher than the England averages
- The under 18 conception rate is statistically higher than the England average
- Smoking at time of delivery has improved but remains higher than the Merseyside and England rate

- Breastfeeding rates have remained static and statistically higher than England
- Levels of childhood obesity have increased and are statistically worse than the North West and England averages
- Hospital admissions amongst young people due to self-harm and due to alcohol are both worse than the North West and England averages.
- Breast cancer screening uptake has reduced and is statistically worse the North West and England. Previously the uptake rate had been better than the North West average
- There has been an increase in the percentage of working age adults claiming out of work benefits
- The rate of working age people economically inactive due to long-term sickness is higher than the North West and England rates
- Older people being admitted to hospital due to injuries from falls remains a challenge locally with rates above the North West and England averages

3.6 **Developments for the JSNA during 2023 and 2024**

It is important to recognise that the JSNA is an on-going, continuous process, refreshing data to ensure its timeliness, and producing 'deep dive' needs assessments to assist commissioning decisions.

The ongoing catch-up programme for the JSNA and system changes with the establishment of the ICB local place mean now is a good time to agree the work programme for the remainder of 2023/24 and even into 2024/25.

The process for agreeing and developing a work plan for the remainder of 2023/24 and into 2024/25 will be managed in collaboration with key stakeholders and members of the Health and Wellbeing Board.

The next Pharmaceutical Needs Assessment (PNA) process will need to start July 2024

Each Health and Wellbeing Board has a separate statutory duty to develop a PNA, with both timeframe and process governed by Department of Health & Social Care regulations. The next PNA must be published on or before 1 October 2025. This means a final version being presented at the July meeting.

One Halton

The JSNA work will need to support the development of One Halton. The team will work closely with the One Halton ICP Board and One Halton Priority Sub-Groups on this to identify priority areas requiring support.

Cheshire & Merseyside Population Health Dashboard

The team have led on the development of the dashboard, using the Combined Intelligence for Population Health Action (CIPHA) platform, on behalf of the Cheshire & Merseyside ICS and Directors of Public Health. The dashboard focusses on health outcomes across a wide range of priority topics. It is built from a wide range of local and national sources.

Whilst not developed for One Halton Local Place specifically, it will nevertheless provide a useful source of outcome based metrics. It includes metrics across all of our One Halton Health and Wellbeing Strategy priorities – wider determinants, starting well, living well and ageing well. It also includes the All Together Fairer (formerly known as Marmot) Beacon Indicators.

Both CIPHA, other ICS data tools and other sources such as Midland & Lancashire Commissioning Support Unit (CSU) Aristotle data portal mean the JSNA now sits within a much richer and more timely data landscape. This likely requires a new data-to-decision journey/model locally, more integrated than before.

4.0 POLICY IMPLICATIONS

4.1 The health needs identified in the JSNA have been used to develop the Health & Wellbeing Strategy.

The JSNA provides a robust and detailed assessment of need and priorities across Halton borough. As such is should continue to be used in the development of other policies, strategies and commissioning plans and reviews such as those of Halton Clinical Commissioning Group.

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 of Children and Young People is a key priority in Halton and this is reflected in the JSNA, taking into account existing strategies and action plans so as to ensure a joined-up approach and avoid duplication.

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 and is reflected in the JSNA.

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. Community safety is part of the JSNA.

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 and will therefore need to be addressed within the JSNA and Health and Wellbeing Strategy.

7.0 RISK ANALYSIS

7.1 Developing the JSNA does not in itself present any obvious risk. However, there may be risks associated with the resultant commissioning/action plans developed based upon it and these will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The JSNA seeks to provide intelligence on which to base decisions on action to tackle health inequalities. This includes analysis of a range of vulnerable groups and the need for targeted as well as universal services to meet the range of needs identified.

9.0 CLIMATE CHANGE IMPLICATIONS

There are no environmental or climate implications as a direct result of this report.

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

None.

HALTON JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

SUMMARY DOCUMENT 2023

Introduction

Joint strategic needs assessments (JSNAs) analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNA underpins the health and well-being strategy and commissioning plans. The main goal of a JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.

Please note that the COVID-19 pandemic affected publication of some key national data sources. There have also been changes in how some of the data we use is analysed by national organisations which has affected availability of trend data.

COVID-19 has undoubtedly had an impact on the health of the population of Halton. Not all of these impacts can be assessed right away, as they may be medium or long term .

This document contains information, analysis and infographics which show the overall state of the borough - the population, economy, employment - and the health of people living in Halton.

With the 2022-2027 Health and Wellbeing Strategy now being in place, this report divides analysis into the strategy priority themes—wider determinants of health, starting well, living well, ageing well.

The JSNA is a key statutory document for Integrated Care Systems (ICS) Partnerships:

> "We expect the ICS Partnership will have a specific responsibility to develop an 'integrated care strategy' for its whole population using best available evidence and data, covering health and social care (both children's and adult's social care), and addressing the wider determinants of health and wellbeing. This should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. We expect these plans to be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities "
>
> *Integrated Care Systems: Design framework* (NHS England & NHS Improvement) 2021

Page 18

Further information and access to specific, topic-based JSNA chapters can be found via this link: https://www4.halton.gov.uk/Pages/health/JSNA.aspx.

If you have any queries or require further information, please contact the Public Health team via the email health.intelligence@halton.gov.uk.

HALTON BOROUGH COUNCIL

OneHalton Working better together

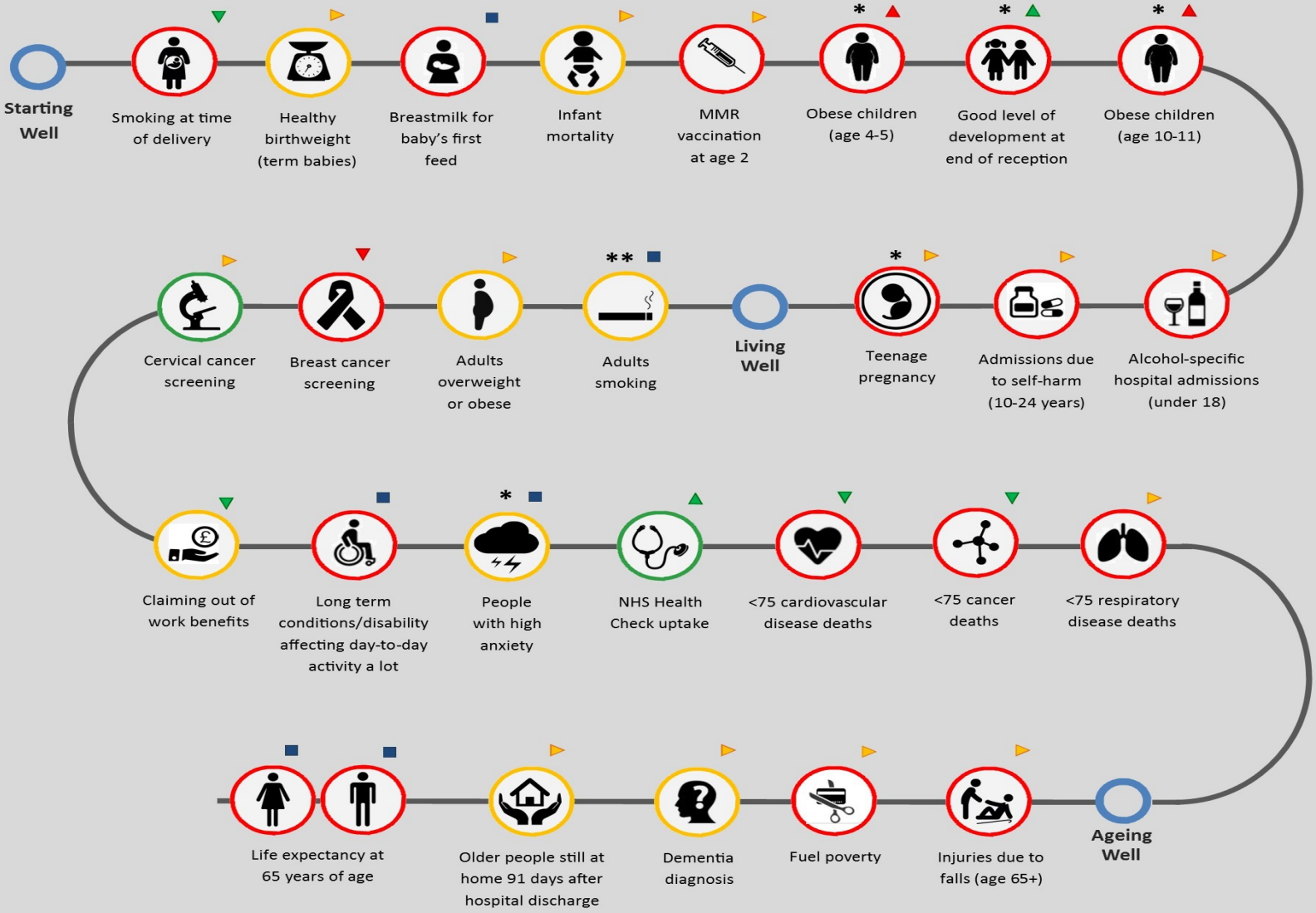
HALTON'S LIFE COURSE STATISTICS

Halton's life course statistics 2022

A comparison to the England

*COVID-19 has impacted the collection of data for the indicator

**Definition of indicator has changed from 2019 to 2020



HALTON FACTS

Population

About **129,800** people live in Halton.

By 2041, this is projected to change:

age 0-14 ↓ 11%
age 15-64 ↓ 5%
age 65+ ↑ 38%

Deprivation

48.6% of Halton's population live in the top **20%** most deprived areas in England.

Child Poverty

16.6% of children aged 0-15 live in relative low income households

KEY

Direction of travel

- Improved since last period
- Similar to last period
- Worse than last period
- No comparator

Statistical significance to England

- Better
- No different
- Worse
- Lower

For more information, please contact Halton Borough Council's Public Health Intelligence Team:

Icons made by Flaticon and available here: www.flaticon.com

Concept developed from Gateshead PHAR 2013/14 and Leicestershire PHAR 2015

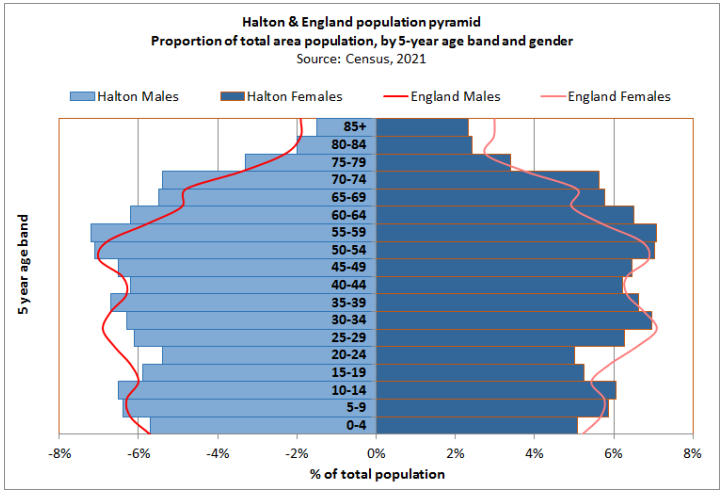
POPULATION

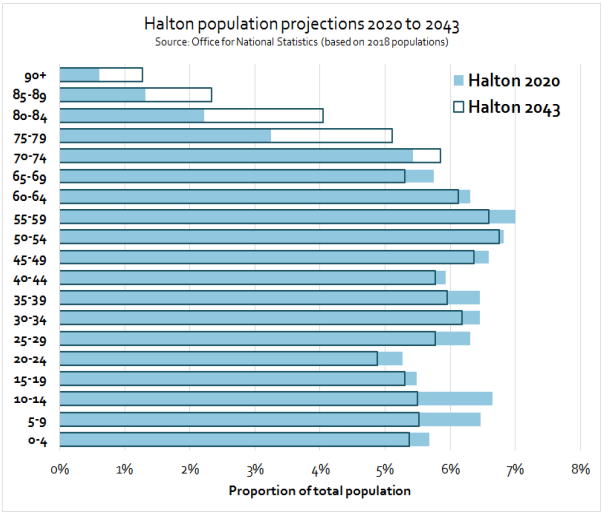
Population structure

There has been a shift towards a greater proportion of Halton's population now being in the 50-79 age bands when compared to the England average, rather than the 50-69 age band, as was previously the case. Halton has a much lower proportion of the population aged between 15 and 44. This emphasises the potential for an ageing population to impact upon the borough's working age population.

This shifting population pattern is expected to continue over the next two decades. The proportion of people over the age of 70 is expected to swell and the proportion of children and people of working age is expected to contract. This is the case nationally also, but is predicted to be emphasised more so locally.

In 2020 7.4% of Halton's population were aged 75 and above, whereas, in 2043 Halton's projected population aged over 75 will be nearly double at 12.8% of the entire population of the area.





Ethnicity

The 2021 Census provides the most accurate picture of our local population broken down by ethnic groups. There are many different levels of this analysis which can be split in to 6,8 or 20 ethnic group categories. The data below is for 8 categories and shows Halton has a much smaller percentage of its population from non-white British ethnic backgrounds than the North West or England.

Ethnic group (8 categories)	Halton		North West	England
	Numbers	%	%	%
Asian, Asian British or Asian Welsh	1435	1.1%	8.4%	9.6%
Black, Black British, Black Welsh, Caribbean or African	511	0.4%	2.3%	4.2%
Mixed or Multiple ethnic groups	1792	1.4%	2.2%	3.0%
White: English, Welsh, Scottish, Northern Irish or British	120301	93.6%	81.2%	73.5%
White: Irish	685	0.5%	0.8%	0.9%
White: Gypsy or Irish Traveller, Roma or Other White	2990	2.3%	3.6%	6.6%
Other ethnic group	764	0.6%	1.5%	2.2%
Total population	128,478		7,417,397	56,490,044

Source: ONS, Census 2021

Employment

Halton has a smaller proportion of it's population who are economically active compared to England, but it is similar to the North West. Like comparators a lower proportion of woman are economically active than men. The borough has lower unemployment rates. However it has a higher proportion of those aged 16-64 who are economically inactive due to long-term sickness.

A lower percentage of males are in employment than the England average (77.2% vs 79.3%), but similar percent of females (72.4% vs 72.1%).

Economic activity rates April 2022 - March 2023				
People aged 16-64	Halton		North West	England
	Numbers	%	%	%
Economically active	58,600	76.3%	76.5%	78.4%
In employment	57,400	74.8%	73.6%	75.7%
Employees	54,200	70.6%	65.6%	65.9%
Self-employed	3,200	4.2%	7.7%	9.5%
Unemployed	1,200	2.0%	3.9%	3.7%
Economically inactive due to long-term sickness	7,100	9.2%	7.4%	5.5%

Source: Nomis, Annual Population Survey

CENSUS POPULATION DATA BY PROTECTED CHARACTERISTICS

Age and gender: Halton's population increased by approximately 2,700 residents between 2011 and 2021, from 125,700 to 128,500. This represents a 2.2% rise which was smaller than the North West (5.2%), and England (up 6.6%). In terms of gender 51% were female and 49% male. 21.4% of Halton residents were under age 18, 59.9% aged 18-64 and 18.6% aged 65 and over.

The census results also demonstrated an ageing population with the median age in Halton in 2021 being 41 years old, an increase of 2 years when compared with 2011.

Disability: The number of people in Halton who reported being "disabled and limited a lot" decreased, from 13.3% to 11.0%. This was a general pattern seen across the country. Despite this levels were higher than the North West 9.1% and England 7.5%. By contrast the percentage of people reporting being "disabled and limited a little" worsened, increasing from 10.8% to 11.5%.

Marital status: The 2021 Census includes data on same-sex marriages and opposite-sex civil partnerships. These were not legally recognized in 2011 in England and Wales. Of Halton residents aged 16 years and over, 39.3% said they had never been married or in a civil partnership in 2021, up from 35.4% in 2011. This increase was similar to the North West and England averages. 42.2% said they were married or in a registered civil partnership

Religion: over 1 in 3 Halton residents (35.2%) identified themselves as having no religion, an increase from 18.7% in the 2011 Census. This was higher than the North West average (32.6%) but lower than England as a whole (36.7%). This coincides with the percentage decrease for people classing themselves as Christian, which declined from 75% to 58.6%. The proportion of people identifying as Muslim increased from 0.2% to 0.6%.

Ethnicity: The 2021 Census provides the most accurate picture of our local population broken down by ethnic groups. There are many different levels of this analysis which can be split in to 6,8 or 20 ethnic group categories.

Looking at broad categories, 96.5% of people in Halton identified their ethnic group within the "White" category (compared with 97.8% in 2011), while 1.4% identified their ethnic group within the "Mixed or Multiple" category (compared with 1.1% the previous decade).

The percentage of people who identified their ethnic group within the "Asian, Asian British or Asian Welsh" category increased from 0.7% in 2011 to 1.1% in 2021.

Sexual orientation: 91.9% of Halton residents aged 16+ identified themselves as straight/heterosexual. This is a higher percentage than the North West (90.1%) and England (89.4%). 1.5% identified as gay or lesbian, 0.94% as bisexual, 0.2% as other sexual orientation. 5.46% preferred not to say what their sexual orientation was.

Gender identity: Halton had a slightly lower proportion of people aged 16 and over with a gender identity different from sex registered at birth compared to the North West and England: 0.19% compared to 0.23% and 0.25% respectively

Pregnancy: Pregnancy is not included in the Census but is a protected characteristic under the Equality Act. The latest annual data is for 2021 (ONS) and shows there were 1,888 conceptions. This equates to a conception rate of 79.1 per 1,000 women, higher than the North West (76.7) and England rates (71.5). All areas saw a reduction in conceptions. The Halton number fell by 113 compared to 2020 (conception rate 84.4)

INEQUALITIES

Inequalities

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

The King's Fund (2020)

Health inequalities across populations can exist due to a variety of "social, geographical, biological or other factors"[1]. The social, economic and environmental factors are often referred to as the **wider determinants of heath**, which are explored on the next page.

Health inequalities are generally measured by looking at **deprivation** levels, resulting in different **life expectancies**, as a measure of general health in a population.

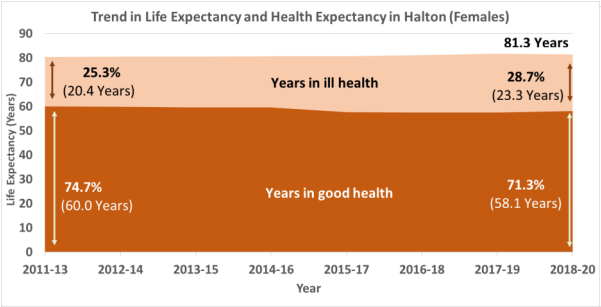
Halton is a deprived borough, relative to England as a whole (23rd most deprived of 317) and almost one third of its population live in areas classified in the 10% most deprived in England.

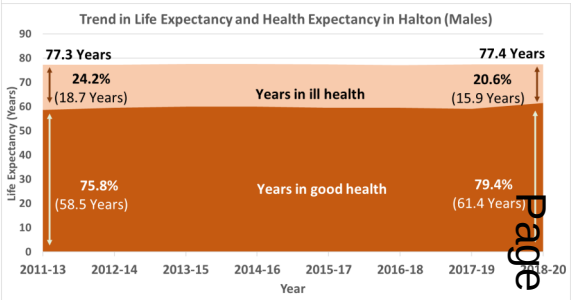
Residents of more deprived areas are more likely to be in worse health , spend more of their lives in poor health, require greater access to healthcare and other services; however they often do not have their greater needs met[2,3].

1. National Institute for Health and Clinical Excellence (2012) Health inequalities and population health
2. PHE: https://www.gov.uk/government/publications/health-profile-for-england/chapter-5-inequality-in-health
3. Cookson et al. (2016) Socio-Economic Inequalities in Health Care in England

Life expectancy and healthy life expectancy

Life expectancy across Halton has been improving but remains below the regional and national averages. It means that on average people in Halton can expect to live 2 years less than across England as a whole. Halton residents also spend less of their lives in good health.





There are also varying levels of deprivation and life expectancy within Halton, meaning that there are internal inequalities. For males there is a **11.7** year gap (an increase from the 2017-19 figures of 9.9 years) between life expectancy at birth for those in the most deprived 10% of Halton, compared to the least deprived 10%. The gap is **9.6** years for females (again an increase from 2017-19 data which was 8.5 years). The deprivation gap is similar to the North West but higher than the England average.

In an effort to address this Cheshire & Merseyside and all its constituent Health & Wellbeing Boards has become a **Marmot Community**. The **All Together Fairer** Board was established in 2022, working with Sir Michael Marmot's team at the Institute for Health Equity and local teams to address these significant challenges.

See JSNA chapter on inequalities in life expectancy on our webpage www.halton.gov.uk/jsna.
All Together Fairer report can be found at https://champspublichealth.com/all-together-fairer/

WIDER DETERMINANTS OF HEALTH

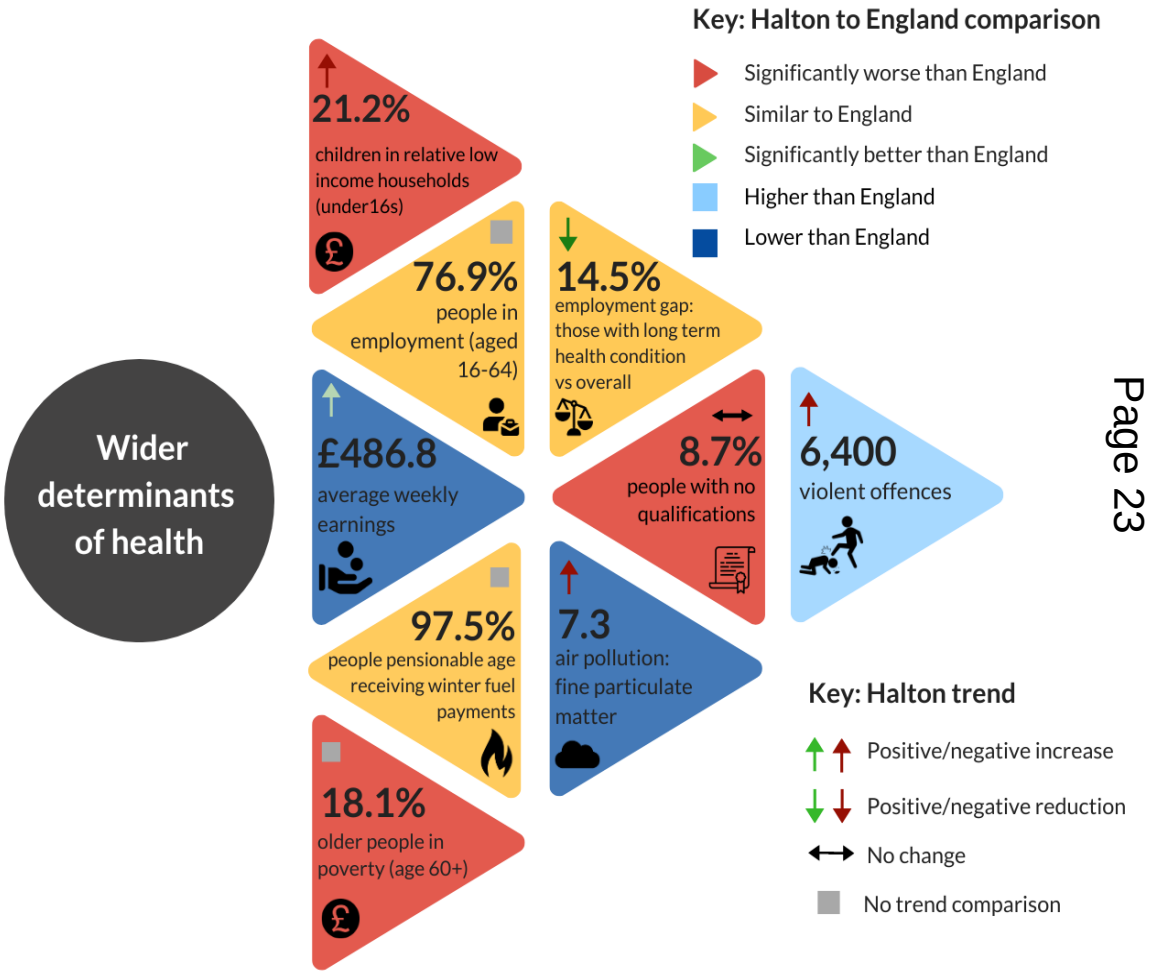
The wider determinants of health

"The wider determinants of health are the social, economic and environmental conditions in which people live that have an impact on health. They include income, education, access to green space and healthy food, the work people do and the homes they live in".

King's Fund (2020)

The social, economic and environmental factors are often referred to as the wider determinants of heath, and these are alterable, to varying degrees[1]. Examples include lifestyle factors (such as smoking), social networks, secure fair paid employment, good quality housing and access to green space.

Poorer education, lower quality housing, lack of available transport and transport links, higher unemployment rates and lower income are all linked to worse health and lower life expectancy. People from more socioeconomically deprived areas are often the most disadvantaged in relation to wider determinants[2], which can impact on health and create health inequalities.



1. https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health
2. https://fingertips.phe.org.uk/profile/wider-determinants/data#page/1/gid/1938133043/pat/6/par/E12000002/ati/102/are/E06000006

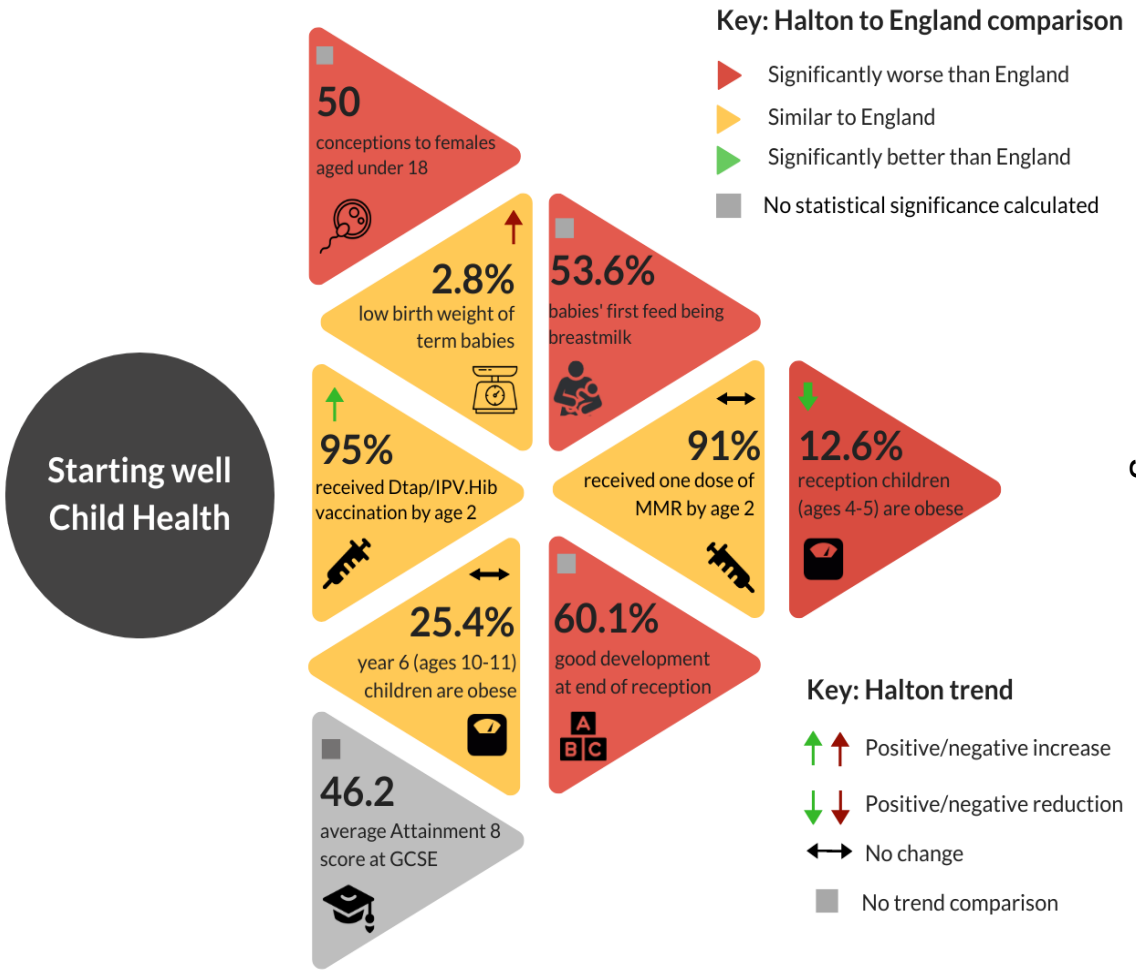
Child health

Early years experience is crucial to children's physical, cognitive and social development. During this development period it is critical that the child has the best conditions and environment in which to achieve the 'best start in life'. Improving the social context within which children live is essential to improving their development and, short and long-term life chances.

There are numerous individually and societally modifiable factors that can play a role in early childhood development, many which are linked to levels of deprivation and poverty. Breastfeeding is incredibly important in child and maternal health, and greater levels of breastfeeding initiation and prevalence of breastfeeding has been linked to reduced levels of childhood obesity and reduced levels of hospital admissions in early life.

The Healthy Child Programme aims to promote health and wellbeing from pre-birth into adulthood. This 0-5 years programme aims to help bonding between children and parents, encourage care that keeps children healthy and safe, protect children from illness and disease via immunisations, reduce childhood obesity through healthy eating and physical activity, identify potential health issues early to enable a positive response and make sure all childcare supports children so that they can be ready to learn once they move onto primary school.

For further information please see Halton's Children's JSNA Chapter
Published data is available from the PHE Fingertips Child and Maternal Health Profiles



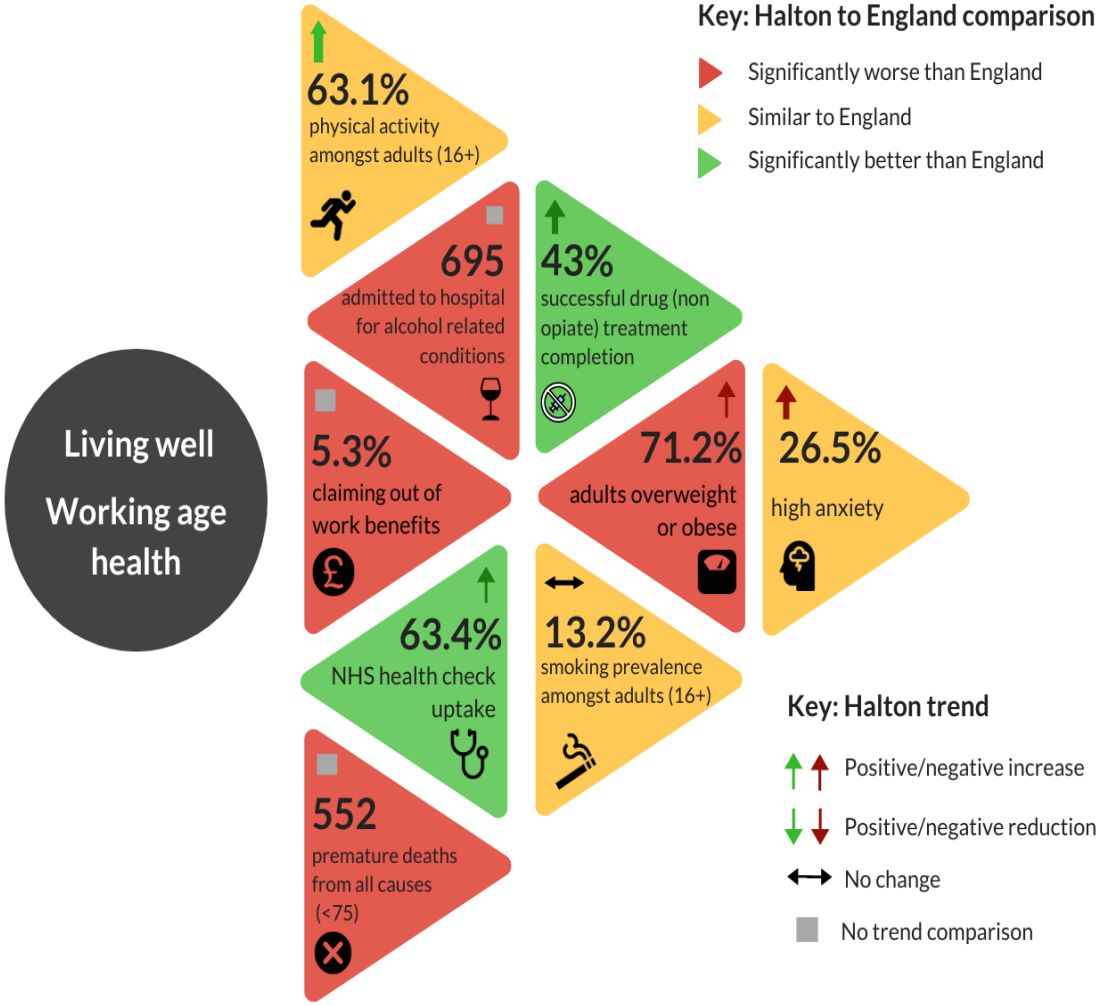
Working age people's health

In the coming decades the proportion of the population who will be of working age is projected to reduce. With more people retired and out of work, there will be a greater emphasis on social and financial support for those older people who have left employment, therefore it is incredibly important that people who *are* of working age are physically healthy and mentally well.

'Lifestyle' factors are incredibly important in helping to promote and maintain good health and curbing or increasing the prevalence of these lifestyle factors can go a long way to reducing the risk of premature mortality from all causes - and specifically from cancer, respiratory conditions, cardiovascular disease and liver disease.
Smoking, low levels of physical activity, being overweight, drinking alcohol to excess and substance misuse are all factors that can influence health, but can be altered given the correct help and support to do so.

In turn, these lifestyle factors are influenced by the environment in which we live and work, often referred to the 'wider determinants of health'. These include secure employment, having enough money to eat well, good standards of housing and education, good transport links and access to green space.

For published data on general health indicators and wider determinants of health, see the Public Health Outcomes Framework.



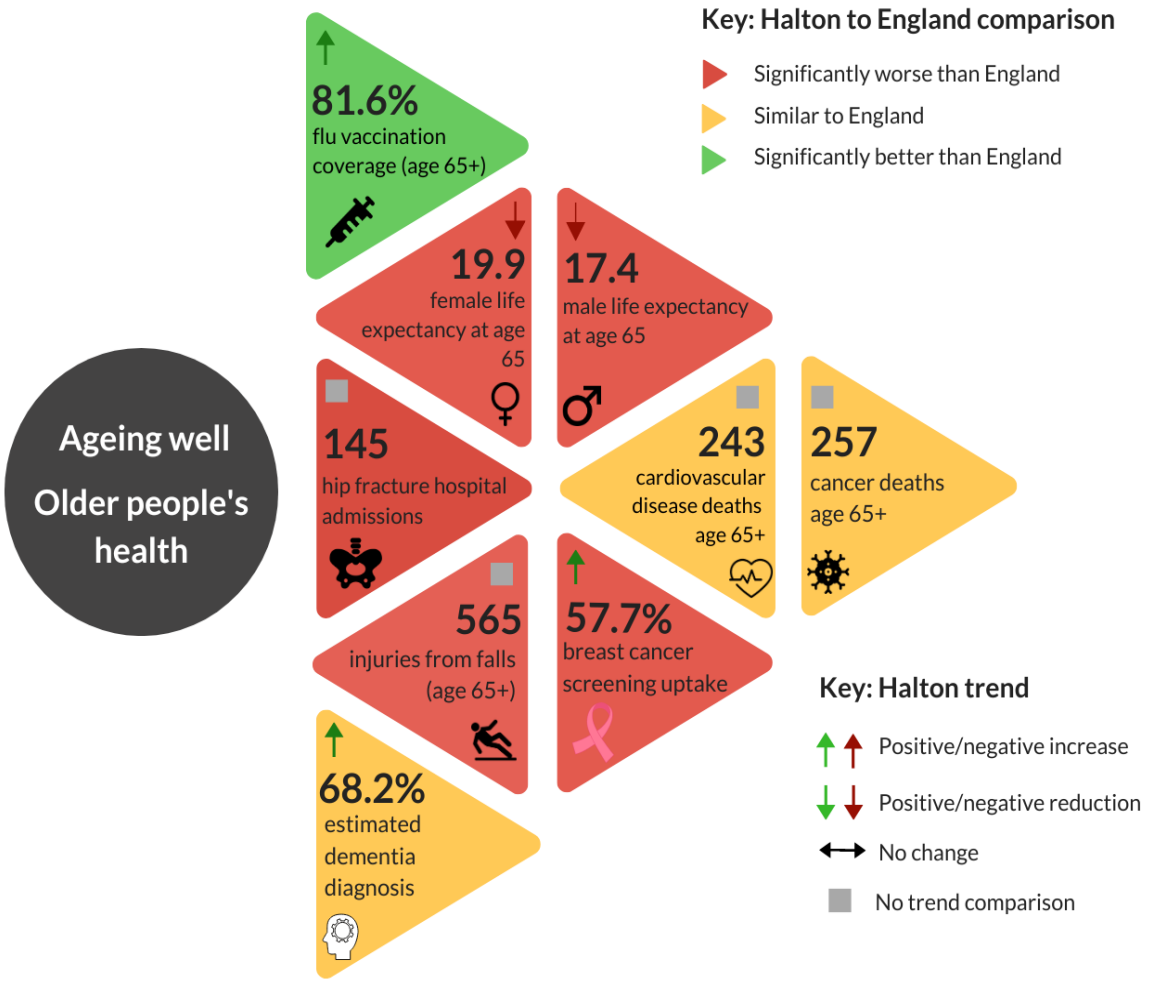
Older people's health

Life expectancy has generally increased over time, so it is important that good health is maintained for as long as possible, to ensure people enjoy a happy and fulfilling retirement. However, even though people are generally living longer, they can still live a substantial proportion of their life with a disability, or in poor health.

Life expectancy at birth in Halton remains lower than the national average, as does life expectancy at 65 years old. For the years 2018-20, it was estimated that at age 65 males could be expected to live on average a further 17.4 years and females a further 19.9 years; however less than half of this would be spent in good-health (44%) for females. For males, just over half would be spent in good-health (55%).

It is incredibly important to provide not just health and social care services, but practical local services (e.g. transport) to better allow mobility and access and to promote greater social inclusion, particularly for those who find it more difficult to make the most of the provision of such services.

For further information please see Halton's Older People's JSNA Chapter
For further data see PHE Fingertips Older People Health & Wellbeing profile



FURTHER INFORMATION

JSNA chapters and further information

There are numerous topic areas covered by previous JSNA chapters. Each chapter investigates a certain topic—looking at risk factors, health needs and service provision— both currently known (at the time of writing) and future health needs. This information supports commissioners and others to make decisions to best meet these needs. Therefore maintaining and using the most up-to-date information, data and intelligence available is crucial to delivering an effective JSNA.

Completed JSNA chapters—as well as other public health evidence and intelligence - can be found through clicking this link:
https://www4.halton.gov.uk/Pages/health/JSNA.aspx

Public Health Evidence & Intelligence Reports and data

People & Groups

Men's and Boy's Health	Children & young people	Maternity
Homeless	Older people	Women & Girls' Health
Inequalities in life expectancy		

Behaviours & Lifestyles

Alcohol	Tobacco	Gambling & fixed odds betting
Healthy weight	Sexual health	Diet & physical activity
Substance misuse		

Conditions

Cancer	Respiratory disease	Diabetes
Mental health	Long term conditions	Musculoskeletal conditions
Circulatory diseases	Excel 2016 ong term neurological	Dental

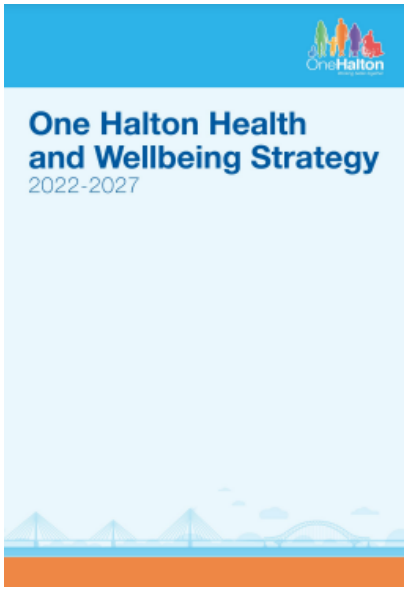
If you have any queries or require further information, please contact the Public Health team via **health.intelligence@halton.gov.uk**

One Halton Health & Wellbeing Strategy

The 2022-2027 One Halton Health and Wellbeing Strategy sets out the vision of the Halton Health and Wellbeing Board (HWBB) and states four broad lifecourse priorities for the borough for the time period the document is active.

These priorities can be life-course and condition specific:

- Tackling the wider determinants of health
- Starting Well
- Living Well
- Ageing Well



https://onehalton.uk/wp-content/uploads/2022/12/One-Halton-strategy.pdf

REPORT TO: Health & Wellbeing Board

DATE: 11 October 2023

REPORTING OFFICER: Kath Parker – Healthwatch Halton

PORTFOLIO: Health & Wellbeing

SUBJECT: Healthwatch Halton Annual Report 2022/23

WARD(S) Boroughwide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide an overview of the Halton Healthwatch annual report for 2022/23.

2.0 **RECOMMENDATION: That the report be received.**

3.0 **SUPPORTING INFORMATION**

3.1 Information included in accompanying report.

4.0 **POLICY IMPLICATIONS**

4.1 None identified.

5.0 **FINANCIAL IMPLICATIONS**

5.1 None identified.

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

6.1 None identified.

7.0 **RISK ANALYSIS**

7.1 None identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 None identified.

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

None under the meaning of the Act.

healthwatch Halton

Together

we're making health and social care better

healthwatch Halton

10 years

Annual Report 2022–23

Contents

"In the last ten years, the health and social care landscape has changed dramatically, but the dedication of local Healthwatch hasn't. Your local Healthwatch has worked tirelessly to make sure the views of local people are heard, and NHS and social care leaders use your feedback to make care better."

Louise Ansari, Healthwatch National Director

Message from our Chair

This year we celebrate 10 years of Healthwatch, and it has been yet another eventful year. As Chair I have been amazed by the amount of work that has taken place to ensure public views about Health and Care Services in our borough have been given to the right people.

This report highlights some of that work that has taken place this year.

I want to start by thanking the staff team for all their hard work in bringing the feedback you give us together, so that those responsible for developing and providing services hear it logically and clearly, so well done!

This year the team have focussed on growing our links with local groups and organisations to ensure we hear from as wide a range of people as possible.

Getting your views and experiences of services has enabled us to feed them in to Children's, Adults, Mental Health and Older Peoples service plans locally, so that changes can be made to improve those services for the very people who use them.

We delivered two reports on access to Dental Services to the Halton Health and Wellbeing Board which resulted in a focus on improving access to NHS Dentistry within the Borough. This Board reports into the newly created Integrated Care Structures so we are sure that your views are represented at that level.

We took your views and experiences directly to service providers, such as our local hospitals, through our roles on the Quality Committees of St Helens and Knowsley Teaching Hospitals NHS Trust, and Warrington and Halton Teaching Hospitals NHS FT. This direct feedback helps shape changes and improvements at the services.

On a wider footprint, the local Healthwatch teams across Cheshire & Merseyside have worked together to ensure a strong public voice is represented and heard within the new Integrated Care System.

I am stepping down from my role as Chair due to family commitments, but I will continue to support the team as a Board Member and I look forward to seeing Healthwatch Halton carry on its essential work on behalf of our population.

Finally, I'd like to thank everyone who has supported the work of Healthwatch Halton over the past 10 years.

Kath Parker
Healthwatch Halton Chair

About us

Healthwatch Halton is your local health and social care champion.

We make sure NHS leaders and decision makers hear your voice and use your feedback to improve care. We can also help you to find reliable and trustworthy information and advice.

Our vision

A world where we can all get the health and care we need.

Our mission

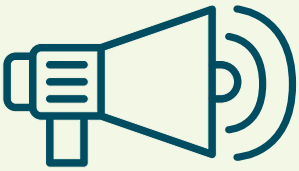
To make sure people's experiences help make health and care better.

Our values are:

- **Listening** to people and making sure their voices are heard.
- **Including** everyone in the conversation – especially those who don't always have their voice heard.
- **Analysing** different people's experiences to learn how to improve care.
- **Acting** on feedback and driving change.
- **Partnering** with care providers, Government, and the voluntary sector – serving as the public's independent advocate.

Year in review

Reaching out



1,204 people
shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care.

People engaged with our information, advice and signposting service **43,701 times** for clear information and advice, online or face to face, about topics such as access to primary care, dentistry, mental health support, and the cost of living crisis.

Making a difference to care

We published **13 reports** about the experiences of people accessing services and the improvements they would like to see to health and social care services.

Our most popular report was

Access to NHS Dentistry in Halton

which highlighted the struggles people faced trying to access NHS Dental Services in Halton.

Health and care that works for you

We're lucky to have

9

outstanding volunteers who gave up **46 days** to make care better for our community.

We're funded by our local authority. In 2022-23 we received

£123,308

We currently employ

3 staff

who help us carry out our work.

How we've made a difference this year

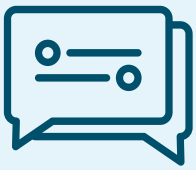
Spring

Our staff took part in Vaccine Champion Training session from the Public Health Team to help improve Covid vaccine uptake.

We joined with neighbouring Healthwatch to give views on the draft Engagement Strategy for NHS Cheshire & Merseyside Health Care Partnership.

Summer

Our volunteers took part in a review of the discharge lounge at Whiston Hospital which led to improved patient experience of hospital discharge.



We teamed up with Cancer Research UK's roadshow to raise awareness of cancer and pass on information about the signs and symptoms of the disease.

Autumn

We made sure patients had the opportunity to feedback on the quality of care at our local hospitals by carrying out 'Listening Events' at the hospitals.

Our staff and volunteers joined in on Patient Led Assessments of the Care Environment to review local NHS service settings

Winter

Our report on the SEND Local Offer has called for improvements in the waiting times for assessments, EHCP's and other support.

When a GP practice in a neighbouring area removed over 500 Halton residents from its patient list, we provided information and supported patients to register with local GP practices.

10 years of improving care

This year marks a special milestone for Healthwatch. Over the last ten years, people have shared their experiences, good and bad, to help improve health and social care. A big thank you to all our Healthwatch Heroes that have stepped up and inspired change. Here are a few of our highlights:

How have we made care better, together?

Social Inclusion

Our engagement with vulnerable adults ensured their views on a review of local Urgent Care services were listened to and acted on by the NHS

Access to GP services

We called for improved access to GP services and out of hours service and made seven recommendations for services to improve people's experiences.

Improving Hospital facilities

Our work with neighbouring Healthwatch led to improved patient and visitor facilities at local hospitals

Musculoskeletal Services

Our public engagement work on MSK services in Halton led to a redesign of the MSK pathway .

Children's Services

After we reported the concerns of families accessing services from Woodview Child Development Centre, a major improvement plan was implemented by NHS Halton CCG.

NHS dentistry

We continued to voice public concerns that improvements to NHS dentistry are too slow, leaving thousands of people in pain.

Healthwatch Hero

Remembering a hero in our local community.

Diane sadly passed away in February this year. Diane had been an active member of our Healthwatch Advisory Board for five years.

Diane believed it was vital that we worked hard to ensure we had great Health and Social care services in our borough. She told us it was essential that services listened to and learnt from the views and experiences of local residents, and that Healthwatch was so important in supporting that voice to be heard.

As well as volunteering with Healthwatch, Diane was chair of her GP Practice Participation Group (PPG) and chair of Halton PPG Plus, which is the patient group for all Halton GP practices.

Diane had a passion for making a difference in local health and care services.

She is very much missed by us all.

Listening to your experiences

Services can't make improvements without hearing your views. That's why over the last year we have made listening to feedback from all areas of the community a priority. This allows us to understand the full picture, and feed this back to services and help them improve.

Advocating for fairer NHS dentistry in Halton

NHS dentistry is in desperate need of reform and this year the Healthwatch network has successfully moved NHS dentistry up the political agenda, advocating for the systematic improvements local people have told us they need.

The dental crisis continues to adversely affect Halton residents. With dentists not taking on new patients NHS patients, there is an increasing inequality of access between those who can afford to pay for private dental care and those who have to struggle on without care. The dental crisis needs action both locally and nationally..

Locally, we found that most practices were not taking on new NHS patients, and that some had more than 500 people on waiting lists, which could take up to five years to clear.

What we did:

- Following on from our 'Big Dental Check-up' report, published in March 2022, we continued to hear from people struggling to access local NHS dental care.
- We produced a follow-up report, 'Access to NHS Dental Services' report published , based on the experiences on 197 people , in December 2022.
- We shared our findings with the Health & Wellbeing board, calling on it to focus on Oral Health as a priority issue.
- Together with Healthwatch England and the rest of the Healthwatch network, we made renewed calls on NHS England and the Department of Health and Social Care to put a reformed dental contract in place.

The responsibility for dental commissioning moves to Integrated Care Systems (ICS) from July 2023, and in advance of this we shared the experiences of local people to ensure the new commissioners are planning ahead. This included highlighting that Halton was one of the areas most severely affected by the dental crisis, with the lowest proportion of children having been able to access dental care. (only 42.2% of children in Halton saw an NHS dentists in the period June 2021 to June 2022).

The Integrated Care Board (ICB) has committed to agreeing and implementing a Dental Recovery Plan. We will continue to share patient experience on this subject until the crisis is resolved.

> "It's ridiculous - the last time I needed treatment I had to travel to West Kirby for help as that was where my old dentist was based. A 60 mile round trip!!"
>
> **Jane, Halton resident**

SEND - Local Offer review

It has been over eight years since the Children and Families Act 2014 introduced significant changes to the delivery of education, health and social care services to children and young people (aged 0-25) with special educational needs and disabilities (SEND).

During this time, the feedback we were getting, from parents, carers, and children and young people, demonstrated however that there was still need for further development.

Working with the support of local partners, including the Halton SEND Parent Carer Forum, we gathered the views and experiences of 227 people, via focus groups and a public survey at the end of 2022, on the SEND Local Offer, and the referral and assessment process.

What we found:

Assessments: For some, assessments, or additional support, could take weeks, months or up to one year or more to take place once the referral had been made.

Lack of joined up services: There was a general agreement that patient information, case histories and care plans were not communicated well between services of different disciplines, and that often parents or carers had to tell their story repeatedly to different professionals.

Local Offer website: Feedback on the website was largely negative, and users found it to be too difficult to navigate, not relevant or up to date, confusing, and not easy to read and understand.

Involvement: While some already felt involved in the Local Offer there was a strong indication that more people would like to get involved in the Local Offer but don't know how to. This shows that the opportunities for involvement in the Local Offer are there, but there is a lack of information on how to access it.

Our report made eight recommendations to the Halton SEND Partnership Board, which is currently in the process of reviewing the recommendations. We will follow up on progress made on this late this year.

> "While we are already in the process of addressing many of the challenges, the Halton SEND Partnership Board is committed to reviewing all the Healthwatch Halton recommendations and working with partners across Halton to address them appropriately."
>
> **Denise Roberts**
> Associate Director of Quality and Safety Improvement for Halton Place NHS Cheshire and Merseyside and Halton SEND Partnership Board Chair

Three ways we have made a difference for the community

Throughout our work we gather information about health inequalities by speaking to people whose experiences aren't often heard.

Creating empathy by bringing experiences to life

It's important for services to see the bigger picture. Hearing personal experiences and the impact on people's lives provides them with a better understanding of the problems.

We shared with our local hospitals the difficulties faced by some women when trying to register with a midwife or access antenatal appointments.

This led to the hospitals reviewing and updating their processes and providing clearer information on their websites.

Getting services to involve the public

Services need to understand the benefits of involving local people to help improve care for everyone.

We worked with local hospital Trusts to set up a series of Healthwatch 'Listening Events' within the hospitals.

Feedback collected at these events gave important insight into the views and experiences of patients and visitors. Following a comment from a patient with Autism, the hospital confirmed that learning disability and autism training is now compulsory for all staff and has been added to everyone's mandatory training

Improving care over time

Change takes time. We often work behind the scenes with services to consistently raise issues and bring about change.

Over the past few years, Healthwatch Halton have been raising the issue of care home residents being discharged back to care homes, with property and paperwork missing from the patients 'Red Bag', with our two local Hospital Trusts. In response to our latest concerns, both Trusts have highlighted the need to ensure a robust discharge process and the correct use of the Red Bag scheme with Matrons / Lead Nurses in the hospitals.

Hearing from all communities

Over the past year we have worked hard to make sure we hear from everyone within our local area. We consider it important to reach out to the communities we hear from less frequently, to gather their feedback and make sure their voice is heard and services meet their needs.

This year we have reached different communities by:

- Holding regular outreach sessions at community centres across the borough
- Holding drop-in sessions with the Traveller Community.
- Meeting with Veterans to hear their experiences of local services
- Engaging with migrants and asylum seekers in Halton
- Supporting the Mental Health Hub sessions

Making reasonable adjustments for medication needs

Many frail and elderly people who have practical problems in managing their medicines rely on receiving their medicines in Multi-compartment Compliance Aids, or as most people know them, blister packs.

We were contacted by the Warden at a local Traveller site on behalf of an elderly resident who had been told he could not receive his prescription medication in blister packs, as his pharmacy was no longer able to provide it. The resident couldn't manage his own medication as he did not read or write. He depended on the blister pack medication to help maintain his independence.

We contacted all Widnes pharmacies on his behalf and were able to find one pharmacy that was still willing to provide medication in blister pack format for the gentleman.

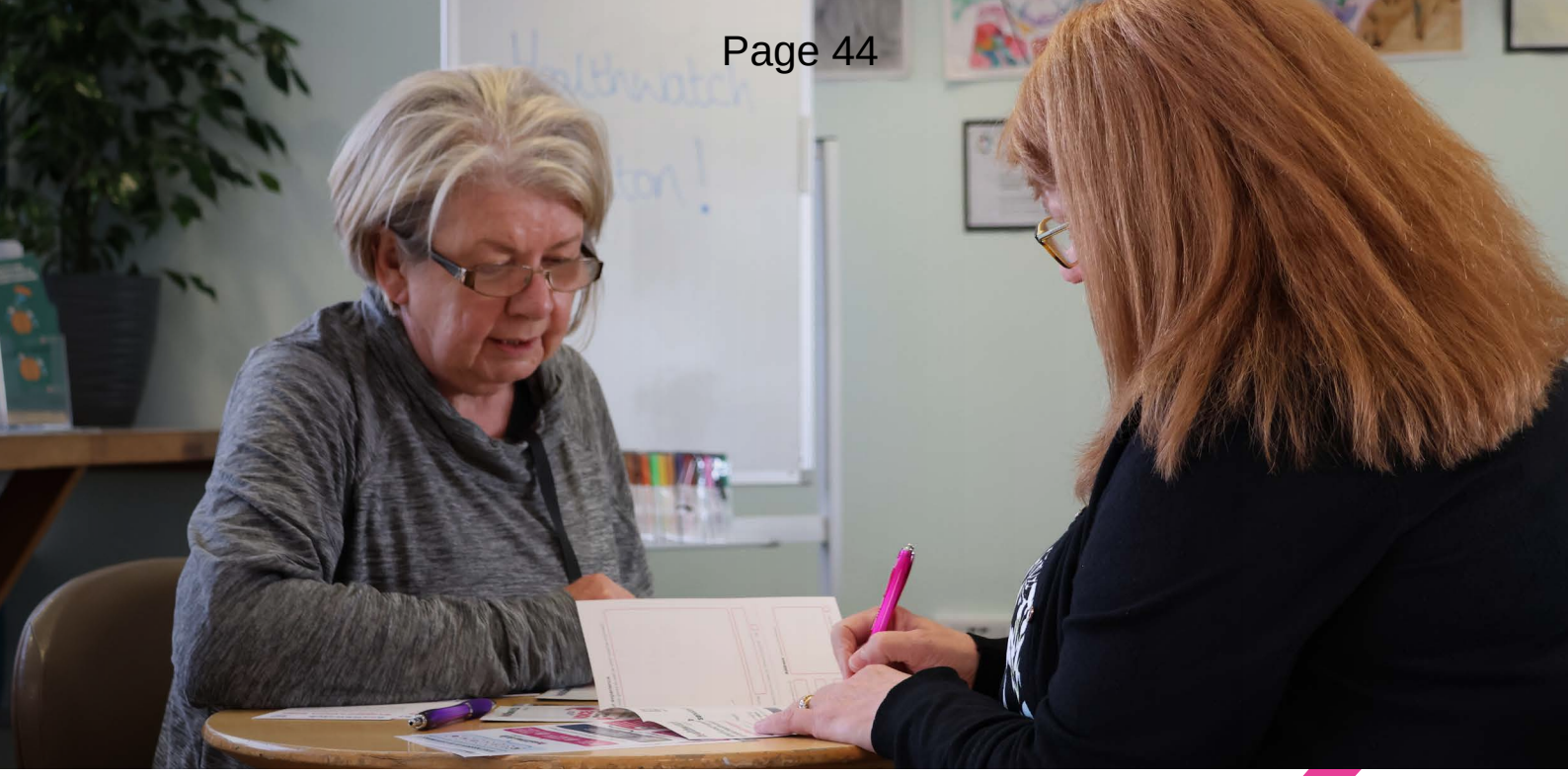
We raised our concerns with NHS Halton and were informed that guidance from NICE and Royal Pharmaceutical Society stated that blister packs should only be used when a specific need has been identified by a health professional. NHS Halton has agreed to look at ways to ensure that patients with specific needs can still receive medication this way.

GP access for asylum seekers

A charity supporting asylum seekers in Halton got in touch with us for information on patients registering with a GP Practice. They explained that a local GP practice was refusing to register patients if they didn't have ID and a permanent address and had turned away some of it

We provided the charity with leaflets and GP Access cards which outline that everyone in England is entitled to register and receive treatment from a GP practice, without providing proof of address or ID.

We also contacted the GP Practice's head office and explained the situation. The area manager agreed that the practice should register the new patients and that additional staff training would be arranged to ensure it wouldn't happen again.



Information and Signposting

If you feel lost and don't know where to turn, Healthwatch is here for you. In times of worry or stress, we can provide confidential support and free information to help you understand your options and get the help you need. Whether it's finding an NHS dentist, how to make a complaint or choosing a good care home for a loved one – you can count on us.

This year we've helped people in a range of ways including:

- Providing up to date information people can trust
- Helping people access the services they need, including emergency dental treatment
- Listening to people's concerns about health and social care services and sharing these with those who have the power to make changes.
- Helping refugees and people seeking asylum understand our local health system and register for a GP.

Help to find dental care in Halton

We have had over 120 people contact us for advice and information on NHS dental services in Halton during the past year. People told us their experiences of trying to access treatment, with many having gone more than three years without a check due to the shortage of dental practices taking on new NHS patients.

The impact of this delayed treatment has resulted in people living with considerable pain, developing medical resistance and dental conditions worsening.

> "I resorted to pulling my own wisdom tooth out, it broke off and now causes pain up the side of my face every day."
>
> **Paul, Halton resident**

Our information and support has meant people who need treatment know their options and have clear information. Working closely with NHS England's Dental Team we were able to support more than 20 people who were in severe pain to access and urgent dental treatment.

> "Thank you for the help and information you've given me to help me decide about my dental treatment."
>
> **Sue, Halton resident**

Healthwatch Halton have met and shared information with the Cheshire & Merseyside NHS England dental commissioning team. We have also presented findings to the Halton Health and Wellbeing board.

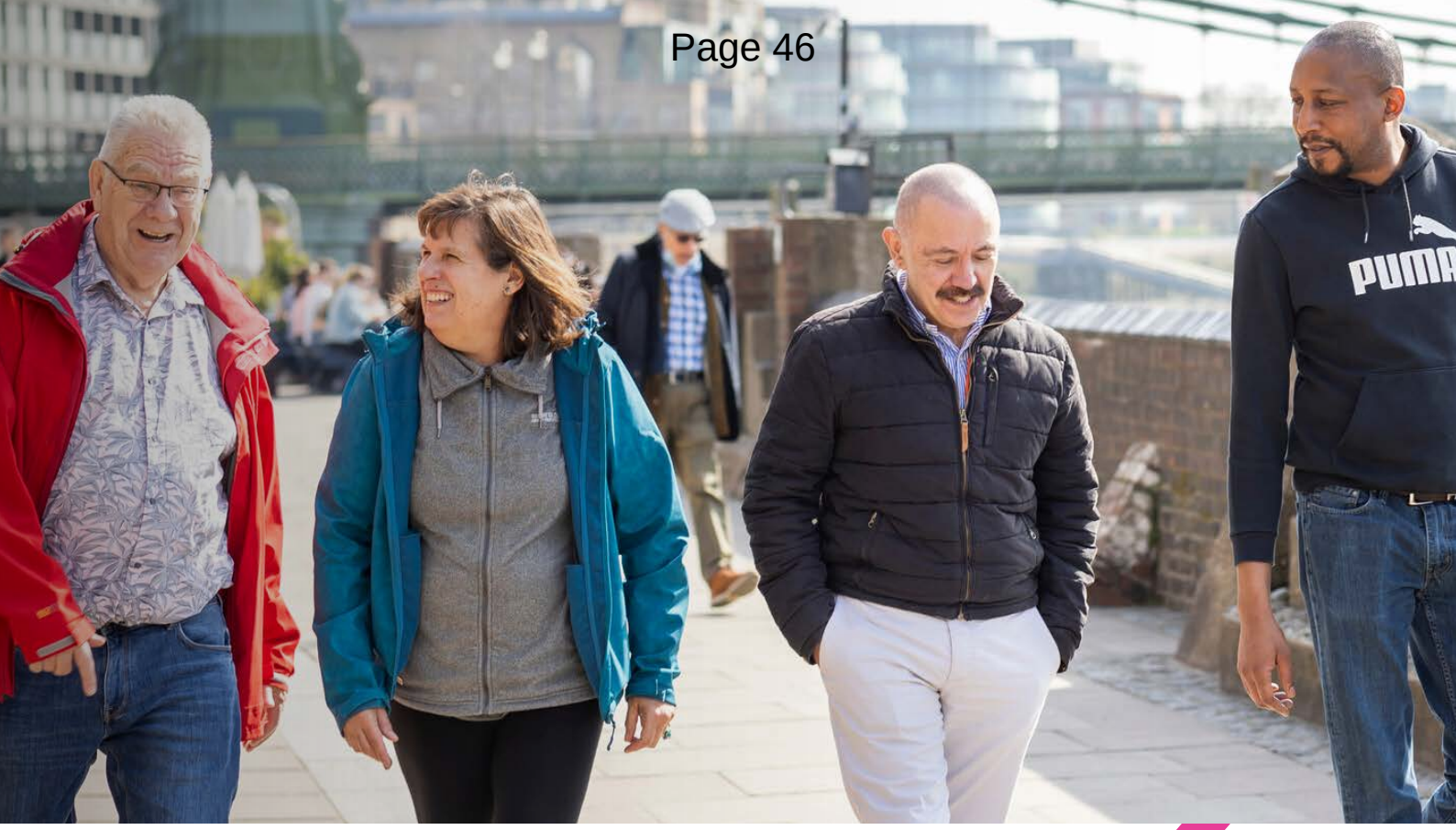
Helping in time of need

In April 2022, we were contacted by a gentleman, in distress, as his wife, aged 79, had been rushed by ambulance to hospital the previous day. It took two hours to stabilise her at home before the ambulance could safely transport her to hospital. Due to Covid restrictions her husband wasn't allowed to go with her.

He tried contacting his wife during the day but received no answer on her mobile phone. He contacted the hospital but they could find no information about his wife. He told us he spent the night alone at home worrying about his wife's condition. In the morning, he tried the hospital PALS team number, but got no answer. He rang the main switchboard, but they couldn't find any trace of his wife in the hospital. By this time he was getting quite distressed. He found our details online and decided to give us a call for help.

We were able to contact the Patient Experience team at the hospital on his behalf. We found there had been confusion with the patient's details, as his wife had recently been discharged from an intermediate care centre and her address details hadn't yet been updated. We let the caller know that his wife had been found, and was in fact still in A&E, over 18 hours after arrival in hospital. We were also able to let him know the good news that he would be allowed to go and visit her straight away in A&E.

He contacted us later in the day to say, *"Many, many thanks for your help... As they took her in yesterday at 4pm very poorly and I'd heard nothing since, plus no-one could tell me where she was, I became frantic, I had visions of finding her in the hospital morgue. Your work is invaluable, so please keep it up and thank you again."*



Volunteering

We're supported by a team of amazing volunteers who are at the heart of what we do. Thanks to their efforts in the community, we're able to understand what is working and what needs improving.

This year our volunteers:

- Visited communities to promote Healthwatch Halton and what we have to offer
- Collected experiences and supported their communities to share their views
- Carried out enter and view visits to local services to help them improve
- Collected the most up-to-date information on changes to services, such as whether NHS dental appointments were available at a practice

Smita

"I joined the Healthwatch Advisory Board at the start of this year and I've enjoyed finding out about more about the work Healthwatch Halton carries out. I also represent Healthwatch on a hospital Patient Experience Committee and have seen first-hand how the patient experiences Healthwatch collects are invaluable in bringing about changes to services."

Julie

"Helping other people to share their experiences with Healthwatch is so important to me. I've taken part in Enter & View visits to local care homes and also helped collect people's experiences of local services.

People are often surprised when I explain to them that sharing their feedback really does lead to change. I enjoy doing my bit to make sure local services are the best they can be."

Barbara

"I have always been interested in health issues and I enjoy engaging with people and listening to their views, either good or bad.

Being part of Healthwatch Halton is gratifying and I also enjoy the involvement and friendship".

Do you feel inspired?

We are always on the lookout for new volunteers, so please get in touch today.

www.healthwatchhalton.co.uk
0300 777 6543
volunteer@healthwatchhalton.co.uk

Finance and future priorities

To help us carry out our work we receive funding from our local authority under the Health and Social Care Act 2012.

Our income and expenditure

Income		Expenditure	
Annual grant from Government	£123,308	Expenditure on pay	£85,589
Additional income	£1,833	Management Fee	£12,378
		Office and operating costs	£22,015
Total income	**£125,141**	**Total expenditure**	**£119,982**

Additional funding is broken down by:

- **£1,000 funding** received from Healthwatch England for training in Board Development
- **£833 funding** received from the Cheshire & Merseyside ICB for engagement work on its draft Cheshire & Merseyside Engagement Strategy

Next steps

In the ten years since Healthwatch was launched, we've demonstrated the power of public feedback in helping the health and care system understand what is working, spot issues and think about how things can be better in the future.

Services are currently facing unprecedented challenges and tackling the backlog needs to be a key priority for the NHS to ensure everyone gets the care they need. Over the next year we will continue our role in collecting feedback from everyone in our local community and giving them a voice to help shape improvements to services.

We will also continue our work to tackle inequalities that exist and work to reduce the barriers you face when accessing care, regardless whether that is because of where you live, income or race.

Top priorities for 2023-24

1. Hospital Discharge - Reviewing the discharge process and collecting the experiences of patients and their families/carers.
2. 14+ LD Health Checks -To review the criteria for Health Checks and help bring about improved access and uptake of the checks.
3. Primary care engagement - Gathering the experiences of people using Primary Care Services in Halton.

Advocacy Hub support

The Advocacy Hub service sits alongside Healthwatch Halton and referrals to it are often received via Healthwatch Halton, and similarly, information and signposting advice is given to advocacy clients through Healthwatch Halton, providing a holistic service to every person who contacts the service.

Healthwatch Halton provides the NHS Independent Complaints Advocacy Service (ICAS) for Halton. The advocacy service helps people to understand how the NHS complaints process works, and supports them where needed.

NHS Independent Complaints Advisory Service (ICAS)

ICAS offers telephone, online, and face-to-face support to help the people of Halton to progress complaints in relation to any NHS service provision provided at hospitals, GP Practices, dentists, pharmacies, opticians, and nursing homes.

During the past year:

1400 people accessed information about the Healthwatch Halton Advocacy Hub on our website, with 297 accessing information on ICAS. The Advocacy Self Help Information Pack was downloaded 117 times.

90 people contacted Healthwatch for information on raising a concern or making a formal complaint about their treatment or care. These were provided with information to progress their complaint themselves, or signposted for further support.

30 people required practical support from our ICAS Advocate to help them through the NHS complaints process, an increase of 25% on the previous year.

> "The whole process is difficult but I was helped greatly by my advocate who was extremely professional, informative and supportive"
>
> **Healthwatch Advocacy Hub Client**

Statutory Advocacy Services

The Advocacy Hub provides statutory advocacy services for NHS Complaints advocacy (ICAS), Independent Mental Capacity Advocacy (IMCA), RPR/ DoLs Statutory Advocacy, Independent Mental Health Advocacy (IMHA) and Care Act Advocacy. The advocacy service supports clients with Acquired Brain Injury, Mental Health Conditions, Autistic Spectrum Disorder, Dementia, Learning Disability or having substantial difficulty and deemed to have no one appropriate or un-befriended. Where non-statutory advocacy referrals are received the advocacy service will provide information and signposting to other sources of support for individuals where relevant and appropriate, encouraging service users to self-advocate wherever possible. Over the past year, the service has continued to see a year-on-year increase in referral numbers. The level of complex cases also remains high, so the team have had another very busy year providing quality advocacy support throughout the borough.

Case numbers for 2022/2023

- 95 RPR cases (a 27% increase)
- 31 DoLs referrals (a 40% increase)
- 80 Care Act referrals (a 36% increase)
- 86 IMCA referrals (a 37% increase)
- 259 IMHA referrals (a 69 % increase)

Statutory statements

Healthwatch Halton, Suite 5 Foundry House, Widnes Business Park, Waterside Lane, Widnes WA8 8GT

Engaging Community Solutions CIC (ECS), Blakenall Village Centre, 79 Thames Rd, Walsall WS3 1LZ

Healthwatch Halton uses the Healthwatch Trademark when undertaking our statutory activities as covered by the licence agreement.

The way we work

Involvement of volunteers and lay people in our governance and decision-making

Our Healthwatch Board consists of five members who work on a voluntary basis to provide direction, oversight and scrutiny to our activities. Insight gathered through signposting and information enquiries, outreach sessions and listening events, helps to shape our priorities and work plans. Our Board ensures that decisions about priority areas of work reflect the concerns and interests of our local community.

Throughout 2022/23 the Board met five times and made decisions on matters such as reviewing and approving our priorities and work plan for the coming year and agreeing to raise the issues highlighted in our report on access to NHS dental care with the Health & Wellbeing Board.

Methods and systems used across the year to obtain peoples experiences

We use a wide range of approaches to ensure that as many people as possible have the opportunity to provide us with insight about their experience of using services. During 2022/23 we have been available by phone, email, social media, and provided a contact webform on our website as well as attending virtual and face to face meetings of community groups and forums.

We ensure that this annual report is made available to as many members of the public and partner organisations as possible. We will publish it on our website and hard copies are made available.

Responses to recommendations

We had one provider who did not respond to requests for information or recommendations.

There were no issues or recommendations escalated by us to Healthwatch England Committee, so no resulting reviews or investigations.

Taking people's experiences to decision makers

We ensure that people who can make decisions about services hear about the insight and experiences that have been shared with us. In our local authority area for example, we share information with service providers and commissioners of service and take information to decision makers for example presenting on the dental crisis to the Halton Health and Wellbeing Board.

We also take insight and experiences to decision makers in Cheshire and Mersey Integrated Care System. The nine Cheshire & Merseyside local Healthwatch are represented on the Integrated Care Board, the Primary Care Commissioning Committee, the Quality and Performance Committee, the Transformation Committee, the Women's Services Committee, subcommittees and Task and Finish groups and the Health Care Partnership to ensure public voice is represented and heard. Individually we are each active partners of ICB groups at our own 'Place' level.

The nine Healthwatch have developed a trusted and effective relationship built up over ten years. Our processes for joint work, designed to fit local needs, allow us to work pro-actively and responsively to ensure local people's lived experience influences decision making.

We are perfectly placed, and coordinated, to respond where there are health and care service issues that relate to a provider who may cover Cheshire & Merseyside area.

A Memorandum of Understanding (MoU) has been written, and endorsed, by all nine Healthwatch Organisations and it promotes openness, honesty and flexibility to allow the gathering and sharing of information between the public and the decision makers to ensure services are provided right time, right place.

"During the first year of NHS Cheshire & Merseyside, our Healthwatch partners have engaged and supported the work of the ICS. They have worked with us and provided the right level of scrutiny and challenge on behalf of the population of Cheshire & Merseyside, asking probing questions and seeking assurance to ensure that Cheshire & Merseyside ICB and wider system partners always put the resident at the centre of our strategic and operational priorities. The nine local Healthwatch are active at a Cheshire & Merseyside wide level, and particularly working within our nine Places, which means they are able to ensure the voice of the public is heard at all levels of the ICS. I'm very grateful for their contribution and advice and look forward to continuing our close working in the future."

Clare Watson, Assistant Chief Executive
NHS Cheshire & Merseyside

Enter and View

This year, we made four Enter and View visits. We made 30 recommendations or actions as a result of this activity.

Location	Reason for visit	What you did as a result
St Patrick's Care Home	Carried out as part of our Enter & View project for the year.	Produced a report with recommendations – the service responded to all recommendations
Croftwood Care Home	Carried out as part of our Enter & View project for the year	Produced a report with recommendations – the service responded to all recommendations
Simonsfield Care Home	Carried out as part of our Enter & View project for the year	Produced a report with recommendations – the service responded to all recommendations
Widnes Hall Care Home	Carried out as part of our Enter & View project for the year	Produced a report with recommendations and provided it to the service provider.

Health and Wellbeing Board

Healthwatch Halton is represented on the Halton Health and Wellbeing Board by our Advisory Board Chair, Kath Parker. During 2022/23 our representative has effectively carried out this role by sharing public feedback with the board, and presenting the findings from our reports, and including our update report about access to NHS dentistry.

healthwatch Halton

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HWHalton

REPORT TO: Health & Wellbeing Board

DATE: 11 October 2023

REPORTING OFFICER: Executive Director - Adult Services

PORTFOLIO: Adult Social Care

SUBJECT: Better Care Fund (BCF) 2023-25 Plan

WARD(S): Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 To update the Health and Wellbeing Board on the Better Care Fund Plan 2023/25, for information, following its submission on 28th June 2023.

2.0 **RECOMMENDATION**

RECOMMENDED: That the BCF Plan 2023/25 is noted for information.

3.0 **SUPPORTING INFORMATION**

3.1 The BCF Planning guidance for 2023/25 was published on 4th April 2023, with a submission date of 28th June 2023.

The vision for the 2 year BCF Plans is that they are intended to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person.

This vision is underpinned by the two core BCF objectives:

- Enable people to stay well, safe and independent at home for longer; and
- Provide the right care in the right place at the right time

3.2 There are two related documents attached to this report:-

- BCF Plan 2023/25 – Narrative ***(Appendix 1);*** and
- BCF Planning Template (Excel Spreadsheet) ***(Appendix 2)***

3.3 In terms of the planning template and the BCF schemes, much of the 2023/25 submission remains a continuation of the successful approach in 2022/23, and as such has been rolled forward from that BCF Plan.

3.4 Following submission on 28th June, all BCF Plans are scrutinised by

regional assurers.

At the time of writing this report, Halton's plan has been recommended for approval by the NHSE Regional Lead. Once we receive formal approval, this will then allow for the release of the NHS minimum contribution amount, as per our plan.

3.5 In line with the governance arrangments outlined in the Joint Working Agreement between Halton Borough Council and NHS Cheshire & Merseyside (Halton Place), prior to its submission, the BCF Plan, including the expenditure plan, was presented and discussed at both the Better Care Commissioning Advisory Group and the Joint Senior Leadership Group.

4.0 POLICY IMPLICATIONS

4.1 None identified.

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

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

6.3 **A Healthy Halton**
Developing integration further between Halton Borough Council and the NHS Cheshire and Merseyside (Halton Place) 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.

6.4 **A Safer Halton**
None identified.

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

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 associated with this report.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 There are no environmental or climate implications as a direct result of this report.

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

10.1 None under the meaning of the Act.

Halton Better Care Fund Plan 2023 - 2025

Halton Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

With being a year of transition for the NHS, the involvement of stakeholders is particularly paramount, in ensuring a system-wide plan. Some plans are still under development following the establishment of the NHS Cheshire and Merseyside Integrated Care Board (ICB) including the overarching NHS Cheshire and Merseyside Integrated Care Partnership (ICP) and the Integrated Care Strategy (in line with the Health and Care Act 2022 amending the Local Government and Public Involvement in Health Act 2007), which will be evidence-based and focussed on system-wide priorities and will be an over-arching document which will feed in to all other plans.

A new One Halton Health and Wellbeing Strategy from autumn 2022 – 2027 has been developed and approved for improving health and reducing health inequalities.

A number of stages to the development of the Strategy have taken place, involving various stakeholders, based around a shared ambition to:

"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 and ensuring high quality services for those who need them".

With partners being fully involved with the development of the Health and Wellbeing Strategy, as described in our previous plan, the BCF plan for 2023 - 25 runs parallel to this and all members of the Health and Wellbeing Board (HWBB) will approve the plan and the ambitions for the metrics, which for this current year, the targets are aligned to the NHS Cheshire and Merseyside: Halton ICB 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 Teaching Hospitals NHS Foundation Trust

In addition to the above Trusts, Halton Borough Council and NHS Cheshire and Merseyside ICB – Halton place also involves the following organisations within Halton:

- Cheshire Constabulary
- Cheshire Fire and Rescue Service
- Runcorn and Widnes Primary Care Network
- Halton Children's Trust
- Halton Housing Trust
- Halton and St Helens Voluntary and Community Action
- Healthwatch Halton

How have you gone about involving these stakeholders?

A series of workshops have taken place to identify key areas of need from data, intelligence and local knowledge, and identified a set of potential interventions. Along with engagement with frontline staff, operational and strategic leads to support the key elements requiring transformational change and development to inform the development of the One Halton Strategy. Development of an engagement plan for public/patient groups aligned with Digital strategy. Consultation completed with small numbers responding.

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.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

New internal governance arrangements have been implemented with effect from 1st April 2023 in respect to the development and monitoring of the BCF Plan, associated Pooled budget and joint working arrangements, as detailed below:-

Joint Senior Leadership Team (JSLT)

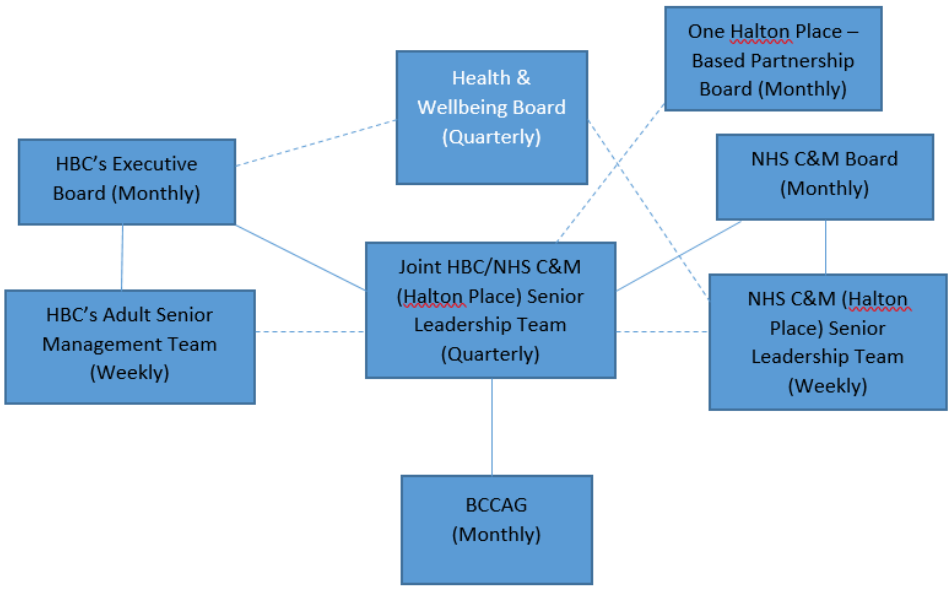
The JSLT is responsible for the direction, oversight, monitoring of the BCF Plan and associated Pooled Budget. The JSLT is supported in this duty via the Better Care Commissioning Advisory Group (BCCAG). The BCCAG reviews in detail information pertaining to BCF Plan, impact of the Pool Budget, quality, performance, activity and finances, and make recommendations to the JSLT on remedial action plans or future use of the Pool as appropriate.

Better Care Commissioning Advisory Group (BCCAG)

Key responsibilities of the BCCAG include (list not exhaustive):-

- To monitor performance of the Better Care Fund plan, including achievement of the Plan's aims and ambitions, and overall plan and service performance, quality, activity and finance measures.
- To develop and prepare the performance management framework, incorporating, BCF mandated measures alongside Place-specific outcome, performance quality, activity and financial measures, identifying and recommending remedial actions to address under performance.
- To identify, develop and make recommendations to the JSLT on the alignment of budgets, focusing on the overall aim of improving the local health and care system to deliver better outcomes for Adults in Halton.
- Based on financial and performance information available, develop and make recommendations to the JSLT, impacting on the strategic, commissioning and operational direction of Adult Services in Halton.

See governance diagram below:-



The BCF Plan is signed off by the HWBB and regular update reports are provided to the Board on progress of the BCF Plan priorities and associated schemes.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

During 2022/23, with the establishment of Place Based Systems and Boards across the country, 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 continue to work 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 and their families and carers. This includes joint accountability and decision-making, improved commissioning and a move to integrated service delivery.

The BCF aligns to the wider integration landscape including One Halton which is a local system partnership whereby 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".

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 NHS Cheshire and Merseyside ICB - Halton place supports the place and programme developments and creates an opportunity to work on tactical, operational and strategic approaches.

A Section 75 Joint Working Agreement (JWA)[i] has been in place between HBC for a number of years (now formerly with the NHS Cheshire and Merseyside ICB and previously NHS Halton CCG). The current JWA sets out our Partnership Flexibilities in respect of Integrated, Joint and Lead Commissioning with principles that underpin this.

The Health and Wellbeing Strategy 2022 – 2027 encompasses four main themes of:

- Tackling the wider determinants of health;
- Support our community in Starting Well;
- Support our community in Living Well; and
- Support our community in Ageing Well.

During the pandemic we were able to focus resources and services to support people to remain at home and return home from hospital (Home First). The BCF has been aligned to this and services have been reconfigured to reflect this approach.

Priorities for the BCF in 23-25 are in line with those for 22/23. These are:

- Support Local Authorities duties within the Care Act – namely resources to support care homes and domiciliary care provision
- Maintain and expand the home first / D2A approach with additional resource to support hospital discharge and trusted assessment
- Support community health and social care community, intermediate care and equipment services
- Maintain and improve support for carers through investment.

National Condition 1: Overall BCG plan and approach to integration.

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integrated of health and social care. Briefly describe any changed to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Through the One Halton Board and the key sub groups executive lead officers and key officers across the place drive our approach to embedding integrated and person-centred health, social care and housing continues to improve. The shift towards strategic commissioning and a more collaborative approach to planning and improving services continues in 2023-25. This means that, instead of focusing on procurement and contract management, the role of commissioners is to work closely with key partners across the system (including with providers) to understand population needs, determine key priorities and design, plan and resource services to meet those needs, so the structures being introduced in respect to One Halton and the provider collaborative will support and enhance this way of working.

During the pandemic we were able to focus resources and services to support people to remain at home and return home from hospital (Home First). The BCF has been aligned to this and services have been reconfigured to reflect this approach.

The 2023-25 Delivery Plan sets out the key areas of opportunity for the JSLT and BCCAG to move forward with an integrated pathway approach. The areas identified are those in a shared space across health and social care, with a clear interface between health and social care.

There are two priority aims from 2022/23 which will help inform the work of the BCCAG and JSLT these aim are to support people to:-

- live an independent life; and
- regain independence following a change in circumstances.

Performance frameworks and monitoring of the BCF plan continue to be developed

National Condition 2: Enabling people to stay well, safe and independent at home for longer.

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- Steps to personalise care and deliver asses-based approaches

- Implementing joined-up approached to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- Multidisciplinary teams at place or neighbourhood level, taking into account the visit set out in the Fuller Stocktake
- How work to support unpaid carers and deliver housing adaptations will support this objective.

Locally in Halton, the Intermediate Care review implementation has progressed, incorporating the work and learning from the pandemic and work undertaken from the frailty service. Detailed planning work has focused on both the available evidence of utilisation, incorporating current and future requirements of community services and staffing capacity and skill mix. Several departments within Bridgewater Community NHS Foundation Trust, Halton Borough Council, NHS Cheshire and Merseyside ICB – Halton place (previously NHS Halton CCG) and Warrington and Halton Teaching Hospitals NHS Foundation Trust and St Helens and Knowsley Teaching Hospitals NHS Trust have undertaken this work. Work across Cheshire and Mersey ICB on intermediate care, led through the provider collaborative, will support this work

In 2022/23 Halton maintained the level of people receiving, interventions in their own homes. This has continued to be achieved through the focused work of all staff, and maintaining capacity in long term services (notably the domiciliary care), simplified processes for hospital discharge, and focused multi-disciplinary / multi-agency work to improve pathways through short term services utilising nationally endorsed models (ECIST et al) concentrated on day-to-day caseload management. Both acute trust footprints plan to undertake further analytical work to improve hospital discharge and D2A processes in 2023/24.

This demonstrates that investment in the right community resources can improve outcomes for individuals, reduce reliance on short-term community bed-based services (and therefore reduce the number required), reduce the utilisation of acute hospitals (with potential to reduce admissions, readmissions and length of stay) and enable further investment in the community infrastructure. The capacity and flexibility to meet demand across services supported by the BCF and discharge funds in 2022/23 will be increased in 2023-25 particularly in relation to hospital discharge processes where the need for additional staff in the discharge process has been identified.

Another key collaboration that contributes steps to personalise care and deliver asset-based approaches and multi-disciplinary teams at place level is the Neighbourhood Teams project with the aim of defining and developing the culture, systems and pathways in which Community Multi-disciplinary teams in Halton will work and communicate in a continuous and integrated way. The main scope of the project includes a needs-based approach encompassing the whole population (adults, children, families, care homes). A strengths and asset-based approach will be adopted throughout all partner organisations operating in Halton, and we will define what place means at delivery level (i.e. different levels of place e.g. Borough, Town, neighbourhood levels).

The ICB is developing and rolling out the national virtual ward programme, with ARI virtual ward already receiving early supportive discharges on to remote monitoring and now progressing for step up access from primary care and community teams. The frailty virtual ward are due to start to test their process and open beds in July 2023 with both step down, prior to admission to an acute ward and step up pathways from the community. Learning for the level of remote monitoring that can be utilised is still being gathered from across the country.

Primary Care in Halton is now seeing more patients both face to face and with virtual appointments than pre-pandemic, and the system is looking to transform the way same day primary care is offered, in collaboration with the Urgent Treatment Centres and community teams.

Public Health is leading targeted work to tackle fuel poverty through their winter warmth and cost of living programmes as well as continuing to offer their sure start to later life services to reduce deterioration and ill health, and provide training to care homes and community teams in keeping residents active and managing falls.

National Condition 2 (cont) – rationale for estimates of demand and capacity for intermediate care to support in the community. This should include:

- Learning from 2022-23 such as
    - Where number of referrals did and did not meet expectations
    - Unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - Patterns of referrals and impact of work to reduced demand of bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services;
- Approach to estimating demand, assumptions made and gaps in provision identified
    - Where, if anywhere, have you estimated there will be gaps between the capacity and the expected demands?
    - How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in the wider BCF plans.

The service capacity delivered in 2022/23 mostly met demand in terms of bed and community support services. Use of transitional care bed capacity was low and focused mainly on people with care and support needs where housing issues prevented a return home directly from hospital. Processes through hospital and to discharge have been identified as a key area to work on and will be the subject of further detailed work with external support in 2023/24. Additional resource has been allocated to support discharge planning in 2023-25.

The 2023-25 demand and capacity assumptions have utilised real time data from 2022/23 where available. This has been pathway information from one hospital and extrapolated based on population for the other; utilisation of intermediate and

transitional care in 2022/23; demand analysis across the year; flow through community services. Based on 2022/23 data, demand for Pathway 1 Hospital Discharges fluctuated throughout the year. These fluctuations did not significantly vary throughout the year. As the 2023-25 demand assumptions have been based on the 2022/23 data available, we anticipate seeing a peak in demand during July 2023 and a trough in February 2024. The development fund will enable flex of capacity throughout the year, in particular during peak times and where we see an increase in Length of Stay during the winter, due to the complexity of cases.

National Condition 2 (cont) – describe how BCF funded activity will support deliver of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- Unplanned admission to hospital for chronic ambulatory care sensitive conditions
- Emergency hospital admissions following a fall for people over the age of 65
- The number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population

Across the three main Mid Mersey boroughs around the catchment of St Helens and Knowsley Hospitals there is a collaborative workstream to focus on admission avoidance, with a specific aim to reduce ambulatory care sensitive condition admissions, a workshop has been held, lead by Aqua, with partners to analyse and review respiratory admissions, particularly COPD, Asthma and acute respiratory infections. The work will also go on to review admissions for cellulitis, UTIs and gastrointestinal complaints that all have similar presentations in older people that could be care for in the community.

Halton Adult Social Care support 3091 people age 18 and over per 100k population in the community and 399 per 100k population in residential and nursing care; this equates to 13 per cent of the overall population of people who receive services. During 2022/23 we had 595 people per 100k population over the age of 65 placed in residential and nursing care, which is below our target and those who received a Reablement service on discharge from hospital, were able to remain at home with support or independently in 84.7 per cent of cases in 2022/23.

The HICaFS service provides an MDT response within 2 hours and same day to assess and provide diagnostics, treatment, support and rehabilitation to maintain people in their own homes to prevent hospital admission. This supports the developing virtual ward approach to the management of frailty within the community. Additional BCF resource will be utilised in 2023-25 to strengthen this approach.

National Condition 3 Use this section to describe how your area will meet BCF objective 2: Provide the right care in the right place at the right time.

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commission will support this and how primary, intermediate, community and social carer services are being delivered to support safe and timely discharge, including:

- Ongoing arrangements to embed a home first approached and ensure that more people are discharged to their usual placed or residence with appropriate support, in line with the Governments hospital discharge and community support guidance.
- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.
- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

The focus of the delivery plan is on ensuring sufficient resources for both hospital discharge and community response. The approach to D2A and the capacity and demand assumptions have informed the investment strategy for the BCF, iBCF and discharge grants. Domiciliary care, intermediate care and wider community services are the main features of the investment plan, with additional investment in hospital discharge processes.

During 2022/23, capacity to support hospital discharges effectively met demand, through the use of discharge funding made available at Place. This funding, in the main, was used to fund Transitional Care beds and additional hours to support Pathway 1 discharges.

When the national discharge fund was announced in the autumn 2022, partners worked collaboratively to identify numerous schemes where it was felt that they would have the most positive impact in freeing up the maximum number of hospital beds and reducing bed days lost, including from mental health inpatient settings.

Due to the time limited nature of the funding made available last year, a number of schemes didn’t come to fruition but the funding that this freed up was used instead to deliver more Intermediate Care provision, along with funding additional packages of care.

When drawing up plans for the use of the Discharge funding for 2023/24 we reviewed the outcomes from the previous schemes and the impact that this had had on capacity to deliver more hours of care/packages, speediness of discharges etc. As a result of this it was agreed between partners that the most effective use of the funding for 2023/24 would be on the provision of Intermediate Care, both within the community and bed based in being able to support discharging more people in a safe and timely manner.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support in the community. This should include:

- Learning from 2022-23 such as
  - Where number of referrals did and did not meet expectations
  - Unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - Patterns of referrals and impact of work to reduced demand of bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services;
- Approach to estimating demand, assumptions made and gaps in provision identified
  - Where, if anywhere, have you estimated there will be gaps between the capacity and the expected demands?
  - How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in the wider BCF plans.

The service capacity delivered in 2022/23 mostly met demand in terms of bed and community support services. Use of transitional care bed capacity was low and focused mainly on people with care and support needs where housing issues prevented a return home directly from hospital. Processes through hospital and to discharge have been identified as a key area to work on and will be the subject of further detailed work with external support in 2023/24. Additional resource has been allocated to support discharge planning in 2023-25.

The 2023-25 demand and capacity assumptions have utilised real time data from 22/23 where available. This has been pathway information from one hospital and extrapolated based on population for the other; utilisation of intermediate and transition care in 2022/23; demand analysis across the year; flow through community services. Based on 2022/23 data, demand for Pathway 1 Hospital Discharges fluctuated throughout the year. These fluctuations did not significantly vary throughout the year. As the 2023-25 demand assumptions have been based on the 2022/23 data available, we anticipate seeing a peak in demand during July 2023 and a trough in February 2024. The development fund will enable flex of capacity throughout the year, in particular during peak times and where we see an increase in Length of Stay during the winter, due to the complexity of cases.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changed or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Additional investment in 23/24 will support additional capacity to further strengthen our home first / D2A approach. Work across the 2 hospital footprints on processes through and out of hospital to home in 23/24 will support improved pathways and processes to reduce length of stay and no right to reside numbers. The development fund will support changes of approach throughout the years as well as provide additional flexible capacity as demand patterns change.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

A self-assessment of implementation of the High Impact Change Model has been completed and agreed actions for improved future performance have been identified as follows:

Impact change	Action	How will you know it has been successful?
Change 1: Early discharge planning	The 100 day challenge for the high impact changes needs to be reviewed prior to winter and early discharge planning has been identified as a priority area to work on. Planned – Plans in place Emergency – Plans in place Red bag scheme – the red bag scheme is not being used (it has previously and will be reviewed) Working with partners and in line with guidance for elective care all patients discharge is planned prior to admission. For non-elective care Halton is working with the local trusts to identify patients upstream that may require ongoing care after discharge to allow the collection of information and assessment of need to begin at the earliest opportunity. The hospitals have implemented the where best next principle to consider the right care and right place approach.	The percentage of patients with no right to reside will reduce to the national target of 10% and average lengths of stay will improve overall Halton is monitoring the lead times between when a patient no longer has the right to reside, the time assessment commences and the time to discharge with the aim to optimize the discharge process to avoid unnecessary delays. There will always be complicated cases that have protracted care planning and the lessons learnt from long stay patient will help inform further developments
Change 2: Monitoring and responding to system demand and capacity	System and partnership working needs to be part of the CMAST and Out of Hospital provider alliance workplans in collaboration with the Place Based delivery programmes. Winter preparations need to make the necessary capacity available for any increased demand and be able to be flexible to ensure escalation is possible if threshold triggers are reached.	Improved system partnerships and less congestion in set points of the pathway Patient tracking through the discharge process allows ongoing undertaking of the journey for each individual. There is any single consistent bottle neck within the local systems but a

	Responsive capacity – Mature Improving how the system flows – plans in place Effective information sharing – Established Daily and weekly system pressure calls are undertaken with partners to understand the demand across the sectors and to identify gaps and opportunities. Venn modelling has previously been undertaken, and consideration for Newton demand and capacity analysis is being held with one acute provider and an internal audit process with the other main acute provider.	series of small variables that disrupt flow, but the common feature is the collection and sharing of the relevant information to allow a safe discharge. Both acute providers are striving to ensure discharge information is complete and accurate. Currently demand at the emergency departments, admissions and acuity of patients is greater than anticipated, and all partners have responded to this prolonged surge through escalation and collaborative solutions.
Change 3: Multi-disciplinary working	Improvements have been made and capacity has been increased but there are still challenges and barriers to effective communication between the teams. Halton has a discharge steering group in place to review the current processes and make improvements. Without system interoperability there will be a limitation on the full extent to shared records. MDT working – Established Discharge planning and assessment – Plans in place Daily discharge tracking meetings are undertaken between health and social care. VCSE aren't part of the assessment of need but are part of the operational discharge. Social workers are present on the ward to undertake assessments of need and carry out best interest meetings with patient, families, advocates, ward staff and wider teams as required. Patients with differing ongoing needs have different requirements for their assessment and planning with simple cases being able to be carried out with purely with the patient, while complex patients requiring multi agency planning meetings.	Reduction in the time to gather all the information required to discharge a patient, and improved timeliness of social worker involvement in the discharge planning, which will reduce the time taken to arrange a care package and clear the hospital beds. Ongoing improvements in MDT working has reduced the frequency of differing opinions of need and the over prescribing of ongoing care. The management of patients expectations is a joint role between health and social care to provide the patient centered care meeting their best interests.
Change 4: Home first	All boroughs across Mid Mersey have different processes and are at different positions to be able to move to a home first and discharge to assess model. There needs to be agreement on a joint framework to move to a discharge to assess model. Discharge to assess – not yet established Reablement and pathways – Mature Embedding and home first mentality – Mature The principles of home first and Reablement	Increased decisions about patient needs and care plans being made in their own home with their families. Reduced levels of patients remaining in hospital who no longer have the right to reside. The aim is to continue to increase the number of patients discharged to their normal place of residence, with reduction in any readmissions.

	first are fully embedded within the borough, including when patients require community rehabilitation or transition their ultimate aim is to return to their usual place of residence. True discharge to assess is not in place for all patients as it is often clear that their, and their families, needs can not be met in their own home. If a patient is placed in 24 hour care their continue to be assessed for the next 4 weeks to determine if there is a improvement and they care return to their home. In Halton there is a single point of access to intermediate care through the Halton Intermediate Care and Frailty Service	
Change 5: Flexible working patterns	Continue the existing arrangements for seven day working and support the hospitals to increase the pathway 0 discharges over the weekends. Assessment and decision making – not yet established Discharge services – Plans in place Care Packages – Established Hospital decision making for discharges is still heavily focused on 5 day working, with a smaller element of pathway 0 discharges at the weekend for patients that don't require higher levels of services. There are limited capacity for TTO preparation and equipment Weekend PTS is in place and will be increase in the next year. Many services for patients that require ongoing care will accept patients at the weekend, while the planning will have been undertaken during the week, and a few care home will admit at the weekend but generally during the weekdays.	Improved continuous processes would reduce the variations between the peaks and troughs over the week. The focus is on improving the pathway 0 discharges at the weekend that don't require high input from multiple partners. Improved processes are aimed to reduce the variation and cycles that are seen during the week to move to a consistent decision making and discharge across the weekdays.
Change 6: Trusted Assessment	Independent care sector assessment – not yet established Within hospital – established Adult social care – N/A Local care home do require to undertake their own assessment of patients before acceptance and admission. Therapy and clinical assessment undertaken in the hospital are utilized for their patients ongoing needs without further reassessment by community providers. Access to intermediate services it carried out be the patients social worker assessment and process through the single point of access. There is sufficient capacity within the social worker teams to undertake a timely assessment	Improvements in the quality, accuracy and timeliness of discharge information will improve the assessment processes allowing a lighter touch approach and a reduction in delays for clarifications.

	and third parties are not required.	
Change 7: Engagement and choice	Information and support decide care – established Choice protocol – Mature VCSE provision - ??? On admission patients are provided with information about the process that will be undertake to plan their discharge, with recognition of the importance of a timely discharge for the flow in the acute sector and to their recovery. Choice protocols are in place within each acute provider with joint decision between health and social care on how they are escalated when required. Patients that require advocacy to act on their behalf when they lack capacity and IMCA is provided.	Home first principles are in place and all partners work to the best interest and wishes of the patients. If patients do not have capacity, their families and person with LPA are fully engaged with the best interest decisions. The aim is to support patients who chose to return to their own home to do so with the necessary support required.
Change 8: Improved discharge to care homes	The Enhancing Care in Care Homes plans should be in place by the end of the current financial year. Discharge support – Established Enhanced primary care – Exemplary Access to out-of-hours/urgent care – Established The Halton Care Home steering group and liaison provide a supportive roll in working with care home to improve the acute discharges, admissions, capacity, occupancy and care for residents. All care homes have an aligned GP practice that providers medial support to the home with ward round and MDTs. The HICAFs service includes the community rapid response service to provide a 2 hour response to patients that require assessment and care. There is limited provision out-of-hours but there is a consistent offer to residents in a care home as to residents in their own home.	Reduction in patients being conveyed to hospital to receive care. Improved experience of residents in care homes. Further development of the EHCH, UCR and virtual ward programs will aim to support care homes to maintain patients in their beds without the need for conveyance to an acute setting. If a patient is admitted to hospital, there is also an aim to return their to their home through early supportive discharge to reduce the risks of acute decompensation and cross infection.
Change 9: Housing and related services	Continue to monitor the situation and review if there are issues identified. Systematic response and demand/capacity – established. Early needs assessment and response – established Integration/joint working – established Home adaptations, equipment, telecare and health – mature	Reduction in delays to discharge due to waiting for home adaptations to be undertaken.

	The housing status of patients is recording at the point of admission. Assessment of the patients ability to cope within their home is undertaken Environmental and home visits are undertaken when required Patients requiring equipment, adaptations, downstairs living, telecare etc. is part of the assessment and discharge planning process	

National Condition 3 (cont)

Please describe how you have used BCF funding, included the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid cares including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Our whole system approach is delivering to improve outcomes supporting unpaid carers. Our Carers Strategy group (a multi-agency partnership) provide strategic oversight of our approach and has membership from health and social care sectors, including representation from both adults and children's services, alongside third sector representation.

In delivering against our Care Act duties there is a jointly commissioned service with our Halton Carers Centre, with service specification and performance monitoring jointly reviewed between NHS and Social Care commissioners.

Halton Carers Centre are the primary point of contact for all carers', including young carers and young adult carers, to access a wide range of universal and targeted services that will support them to improve their quality of life throughout all stages of their caring role. This is delivered via services to meet these objectives including:

- Identification of carers
- Provision of information, advice and guidance
- Signposting carers to appropriate advice and support
- Advocating on behalf of carers
- Providing short term intensive support to carers where there is significant risk of carer breakdown
- Expanding and diversifying provision of activities and peer support for carers
- Supporting carers to take part in education, training or work opportunities

We are supporting unpaid carers through BCF funding allocated to Halton Carers Centre to deliver a Carers' Personalised Break Fund to enable carers to have a break from their caring role. This provides support to a range of carers that works towards

the prevention, reduction and delay of the need for care and support for individuals and to improve people's wellbeing.

Further funding is allocated to support provision of a home-based respite care service, which provides breaks for carers and to assist people to live in their own homes to remain independent for as long as possible. This service provides home care normally provided by the unpaid carer and allows that carer to have respite from their role. BCF funding supports the provision home based respite care in Halton to unpaid carers. The LA also have a budget for carers' breaks, respite and direct payments.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding that supports independence at home?

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 or a combination of these. Halton has schemes in place such as the 50/50 funding agreements (a joint working arrangement between the council and housing associations). 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. telehealth care.
- 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.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2022 (RRO) to use a portion of DFG Funding for discretionary services?

Yes

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

£518,890

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of peoples with protected characteristics? This should include:

- Changes from previous BCF plan
- How equality impacts on the local BCF plan have been considered

- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5,

The One Halton Health and Wellbeing Strategy 2022 – 2027 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 BCF is considered as part of the wider borough work on health inequalities, and will contribute to the following actions to reduce inequalities in Halton:

- Supporting a community development asset-based approach and community-led initiatives that build capacity for local people to become more informed and involved in decision about their health.

- Improving access to services for people and groups most at risk of poor health.

- Developing the health and social care workforce to ensure they have the knowledge, skills and understanding about how to identify and respond to need and inequalities, signposting and referring appropriately.

- Delivery of Core20PLUS5 NHS initiative supported by partners and the community.

- The Core20PLUS5 NHS approach is designed to support Integrated Care Systems to drive targeted action in health inequalities, and to address health inequalities for the population in the 20% most deprived areas, according to IMD, along with specific population groups experiencing poorer than average health access, experience and/or outcomes. For the BCF, this will focus specifically on Older People, and resulting actions will redefine services to reduce differences.

The Local Authority and the NHS Cheshire and Merseyside ICB - Halton place are also 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 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- 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:	Suzanne Salaman
E-mail:	suzanne.salaman@halton.gov.uk
Contact number:	0151 511 8694
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	

	Role:	**Professional Title (e.g. Dr, Cllr, Prof)**	**First-name:**	**Surname:**	**E-mail:**
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Marie	Wright	marie.wright@halton.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Mr	Graham	Urwin	graham.urwin@cheshireandmerseyside.nhs.uk
	Additional ICB(s) contacts if relevant	Mr	Tony	Leo	anthony.leo@cheshireandmerseyside.nhs.uk
	Local Authority Chief Executive	Mr	Stephen	Young	Stephen.Young@halton.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Mrs	Sue	Wallace-Bonner	Susan.Wallace-Bonner@halton.gov.uk
	Better Care Fund Lead Official	Mr	Damian	Nolan	Damian.Nolan@halton.gov.uk
	LA Section 151 Officer	Mr	Ed	Dawson	ed.dawson@halton.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

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.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

REPORT TO: Health and Wellbeing Board

DATE: 11th October 2023

REPORTING OFFICER: Director Customer Experience, Halton Housing

PORTFOLIO: Health and Wellbeing

SUBJECT: Halton Housing Support

WARD(S) Borough Wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of the report is to provide the Halton Health & Wellbeing Board with an update on how Halton Housing support the housing and broader health needs of older people in the borough.

2.0 **RECOMMENDATION: That the report be noted.**

3.0 **SUPPORTING INFORMATION**

3.1 Over 32% of Halton Borough's population is aged 55 or older, with the number of people aged 65 and over rising faster than any other population group.

3.2 Halton housing recognises the importance of housing in providing support and care for older people. We are committed to helping older people live independently for as long as possible and working in partnership to ensure that older people have the right support in place to suit their needs.

3.3 Just under 30% of Halton Housing homes have at least one person living there that is aged 65 or over. 93% of our customers aged 65 or over live in general needs housing and 7% in housing with support in place.

3.4 Halton housing do a range of things to support the housing and broader health needs of older customers and the presentation details:

- Aids and adaptions
- Housing with support schemes
- Safeguarding
- Partnership working
- Social / Community events
- Welfare Benefits & Money Advice
- Cost of living support

4.0 **POLICY IMPLICATIONS**

None

5.0 **FINANCIAL IMPLICATIONS**

None

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

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

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

6.3 **A Healthy Halton**
Halton Housing support the Council's priorities for a Healthy Halton. We provide older people an affordable, safe, and comfortable place to live. Supporting them to live as independently as possible in their own homes wherever possible, providing aids and adaptations to achieve this where necessary. We provide housing with support for those that need it the most. Working closely with social care providers to ensure our customers receive the appropriate level of support and care for their needs. We also lead on initiatives to tackle social issues such as loneliness.

6.4 **A Safer Halton**
Halton Housing supports the Council's priority to create a Safer Halton. We are well placed to identify care and support needs and identify vulnerable adults that may be at risk working closely with adult social care and other agencies to keep our elderly customers safe.

6.5 **Halton's Urban Renewal**
None

7.0 **RISK ANALYSIS**

7.1 None identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 None identified.

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

None under the meaning of the Act.

REPORT TO: Health & Wellbeing Board

DATE: 11 October 2022

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health & Wellbeing

SUBJECT: Flu and Covid-19 vaccination, winter 2023/24

WARD(S) Boroughwide

1.0 **PURPOSE OF THE REPORT**

This report presents a summary of the flu and Covid-19 vaccination programmes for winter.

2.0 **RECOMMENDATION: That**

1. **the Board note the content and process of planning for winter to protect our population against additional threats that the season brings; and**
2. **each individual agency uses all opportunities to promote positive prevention messages and community support as widely as possible.**

3.0 **SUPPORTING INFORMATION**

3.1 **Background**

3.1.1 Vaccination is the most important means of protecting the population from infectious respiratory diseases, particularly during the winter months when rates of infection peak. High rates of vaccination across local populations are important for preventing the circulation of infection, and for protecting individuals from illness. This is particularly important for individuals who are at higher risk of infection, or at greater risk of complications from respiratory disease – such as people who are immunocompromised, have co-existing conditions, or who are pregnant.

3.1.2 In addition, programmes of staff vaccination support business continuity, by protecting organisations from disruptions to services associated with staff absence which contribute to winter pressures. This is particularly important for organisations who provide essential services, such as health and social care organisations. Vaccination of health and social care staff also protects the people for whom they care.

3.1.3 UKHSA have identified a new Covid-19 Omicron variant – BA.2.86 – and, as a result, have brought forward this winter's flu and Covid-19

vaccination programmes from October to September. Although BA.2.86 is not considered to be a variant of concern (VOC), a precautionary approach has been adopted to ensure that population groups eligible for vaccination are protected as early as possible this winter.

3.2 Flu is a highly infectious disease, with symptoms - including fever, chills, aches and fatigue - that develop rapidly. Although healthy individuals usually recover from flu within 7 days, vulnerable individuals are at risk of hospital admission, permanent disability and even death. Flu season normally extends from October to May, although rates of seasonal flu are usually at their highest between December and March. Flu adds to the increased burden of illness that challenges the health and social care system every year.

3.3 **Flu Vaccination**

The aim of the national flu immunisation programme is to protect people who are at higher risk of becoming more seriously ill or suffer complications if they catch flu. The Joint Committee on Vaccination and Immunisation (JCVI) identifies population groups each year who are eligible for flu vaccination.

3.4 **Eligibility**

3.4.1 Groups eligible for flu vaccination for the 2023/2024 flu season are:

- All those aged 65 years and older
- People aged 6 months and over in clinical risk groups (including pregnant women)
- Children aged 2 or 3 years on 31 August 2023
- Primary school children (YR-Y6)
- Secondary school children (Y7-Y11)
- Household contacts of immunocompromised individuals
- Health and social care staff in direct contact with patients/service users without an employer-led occupational health scheme
- People living in long-stay residential care homes
- People in receipt of carer's allowance, or who are the main carer of an elderly or disabled person who will be at risk if they fall ill.

3.4.2 Eligible cohorts will be invited for flu vaccination in order of priority to ensure that the most vulnerable groups are protected first. People should wait to receive an invite to book a vaccination, and will then be able to book a vaccination appointment through the National Booking System. Local systems have been asked to work to specifically increase rates of vaccination of pre-school children and pregnant women.

3.4.3 Frontline health and social care workers should be provided with flu

vaccination through their employers' occupational health programmes. Frontline health and social care workers who are employed by organisations without an occupational health programme are eligible for NHS vaccination.

3.5 **Flu vaccination delivery**

3.5.1 Flu and Covid-19 vaccine can be administered to individuals at the same time. This is not associated with a higher risk of side effects, and ensures that individuals are protected from both viruses as early as possible.

3.5.2 Providers are expected to deliver a 100% offer to eligible groups. There are no defined national targets for flu vaccination this year, but providers are expected to equal or exceed last year's uptake rates, particularly for clinical risk groups, pregnant women and eligible 2 and 3 year olds. Providers must also have plans in place to address inequalities in vaccination uptake.

3.5.3 **Primary Care**

All GP practices across Halton are delivering the flu vaccination to eligible patients. Most practices will offer appointments and some will also offer drop-in clinics. Pharmacies in Halton are also offering flu vaccination to people who are eligible for the NHS flu programme. Delivery of the service varies: some pharmacies may offer timed appointments but others offer drop in clinics. Pharmacies can also opt to offer the flu vaccination privately to people who are not eligible under the NHS programme

3.5.4 **Schools and nurseries**

Children under the age of 18 years receive nasal spray vaccination, unless there is a specific clinical reason why they should receive injected vaccine. Eligible children of school age will be offered the vaccination by the School-aged Immunisation Team (Bridgewater Community Healthcare NHS Foundation Trust). The School-aged Immunisation Team will work closely with the Council to help maximise uptake and provide the most effective and efficient service. Children in clinical risk groups will be offered vaccination at school, but can also be vaccinated by their GP practice.

3.5.5 The School-aged Immunisation Team will also be holding vaccination clinics in Early Years settings for eligible pre-school children with the aim of increasing uptake rates. These clinics will be offered in pre-school settings on school sites. The main vaccination offer for pre-school children will continue to be in general practice, and all eligible children aged 2 and 3 years will be able to access vaccination through their GP.

3.5.6 **Care homes and Care Staff**

Vaccinations in care homes are provided by the care home's nominated GP. Care home staff should be vaccinated at the same

time as residents wherever possible. Health and care workers who are not vaccinated in the care home setting can access vaccination at their GP or a pharmacy. Vaccination of care home residents should begin on 11 September and be completed by 22 October 2023. Flu and Covid-19 vaccination should be co-administered during care home visits wherever possible.

3.5.7 **Oversight**

Halton Flu Group will meet monthly throughout the flu season to oversee the planning of the seasonal flu programme, ensuring that relevant and robust procedures are in place. Membership of Halton Flu Group includes Halton Borough Council (public health and Adult Social Care), ICB Halton Place, Warrington and Halton Foundation Hospital Trust, Community Infection Prevention and Control team, Local Pharmaceutical Committee, Mersey Care and the NHSE Screening and Immunisation Team.

3.6 **Covid Vaccination**

During 2023, there has not been a universal Covid-19 vaccination offer to the general population. Instead, there has been a shift towards a seasonal vaccination programme approach – mirroring the approach to flu vaccination. Specific cohorts will be eligible for a Covid-19 vaccination as part of the current campaign. Individuals in eligible cohorts who have never previously received a Covid-19 vaccination should receive a single dose during the autumn/winter 2023 campaign.

3.7 **Eligibility**

3.7.1 The following cohorts will be eligible for Covid-19 vaccination during autumn/winter 2023:

- Residents in care homes for older adults
- All adults aged 65 years and over
- People aged 6 months to 64 years in a clinical risk group
- Frontline health and social care staff
- People aged 12-64 years who are household contacts of immunosuppressed individuals
- People aged 16-64 years who are carers
- Staff working in care homes for older adults.

3.7.2 Individuals must leave an interval of three months since their last dose of Covid-19 vaccine. Those at highest risk will be invited for vaccination first.

3.7.3 Vaccines developed by Pfizer, Sanofi and Moderna will be administered during this winter's programme. These vaccines have been updated for the current winter season, to produce higher levels of antibody against some strains of Omicron.

3.7.4 Patients eligible for the autumn/winter 2023 Covid-19 vaccination programme are advised to wait until they receive and invitation to make an appointment for vaccination. Residents can make an appointment through the National Booking Service for vaccination at a community pharmacy. In Widnes, people can receive Covid-19 vaccination on a walk-in basis at pharmacies. Details of walk-in vaccination centres are available on the NHS website. Several GP practices are offering the vaccination at their practice for eligible patients. Patients whose GP is not offering Covid-19 vaccination can access Covid-19 vaccination through community pharmacy and at Highfield Hospital. Nearly all local GP practices are delivering Covid-19 vaccination in care homes – in instances where this is not the case, community pharmacy is delivering vaccination to care home residents.

4.0 POLICY IMPLICATIONS

4.1 Vaccination programmes are a national requirement, monitored through monthly returns to NHS England. Planning for and protecting people against harms and threats is a key element to a number of policy areas.

5.0 FINANCIAL IMPLICATIONS

5.1 There will be financial impacts in the implementation of the national programmes – vaccinations within primary care and to risk groups is covered through national arrangements and financial agreements. Individual employer organisations of health and social care staff are required to resource arrangements for the provision of vaccination. Resource is required to promote vaccination uptake amongst all eligible groups and maximise the programmes impact.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Ensuring high uptake of flu vaccination amongst children protects not only the children themselves, but also the wider population, because children frequently transmit flu to other members of the community. Children who catch flu will be absent from school, and this may have a detrimental impact on their education.

6.2 **Employment, Learning & Skills in Halton**
Flu vaccinations protect the workforce for the reasons already given above.

6.3 **A Healthy Halton**
Respiratory infections and outbreaks contribute to winter pressures on the health and social care system and are responsible for a large proportion of excess winter deaths. Cases of flu and Covid-19 place a significant burden on primary and secondary health care systems.

Flu and Covid are largely preventable illnesses. Ensuring good uptake of vaccination for risk groups and health and social care staff, will prevent illness and death within Halton.

6.4 **A Safer Halton**
None.

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

7.0 **RISK ANALYSIS**

7.1 Failing to adequately implement the national flu plan and protect our community from additional seasonal threats and harms puts the population at significant risk of outbreaks, increased burden of illness and ill-health and challenges local households and communities. Failure to plan and mitigate against identifiable risks is a corporate and an integrated health and care system risk.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 All plans are developed with the basis of reducing inequalities in mind and are developed in line with all equality and diversity issues within Halton taking into account the implications for, and impact upon, individuals with protected characteristics.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 None.

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

'None under the meaning of the Act.'

REPORT TO: Health & Wellbeing Board

DATE: 11 October 2023

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health & Wellbeing

SUBJECT: Cost Of Living Support

WARD(S) Boroughwide

1.0 **PURPOSE OF THE REPORT**

1.1 To highlight the work done by the Public Health Team, Health Improvement Team and partners in initiatives providing support to the people of Halton related to the rising cost of living and to provide details on planned initiatives as we approach winter.

2.0 **RECOMMENDED: That the report be noted.**

3.0 **SUPPORTING INFORMATION**

3.1 **Background**

3.1.1 Before the Covid-19 pandemic, responses to poverty were sporadic, with a mixture of national and local schemes alongside community responses that generally operated independently of one another, with limited overarching coordination between services. The pandemic response highlighted many of the gaps in support available across the borough. Coupled with increasing demand from residents, linked with rising cost of living challenges, there has been an impetus to work collectively across the borough going forwards.

3.1.2 The Public Health team has led this collaborative working in the form of two networks, Feeding Halton and Affordable Warmth, focusing on food poverty and fuel poverty respectively. The groups' memberships consist of local authority departments, commissioned services, and third sector and community groups. The aim of both networks is to bring together any resources available to residents that tackle poverty to ensure a coherent approach to intervention and to provide direction for future services.

3.2 **Current level of demand**

Over the last two years, both of the Foodbanks operating in Halton have seen large spikes in demand which follow a steady rise in demand over the previous decade. September 2022 was the first

month in which more than 1000 residents used the borough's Foodbanks, and 40% of those receiving food parcels were children. Fuel poverty followed similar trends during the same two-year period. After a small drop in those requiring help with energy during Covid, the Citizens Advice Bureau (CAB) has seen a large rise in those requiring support, reaching 1200 a month in Winter 2022 – this represents an eight-fold increase in just two years.

3.3 **Food Poverty Initiatives**

Over the last 18 months, the Public Health team has worked with the national charity Feeding Britain, and local partners, to set up five social supermarkets as part of our effort to help residents cope with rising food prices. Social supermarkets sell redistributed surplus food from retailers and wholesalers at discount prices in the community. We have worked closely with three groups who run the shops: Halton Veterans, Four Estates and HBC Day Services. The shops provide a stepping stone away from Foodbank use, and a bridge between emergency handouts and using standard retailers. During the last 12 months, an arrangement has been reached with a regional catering company who will provide free food to the social supermarkets (worth approximately £3000 per year) as the social value element of their contract.

3.4 **Affordable Warmth and Energy Efficiency Initiatives**

Cold homes are associated with excess winter mortality, and with the exacerbation of existing health conditions, including asthma and other respiratory conditions, and arthritis. Living in a cold home also increases the risk of heart disease and cardiac events. Improving homes via solutions like energy efficiency and heating systems can reduce health risks.

3.4.1 The Council's has taken on a new role in delivering national retrofit schemes to improve energy efficiency and make home heating more affordable. Retrofit schemes consist of home improvements, such as improving insulation, to help address climate change as well as reducing the risk of fuel poverty for the occupants. The Council is exploring a new partnership with Energy Projects Plus, an existing partner that works in the Liverpool City region delivering energy advice and offering home visits to residents in need. This new partnership arrangement would improve the outreach of multiple schemes and increase take up of energy efficiency grants.

3.4.2 Examples of the financial support available to residents include:

ECO4 flex grant: This is a home energy improvement grant which will run until 31 March 2026. Cold homes significantly impact on physical and mental health. The scheme focuses on low income and vulnerable households and aims to improve the least energy efficient homes. Depending on eligibility, residents can be granted items such as new boilers, underfloor insulation, cavity wall insulation and window glazing.

3.4.3 **Great British Insulation Scheme:** This is a new scheme which provides wall, loft and floor insulation with the aim of reducing the cost of energy bills. This is different from the ECO4 flex grant because eligibility can be based on a residents Council Tax Banding rather than the Energy Performance Certificate (EPC).

3.5 **Winter outreach campaign**

As we approach winter, and food and fuel bills remain high, a six-month campaign has been created to bring together and advertise all the support available to residents. This will build on some of the campaign and outreach activities developed in previous years.

3.5.1 The Council's Cost of Living page has been updated to provide a single point of reference for Cost of Living support. This page was created last year to summarize all the support available to those struggling last Winter with the sudden rise in inflation. It contains information on resources available from the Council and national government. It also provides details of community support which has been brought together through the work of the Affordable Warmth and Feeding Halton Groups. The webpage contains information on how to access emergency support including food bank referrals and short-term energy payments, as well as details of local activities such as warm spaces open in Winter and school holiday activities for children. This year there will be a particular push around income maximization, with links to free benefit checkers to ensure residents are receiving all of the benefits to which they are entitled.

3.5.2 The outreach campaign is targeted at residents, HBC staff and frontline public sector staff.

3.5.3 **Local residents:** There will be direct communications to the public throughout the Winter. It is planned that a six-month social media campaign will include paid advertising to target those in greatest need, directing them to relevant online support. Residents may also receive information about available support with their Council Tax bills. As part of a new initiative from the HBC marketing team, the links which residents click to access online support will be able to track where the resident accessed the link. For example, the number of people that went on to access support that came from links used by GPs can be collated. This insight will be able to highlight those most in need and improve communications planning in future months.

3.5.4 **Front Line Staff:** Staff that deal directly with the public as part of Making Every Contact Count will be equipped to signpost service users to relevant Cost of Living support. A leaflet has been created that summarizes the main pathways people can take to access the main types of Cost of Living support. This will be distributed across

front line organisations, including GPs, Children's Centres and a wide range of smaller community partners.

3.5.5 To ensure front line staff are confident to explain some of this support, Cost of Living briefing sessions will be held from October 2023 onwards. The sessions will cover the types of problems staff may come across, how to navigate the resources available, and where to refer clients depending on their situation. These sessions will be offered to HBC's own staff as well as wider public sector and community partners. A comprehensive range of physical and online resources will be available, including QR codes which link directly to available support. Groups will be encouraged to share these through their own communications in the coming months.

3.5.6 **HBC Staff:** Staff will be encouraged to use email banners to share information about support available to residents. In terms of the welfare of HBC's own staff, a link to the Cost of Living website will be added to every HBC payslip between October and March. Managers will also be encouraged to ensure that staff have time to look through the support available as part of their duty of care to their teams.

3.6 **Pension Credit**

Residents who are over 65 years and receiving council tax benefit are likely to be entitled to Pension Credit. In February 2023, the Public Health team began a piece of work to identify which residents may be entitled to pension credit but were not receiving it. Through liaison with the HBC Council Tax team, approximately 900 residents were identified. All of these residents were contacted via letter. Over 240 residents responded and asked for support in applying. All were offered one-to-one to support at a time convenient to them to complete a pension credit application. The initiative was highly successful. It has been calculated that the income generated for those residents in Halton will amount to approximately £1.2 million over the rest of their lifetimes. This piece of work will be repeated in February 2024

3.7 **Bus Travel Support**

Between June and December 2022, the number of missed GP and hospital appointments in the UK cost the NHS an estimated £290 million. The cost of travel can be a barrier to people attending NHS appointments. To tackle this, bus passes have been provided to those who earn less than £26,000 a year and attend regular GP or hospital appointments. This has been done with the aim of reducing the number of missed appointments to improve the health and wellbeing of local residents. Importantly, the scheme also saves the NHS money. Residents can apply for this support twice between April 2023 and March 2024.

3.8 **Medical Equipment Energy Support**

Many residents in receipt of disability benefits were severely food insecure during the Winter of 2022. Some of these residents are reliant on electrical medical equipment. To alleviate the financial pressures associated with rising energy costs, these residents are eligible to receive a £60 Asda food voucher from the Council. This support is not means-tested - the resident is only required to show evidence that they use electrical medical equipment. This support can be applied for twice between April 2023 and March 2024.

3.9 **NHS Pre-paid Prescription Certificate**

The cost of an NHS prescription is currently £9.65. If a resident is receiving regular or multiple prescriptions at one time, this is an increased pressure on top of other household bills. This added pressure may result in residents not collecting their prescriptions, negatively impacting their health. A three-month pre-paid NHS prescription certificate is being provided by the Council to enable residents to access free prescriptions for a three-month period. This is available to any resident who earns less than £26,000 a year. Residents can apply for this support up to four times throughout the period of April 2023 and March 2024.

3.9.1 Halton's Stop Smoking Team can also refer residents to this scheme if they wish to stop smoking using Nicotine Replacement Therapy. This offer has been extended to this cohort to minimise the financial barriers residents may encounter, improving accessibility of the Stop Smoking Service.

3.10 **Warm Spaces**

During the winter months, the Public Health team will work with stakeholders who provide designated warm spaces in Halton to provide free tea and coffee to residents who attend the warm spaces. This builds on the success of the warm spaces initiative last year.

4.0 POLICY IMPLICATIONS

4.1.1 Initiatives to tackle the Cost of Living crisis will inform the strategic development of the Halton Borough Councils policies across multiple sectors, including housing, employment, education and Public Health

4.1.2 The work of the One Halton Wider Determinants Delivery Group will be informed by the work undertaken by Halton Borough Council on cost of living.

5.0 FINANCIAL IMPLICATIONS

There are no financial risks associated directly with this report.

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

6.1 **Children & Young People in Halton**

Support for families which addresses Cost of Living pressures, and the initiatives within this paper, will impact on the children and young people of Halton and have the potential to improve outcomes for residents of all ages.

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

None

6.3 **A Healthy Halton**

The work programmes identified in this report focus directly on this priority, significantly improving residents' health and wellbeing, enabling them to live longer, healthier and happier lives.

6.4 **A Safer Halton**

None

6.5 **Halton's Urban Renewal**

None

7.0 **RISK ANALYSIS**

7.1 None

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 Initiatives to tackle the Cost of Living crisis in Halton are designed to be accessible to all residents. Resources and information are provided in a variety of ways so as not to digitally exclude any residents.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 Affordable warmth initiatives aim to reduce residents' energy bills. These initiatives also address climate change, by supporting residents to use less fuel.

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

None under the meaning of the Act.

REPORT TO: Health & Wellbeing Board

DATE: 11 October 2023

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health & Wellbeing

SUBJECT: Older People

WARD(S) Boroughwide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide the Health and Wellbeing Board with an update on the Council's health and wellbeing offer for Older Adults.

2.0 **RECOMMENDED: That the report be noted.**

3.0 **SUPPORTING INFORMATION**

3.1.1 **Background Information**
The older population within the borough is increasing, and will form a larger proportion of Halton's population in future. In 2020 7.4% of Halton's population were aged 75 and above, whereas, in 2043 Halton's projected population aged over 75 will be nearly double at 12.8% of the entire population of the area.

3.1.2 Life expectancy in Halton is lower than in England for both men and women. On average people in Halton can expect to live 2 years less than people across England as a whole.

3.1.3 Circulatory disease, injuries, respiratory disease and digestive conditions are the main diseases affecting the older population. They are the top specific causes of emergency hospital admissions. In recent years, cancers, circulatory and respiratory disease, and mental and behavioural conditions have been the top causes of deaths among older people.

3.1.4 In 2020/21 Halton had a higher rate of long-term care packages (6505/100k pop.) than the average among both North West (6085/100k pop.) and England local authorities (5280/100k pop.). The majority of care packages for older Halton residents provide physical support – with ether personal care, or access and mobility.

3.2 **Preventing ill health among older people**
Low-level prevention programmes in later life have been proven to have big health benefits for the individual, including longer life expectancy, maintained levels of functional ability, and an improved

sense of wellbeing. Halton has well-developed low-level prevention programmes across the borough.

3.2.1 **The HBC Health Improvement Team Ageing Well Offer**
The Health Improvement Team (HIT) provides a **universal offer** for all residents across the life course. This offer addresses the wider determinants of health and enables behaviour changes to improve health including smoking cessation, adopting healthier dietary habits, and boosting physical activity levels. We provide a tailored approach for individuals who are managing chronic health conditions.

3.2.2 Within the wider HIT, there are two dedicated teams which focus on improving the health and wellbeing of older people. The **Age Well Team** aims to improve the health of older adults through the delivery of specific targeted initiatives which are designed to combat loneliness, prevent social isolation, reduce falls, enhance wellbeing in care homes, and promote awareness of dementia. A high volume of referrals is received into the service each year.

3.2.3 The **Sure Start to Later Life Team** provides an information and advice service tailored to individuals aged 55 years and older. Its main objective is to provide individuals with the information they need to access appropriate support, precisely when and where they need it. The Sure Start to Later Life Team provides information to enhance health, to promote independence within older people's homes and communities, to optimise income, and to facilitate increased involvement in local communities to alleviate social isolation and loneliness.

3.2.4 **Volunteers** play a key part in supporting older people alongside the HIT, providing support to people living in care home, and supporting older people living in the community who are isolated and vulnerable. The evidence suggests that volunteers help improve people's lives, address health inequalities, and build a closer relationship between services and communities. People who engage in volunteering have been shown to benefit from better physical and mental health, a sense of fulfilment and a greater sense of connection to others in the community.

3.3 **Partnership working**
Over the past two years, the HIT has assumed a leadership role in collaborating with Adult Social Care on various preventive initiatives geared towards enhancing quality of life by means of early intervention, including for older people.

3.3.1 The **Prevention Panel** was introduced to actively seek innovative approaches to addressing the social needs of Halton's residents by exploring alternative support options within the voluntary and community sectors, as well as utilising individuals' existing support

networks. Through the identification and implementation of novel initiatives, the approach has demonstrated remarkable effectiveness in creatively fulfilling people's eligible needs. This model is moving beyond just social needs to include self-care, and empowering individuals and families to look after their own health needs, and to cope with illness or disability.

3.3.2 Through this innovative approach, HIT contributed to recovering a £1 million budget overspend last year for Adult Social Care. This year, the projected overspend is even greater, prompting us to explore alternative strategies to address local needs. This will encompass a comprehensive review of all care packages, with a heightened emphasis on self-care and the implementation of low-level health improvement programmes aimed at enhancing individuals' independence within their homes.

3.3.3 The HIT leads a very successful **Partners in Prevention network**. This serves as a networking platform for professionals across all sectors including key community partners to facilitate resource-sharing and effective signposting. Partners in Prevention meets quarterly. More recently the professional networking event has been combined with a public event. The September meeting is focusing on Healthy and Active Ageing and ties in with the national Falls Prevention Week campaign. Over forty partner organisations will be attending to promote key messages for older adults as well as for the wider population. Feedback from attendees consistently reflects high levels of satisfaction.

3.3.4 **Working with Care Homes**

The HIT plays a fundamental role in the **Enhance Health in Care Home (EHCH) programme**. When the EHCH framework was initially introduced, the primary aim was to shift away from an overly medical model of care. Instead, it emphasised a holistic approach to addressing individuals' needs, placing a strong emphasis on preventive and proactive care, rather than relying on reactive and sometimes unsuitable measures, such as unnecessary hospital admissions.

3.3.5 Thus far, EHCH has focused on enhancing the health and wellbeing of residents. This has been achieved by establishing opportunities for residents to become more involved in their community, rolling out the workplace health offer for staff, providing training for staff, exploring potential funding sources to implement purposeful activities, and collaborating with local businesses to support care homes within the framework of social value.

3.4 **Falls prevention**

There are several community-focused workstreams designed to boost the involvement of older adults in physical activities. Among these, the **Age Well Exercise falls prevention programme** stands

out as highly successful. It serves the dual purpose of acting as a pre-habilitation programme and providing post-falls rehabilitation. The service works collaboratively with all partners across the sector to devise and implement robust referral pathways into the programme. The service is integrated into both the healthcare and social care systems to streamline the referral process.

3.4.1 There is also close collaboration with our healthcare partners, specifically focusing on individuals who are at risk of experiencing falls. A dedicated HIT practitioner is based within Castlefield Health Centre. Their role is to motivate individuals to participate in the local falls programme. This involves providing individuals with information and empowering them to make informed decisions regarding their health to prevent future falls.

3.5 **Winter wellbeing**

During the approaching winter season, the 'Stay Well This Winter' campaign will be intensified, aligning it with cost of living initiatives. The primary emphasis will be on heightening public awareness regarding local resources. There will also be training provided to frontline personnel across various sectors to familiarise them with the local support options, enabling them to disseminate this knowledge to others. Ultimately, the goal is to proactively engage with older adults on every occasion, ensuring they receive support when needed, in the right place, and from the appropriate individuals.

3.6 **One Halton**

The One Halton Health and Wellbeing Strategy has set out a number of Ageing Well priorities that are aimed at enabling older adults to live full, independent, healthy lives. The One Halton Ageing Well Delivery Group has prioritised two key workstreams - Loneliness and End of Life Care - and the Public Health team is actively engaged with this work.

4.0 **POLICY IMPLICATIONS**

The programme of work carried out by the HIT to improve the health and wellbeing of older residents will inform the strategic development of One Halton workstreams moving forwards.

5.0 **FINANCIAL IMPLICATIONS**

There are no financial risks associated directly with this report.

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

6.1 **Children & Young People in Halton**

None

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

None

6.4 **A Healthy Halton**

The work programmes identified in this report focus directly on this priority, significantly improving older people's health and wellbeing, enabling them to live longer, healthier and happier lives.

6.5 **A Safer Halton**

None

7.0 **Halton's Urban Renewal**

None

8.0 **RISK ANALYSIS**

None

EQUALITY AND DIVERSITY ISSUES

Health Improvement and Ageing Well services are designed to be accessible to all older people. Older people with disabilities are enabled to access activities. Resources and information are provided in a variety of ways so as not to digitally exclude any residents.

9.0 **CLIMATE CHANGE IMPLICATIONS**

None

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

None within the meaning of the Act.

REPORT TO: Health & Wellbeing Board

DATE: 11 October 2023

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Terms of Reference Refresh

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the updated Terms of Reference for the Health and Wellbeing Board in the light of several changes that have occurred since the last refresh in 2019 and further feedback from members of the board.

2.0 **RECOMMENDATION: That the Board accept the refreshed terms of reference.**

3.0 **SUPPORTING INFORMATION**

3.1 Health and Wellbeing Boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. The 2012 Act prescribes a core statutory membership of at least one elected representative of the local authority, a representative from each CCG whose area falls within or coincides with, the local authority area, the local authority directors of adult social services, children's services, and public health and a representative from the local Healthwatch organisation.

3.2 In November 2022, the Department of Health and Social Care set out new guidance for all Health and Wellbeing Boards in the light of changes to the NHS and in particular the establishment of Integrated Care Boards (ICBs) and Integrated Care Systems (ICSs). The guidance was to support the ICB and ICP leaders, local authorities and Health and Wellbeing Boards to understand how they should work together to ensure effective system and place-based working and to determine the integrated approach that will best deliver holistic care and prevention activities, including action on wider determinants in their communities.

3.3 The HWBB has previously received guidance presented 18th January 2023 that set out the functions of the HWBB in relation to new strategic partners. The update terms of reference (TOR) are based on these and detailed feedback received from members since the July 2023 meeting. The final version of the TOR are detailed in Appendix A

4.0 POLICY IMPLICATIONS

4.1 As a statutory board, the Health and Wellbeing Board must have a set of agreed Terms of Reference for it to operate effectively and to fulfil legal requirements.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 HWBBs do not commission health services themselves and do not have their own budget but play an important role in informing the allocation of local resources.

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 and will continue to be addressed through the work of the Health and Wellbeing Board.

6.2 Employment, Learning & Skills in Halton

Employment, learning and skills is a key determinant of health and wellbeing and is therefore a key consideration for the Health and Wellbeing Board.

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 has an impact on health outcomes particularly on mental health. There are also close links between partnerships on areas such as alcohol and domestic violence. It therefore remains a key consideration for the Health and Wellbeing Board.

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. It should therefore be a key consideration when developing strategies to address health and wellbeing.

6.6 Climate Change

The HWBB terms of reference have no immediate or indirect effect on the Climate. Printing of documents will be limited, and all versions are available online.

7.0 **RISK ANALYSIS**

7.1 N/A

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**

The Health and Care Act 2022
Health and wellbeing boards: guidance - GOV.UK (www.gov.uk)

Appendix A

TERMS OF REFERENCE HALTON HEALTH AND WELLBEING BOARD

1. Halton Health and Wellbeing board acts as a forum in which key leaders from the local health and care system can work together to improve the health and wellbeing of the local population living and working in Halton.

The main duties include:

- Set the strategic direction to improve health and wellbeing and reduce health inequalities.
- Provide a strong focus on establishing a sense of place.
- Promoting and encouraging partnership working through joint commissioning and integrated provision between health, children's services, public health and social care
- Assessing the health and wellbeing needs in Halton
- Publishing a joint strategic needs assessment (JSNA)
- Publishing a joint local health and wellbeing strategy (JLHWS)
- Publish a pharmaceutical needs assessment (PNA)

2. The Health and Wellbeing Board will provide a key forum for public accountability of NHS, Public Health, Social Care for Adults and Children and other commissioned services that the board agrees are directly related to health and wellbeing in Halton.

The Health and Wellbeing Board has the following responsibilities:

- To be responsible for guiding and overseeing the implementation of the ambitions outlined in the One Halton Health and Wellbeing Strategy and other relevant health and care strategies, guidance and policies that will have an impact on the health and wellbeing of the people living and working in Halton. These include but are not limited to health strategies for England and national operational plans and local or regional health and wellbeing strategies and action plans.
- To promote robust joint commissioning, partnership arrangements and integrated, collaborative provision between health, public health, social care, children's services, the voluntary and third sector.
- To assess the needs of the local population and support the statutory Joint Strategic Needs Assessment (JSNA).
- To identify and monitor the reduction of health inequalities and monitor relevant activity and performance.
- To ensure effective relationships between the HWBB and other strategic boards operating in Halton.
- Halton Health and Wellbeing Board will have oversight of local Combatting Drugs Partnership; Community Safer Strategic Partnership as well as receive reports from other relevant groups.
- To contribute to the development of health, care and wellbeing services in Halton which may arise as a result of changes in government policy and relevant legislation.

- To provide a voice for Halton residents on all matters relating to the commissioning, and provision of health and social care in Halton.

Membership

Executive Board Portfolio Holder for Health and Wellbeing (Chair)
Executive Board Member: Children, Education and Social Care
Executive Board Portfolio Holder for Adult Social Care
Other Local Authority Portfolio Holders for other strategic priorities that sit under Halton's HWBB.
Chair Healthwatch
Chair Halton & St Helens Voluntary and Community Action
Chef Officer Citizens Advice Halton
NHS Cheshire and Merseyside – Halton Place Director
GP Representatives from Widnes and Runcorn areas
Executive Director, Adults
Executive Director, Children
Executive Director, Environment & Regeneration
Director of Public Health
Strategic Director Mersey Care
Strategic Director Bridgewater Community Healthcare NHS Trust
Strategic Director Warrington & Halton Hospitals NHS Foundation Trust
Strategic Director Mersey and West Lancashire Teaching Hospitals NHS Trust
Strategic Director Halton Housing Association
Chair of the Halton Community Safer Strategic Partnership
Police Representative
Fire and Rescue Service Representative
North West Ambulance Service Representative
Local Pharmaceutical Committee Representative

In the event of a representative not being able to attend the board, a substitute of that organisation should be made available.

MEMBERS ROLES AND RESPONSIBILITIES

The quality and commitment of members is crucial to the success of the Health and Wellbeing Board (HWBB). Members need to have vision, skills, experience and influence to make things happen within their organisation and/or sector. All members of Halton's Health and Wellbeing Board when attending meetings, or working on behalf of the Board, will act in accord with the Nolan Principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

1. Information, reports and agendas for meetings will be circulated and shared amongst members.
2. All members are able to provide items or suggest issues for discussion at meetings.
3. All members are able to contribute to the formal decisions and recommendations of the Board.

4. Members will take responsibility for working with partners to ensure priorities and key actions are met.
5. Members will consult and obtain the views of the organisations and sectors, which they represent and reflect or communicate at these meetings.
6. Members will ensure they are fully briefed and informed and are able to share information from their parent organisation or sector, whilst also reflecting confidentiality and data protection issues.
7. Members will bring forward agenda items or information in areas where they can provide expertise or have an interest and will share the information in an accessible format and by agreed deadlines.
8. Members are prepared to regularly attend all Board meetings of which they are a member or send an agreed substitute in exceptional circumstances.
9. Members will act as ambassadors for the HWBB and take responsibility for communicating messages across their own organisations and sector contacts, other partnerships and the public.

Meetings

Meetings of the Health and Wellbeing Board will take place quarterly and shall be open to the press and public. The chair may call an extraordinary meeting at any time. The agenda and associated papers will be sent out a minimum of one week (five clear working days) in advance of the meeting. and the agenda, reports and minutes will be available for inspection at Halton Borough Councils website at least five working days in advance of each meeting. The board will be formally minuted.

The Board will establish its own forward planning programme of activity which will be reviewed at each meeting to ensure it remains both strategic and timely. The ‘Forward Plan’ will be used to facilitate discussion as to priority areas, new items and agenda timetabling. Any reports for a meeting of the Board should be submitted to the Democratic Services team no later than fourteen working day in advance of the meeting.

No business will be conducted that is not on the agenda.

Chair

The Chair will be an elected member of Halton Borough Council

Quorum

The meeting will be quorate provided that at least 50% of all members are present. This should include the Chair or Vice Chair and at least one officer of the ICB and one officer of the Local Authority are present. Where a Board is not quorate, business may proceed but decisions will need to be ratified.

Decisions

Where a decision is required, that decision will be made by agreement among a majority of members present. Where a decision needs to be ratified by one of the statutory agencies, the ratification process will be in accordance with the agreed process within that particular agency.

Minutes

Minutes of the proceedings of each meeting of the Board will be drawn up circulated and agreed as a correct record at the subsequent meeting, once any required amendments have been incorporated.

Review

The membership and terms of reference of this partnership will be reviewed regularly (normally annually) to ensure that they remain relevant and up to date.