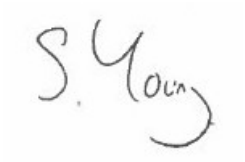
Public Document Pack

Health and Wellbeing Board

Wednesday, 12 March 2025 2.00 p.m.
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 to be confirmed.

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

Part l

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 15 January 2025 at The Board Room - Municipal Building, Widnes

Present: Councillor Wright (Chair)
Councillor Ball
Councillor T. McInerney
Councillor Woolfall
D. Nolan, Adult Social Care
I. Onyia, Public Health
L. Gardner, Warrington & Halton Teaching Hospitals
A. Hindhaugh, Halton Borough Council
L. Hughes, Healthwatch Halton
C. King, Halton Housing
A. Leo, Integrated Commissioning Board
W. Longshaw, St. Helens & Knowsley Hospitals
T. McPhee, Mersey Care NHS Foundation Trust
A. Moore, Cheshire Constabulary
H. Patel, Citizens Advice Bureau
S. Patel, Local Pharmaceutical Committee
J. Rosser, Public Health
J. Wallis, Bridgewater Community Health Care NHS
R. Walsh, Public Health
F. Watson, Public Health
S. Yeoman, Halton & St Helens VCA
K. Butler, Democratic Services

Action

HWB17 MINUTES OF LAST MEETING

The Minutes of the meeting held on 9 October 2024, having been circulated were signed as a correct record.

HWB18 ORAL HEALTH

The Board received a report from the Director of Public Health which provided an update on child oral health programmes.

It was noted that tooth decay was the most common reason for hospital admissions in the 4-9 year old age group and a North West study found that 1 in 4 children had an average of 3 missed days from school because of dental pain and infection. The study also revealed that almost 4 in 10 children had sleepless nights because of dental pain. Poor oral health was not only a cause of decay in baby teeth but it was also a strong predictor of decay in adult teeth.

Halton had some of the poorest oral health amongst 5 year olds in the North West. A 2021/22 survey found that over a third of 5 year olds had experienced dentinal decay, which was significantly higher than the National average. Children living in the most deprived areas were almost 3 times more likely to experience dentinal decay compared to those living in the least deprived areas.

Members of the Board were advised that the Public Health Team had developed a Halton Supervised Toothbrushing Programme which would be embedded in the Early Years settings as part of the Halton Healthy Early Years Settings Award. This would help to ensure that oral health was seen as an integral part of general health and over time, it was anticipated that the scheme would be rolled out to childminders and schools (up to age 7). The scheme would be rolled out across Halton but limited by funding and therefore the most deprived areas would be targeted first.

Another initiative that was ongoing in Halton was the distribution of fluoride toothpaste and toothbrush packs. This had been funded by the Regional Oral Health Programme and, to date, approximately 1800 packs had been distributed across the Borough which included family hubs, libraries, asylum seeker children, foodbanks and children in contact with social care, including foster carers.

The Board noted and discussed the report and members were encouraged by the ongoing work, in particular, the Supervised Toothbrushing Programme. It was agreed that focus should be given to younger children and it was suggested that the best age to target children was before they started school. The Early Years settings were very supportive and it was hoped, that in time, work would commence with schools. Healthwatch Halton suggested that consideration should also be given to engaging with new parents and educating families at the earliest stage.

Improved oral health care was a National concern and the British Association for the Study of Community Dentistry (BASCD) were keen to implement more toothbrushing programmes.

RESOLVED: That the Board support the ongoing participation in regional and local plans.

HWB19 INFANT FEEDING

Members of the Board received a report and

presentation from the Director of Public Health which provided an update on the development of the Infant Feeding Services and the outcomes in Halton as a result of the investment from the Department of Health and Social Care through Family Hubs.

The report outlined the benefits of breastfeeding but rates in Halton were significantly lower than the England average, despite slow and steady increases over the past 10 years. Between 2014 and 2023, breastfeeding at 6-8 weeks increased from 21.8% to 25.7% in Halton. The England average in 2023 was 49.2%.

Halton's Infant Feeding Team delivered antenatal infant feeding workshops, contact and visits new parents upon discharge from hospital. It also facilitated breastfeeding groups and "introducing solid food" workshops. The service also worked in partnership with the Family Hubs leads and Early Help officers and together facilitate groups and activities to promote and support breastfeeding.

Halton holds the Breastfeeding Friendly Initiative (BFI) accreditation status and the renewal would be completed in Summer 2025. BFI accreditation demonstrates that settings meet the evidence based standards for supporting optimal infant feeding. In addition to this, a significant focus had been placed on overcoming cultural barriers to breastfeeding in Halton and a number of approaches were in place to change this and these were outlined in section 3.11 of the report.

The Board noted and discussed the information presented and subsequently the following additional information was noted:

- There was no indication that the rising rates was due to expense, it appeared to be more around convenience and health benefits;
- There were 18 fatherhood champions who inform Government policy, one of which was an Infant Feeding Specialist. Dads are supported via the digital platform which gave hints and tips on how dads could support their partner; and
- Infant feeding was second to smoking cessation as the most cost effective intervention. Employers were encouraged to look at their policies for their staff.

RESOLVED: That the Board note the importance of the continued partnership working in Infant Feeding Services

across Halton.

HWB20 UPDATE ON THE PROGRESS MADE ON THE DFE & DHSC FUNDED FAMILY HUB PROGRAMME

The Board received a report and presentation from the Director of Public Health, which provided an update on the progress to date in implementing the DFE and DHSC Funded Family Hub Programme. This included a focus on perinatal mental health and parent infant relationship and a copy of this Strategy was included in appendix 1 of the report.

In April 2022, the DfE and DHSC selected 75 Local Authorities who would become pilot areas for the Family Hubs and Best Start in Life Scheme and Halton was included. Since December 2022, work had been ongoing to develop the principles of the Family Hub Model.

The goal of a Family Hub was to make a positive difference to parents, carers and their children by providing a mix of physical and virtual spaces, as well as outreach, where families can access non-judgemental support for any challenges they may face. Family Hubs provide a universal "front door" to families and offer a "one stop shop" of family support services across social care, education, mental health and physical health needs, with a comprehensive "Start for Life" offer for parents and babies.

In December 2022, Halton launched 3 Family Hub sites in Widnes and 3 in Runcorn and these were based in:

- Windmill Hill;
- Brookvale;
- Halton Lodge;
- Kingsway;
- Warrington Road; and
- Ditton.

In July 2024, the Family Hubs launched "Family Hubs Online" which was a digital automation solution that delivered national and local content and services, which could be easily accessed via any device 24/7. Within 5 months, Family Hubs Online had received over 7,000 users and the top 5 pages viewed were: family hubs home; events; HENRY – healthy families; Start for Life and Adults. Further developments were ongoing on the platform and these were outlined in the report.

Halton was awarded funding to transform services across 6 strands which included:

- Transformation;
- Parenting;
- Infant Feeding;
- Perinatal mental health and parent infant relationship
- Early language and home learning environment; and
- Start for Life and parent/carer panels.

It was important to fund Family Hubs, as it was highly cost effective to support early years and the benefits achieved would have an impact on future services.

The report also outlined the successes of Halton's ambitious approach, which as a result had received, local, regional and national acknowledgement.

The Board noted and discussed the information presented to them and congratulated staff on the success of their work. The Chair also shared some feedback from a service user who had spoken highly of their experience and expressed gratitude for the help they had received.

RESOLVED: That the Board adopt the Halton Family Hub Perinatal Mental Health and Parent Infant Relationship Strategy.

HWB21 ADULT SOCIAL CARE ANNUAL REPORT (2023-2024)

The Board received the Adult Social Care (ASC) Annual Report 2023/24, also referred to as the Local Account. The theme of this years' report was "prevention and wellbeing".

The report highlighted the work that had taken place over the last 12 months in responding to National and Local drivers of prevention as a catalyst for change in how services were delivered to prevent or delay the need for statutory services.

The report also contained high level data on service usage, spend, customer care and safeguarding.

RESOLVED: That the Board note the report.

Meeting ended at 4.00 p.m.

REPORT TO: Health & Wellbeing Board

DATE: 12 March 2025

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health & Wellbeing

SUBJECT: Tobacco

WARD(S) All

1.0 **PURPOSE OF THE REPORT**

1.1 To provide members of the Board with an update on tobacco programmes included planned next steps.

2.0 **RECOMMENDED: That**

1) **the report be noted; and**
2) **the Board supports ongoing activity in local and regional plans.**

3.0 **SUPPORTING INFORMATION**

3.1 **Despite a decline in prevalence over recent years, smoking is still the main preventable cause of death, disability and ill health** in England. It causes around 75,000 deaths a year, 1 in 4 of cancer deaths and kills up to two-thirds of its long-term users.

3.2 The smoking prevalence in Halton is estimated at **around 13.7% of adults.** This means that Halton is close to the national average (12.4%) but there is no safe level of smoking so continued efforts to reduce local prevalence are needed.

3.3 ASH (Action on Smoking and Health- UK's main charity campaigning for tobacco control) **estimates that it costs Halton around £89M in productivity, £5M in healthcare and £45M in social care. In addition, there is an estimated loss of £102M due to premature deaths from smoking in Halton.**

3.4 **Halton Borough Council signed the Local Government Declaration on Tobacco Control in 2014.** It is a statement of a council's commitment to ensure that work on tobacco is part of wider public health work and commits the council to take comprehensive action to address the harms from smoking.

3.5 Halton's local tobacco alliance was paused due to the pandemic. **The local tobacco alliance was reformed in 2024**, as part of the 'Live Well' programme within One Halton and is chaired by a consultant in public health on behalf of the Director of Public Health.

3.6 Local partners (including NHS providers and commissioners, medicines management, VCFSE partners and an ongoing programme of reaching out to other agencies and organisations). have joined together to help Halton to become smokefree by 2030, reflecting government ambitions for a 'smoke free generation'. The alliance provides a focus and platform for partners to advocate, coordinate and monitor activities and programmes that contribute to Halton becoming 'smokefree by 2030'. This means an aim to reduce prevalence of smoking to 5% or less by 2030.

3.7 The alliance is working through a self-assessment to inform a new local strategy which will be underpinned by MPOWER measures. These measures were developed by the World Health Organisation and provide a framework to help implement effective interventions to reduce the demand for tobacco. MPOWER stands for:

- **Monitoring tobacco use**- the recent introduction of a new smoking dashboard for use across Cheshire and Merseyside providing information at ward level will help inform local system.

- **Protecting people from tobacco smoke** there is already a smoke-free indoor public places ban in place protecting people from the harms of second- hand smoke. Efforts to reduce prevalence further should help to reduce effects in private spaces also

- **Quitting tobacco** Efforts across the system are being reviewed to identify further opportunities for supporting those trying to quit tobacco whilst balancing efforts to 'stop the start' of both tobacco and vapes (the latter should only be used as a stop smoking aid).

- **Warning about the dangers of tobacco** This spans from health warnings on tobacco (and recent consultation on vape packaging also) through to media campaigns at national and regional levels. Local efforts are to align with these existing campaigns to maximise the reach.

- **Enforcing tobacco advertising, promotion & sponsorship bans** There are already bans on advertising of tobacco, there has been national consultation on advertising of vapes as there is ongoing debate on the benefits of vapes to those trying to stop smoking versus the risks to those (particularly children) being attracted to start

vaping in part it is believed, due to the packaging and range of flavours.

- **Raising taxes on tobacco-** there are already considerable taxes on tobacco and a new duty on vaping is also being examined.

3.8 Our local strategy will also be aligned to national guidance for local authorities as well as the regional programme known as All Together Smokefree. **All Together Smokefree,** funded by local authorities and the ICB within Cheshire and Merseyside, is currently working with Healthwatch to speak to the public to raise awareness of stop smoking services and gather opinions and stories from communities as well as highlighting the current Tobacco and Vapes Bill.

3.9 Within the local authority there are two principal areas of work; **tobacco control** and **stop smoking services.**

3.10 **Tobacco control,** led by the **Trading Standards team** which has a range of powers to deal with the illicit tobacco and vapes. **Illicit tobacco reduces the public health impact of tobacco tax rises** and increases demand for tobacco products. **Illegal vape products are also an issue**; consumers risk health and safety concerns as well as unregulated ingredients including illegal quantities of nicotine.

3.11 **The Trading Standards team has adopted a multi-faceted approach to tacking illicit tobacco and illegal vapes**. As well as prosecuting offenders, the team uses intelligence to target premises and disrupt illegal activity by seizing illegal and illicit products to remove them from the market, of using tobacco detection dogs.

3.12 **Since 2019 the team have seized nearly 151,871 illegal cigarettes with a value of around £136,684**, and **since 2024 the team have seized around 7,331 illegal vapes with an estimated value of £51,000.**

3.13 The most recent approach is the use of **Closure Orders under the Anti-Social Behaviour Crime and Policing Act 2014 to close premises that are persistently found to sell illegal products, and also sell the illegal products to children**. Two premises have been closed to date, and there are other premises intended for closure in the coming months. One of which we have received intelligence from working closely with the stop smoking service, illustrating the crossover in our work, and how partnership is working within the public health directorate.

3.14 **There are also the additional sanctions for HMRC to fine businesses up to £10,000 for each seizure of illicit tobacco and**

to remove their ability to sell tobacco. Trading Standards are able to refer cases to HMRC to administer the sanction and provide the valuable intelligence regarding those involved in the illegal manufacture, importation or distribution of tobacco in the UK.

3.15 **Stop Smoking Services** for residents of Halton are largely provided by the Public Health Improvement Team. Additional services for residents are also provided by 15 pharmacies and GP practices who may provide similar services. Tobacco dependence services within NHS trusts to help patients to stop smoking are also available to Halton residents. The Health Improvement Team supports clients to stop smoking over a 12-week programme offering behavioural support on a weekly basis, including carbon monoxide readings, alongside a choice of Nicotine Replacement Therapies (NRT), stop smoking medications and vapes. The service is delivered from a variety of community venues across Halton including Widnes Market, community centres and Family Hubs.

3.16 Referrals into the service are received from a variety of organisations and professionals (as well as self-referrals from Halton residents). **Around 1500 referrals have been received over the last year (until 6th February 2025).**

3.17 There is an ongoing national focus on stopping smoking. This year, Stop Smoking Services in Local Authorities received government funding to increase demand into their service by increasing capacity which should result in an increased number of people quitting smoking.

3.18 The team has been working with partners including CGL (Change, Grow, Live) a service to promote recovery from addiction and dependence. Smoking cessation training, including the use of vapes as a 'quit aid' was delivered to staff and is being enhanced by the supply of vapes via the national Swap 2 Stop Government funded scheme.

3.19 Finally, most people who quit smoking do so without using Stop Smoking Services. People who quit with the support of high-quality local stop smoking services have at least triple the success with quitting, compared to no support. The team are working with Healthwatch to gain insight as to why people may not use services and to also increase awareness of services.

3.20 **Whilst vapes are one of the most effective stop smoking aids however, it is important to remember that vaping is not risk free** and advice from the Chief Medical Officer is that vapes are only for those trying to stop smoking and not for those who have never smoked. In 2022, UK experts reviewed the evidence and found that 'in the short and medium term, vaping poses a small fraction of the risks of smoking'.

3.21 **There is growing concern that children are increasingly attracted to vaping** nationally around a quarter of 11 to 15 year olds have tried vaping and nearly 1 in 10 do vape regularly. A survey of primary and secondary schools in Halton to understand substance use received 10 or more responses from 3 secondary schools and 3 primary schools with a total number of 561 responses. The survey reported that around 1 in 10 children (aged between 10 and 16 years old) used vapes at least on a monthly basis with around 27% of those who had tried a vape, had done so aged 10 or younger.

3.22 The Health Improvement Team have delivered tobacco and vape training to members of the Children and Young People team, further enhancing their knowledge and providing them with the latest information on vaping for them to deliver in Halton schools.

4.0 POLICY IMPLICATIONS

4.1 Actions across Halton are informed by the evidence base and underpinned by existing legislation. The Tobacco and Vapes Bill is going through the parliamentary process. At the time of writing, the Bill (as amended by the Public Bill Committee) is due to have its report stage and third reading on a date to be announced.

4.2 This legislation has been described as a significant opportunity to allow future generations to grow up smoke free, without the individual and societal impacts of smoking currently affecting the UK. The Bill has public support and is also widely supported across health organisations and systems; the Cheshire and Merseyside Public Health Collaborative (CHAMPS) submitted evidence in support of the Bill to the Tobacco and Vapes Bill Committee.

4.3 The intention of the Bill is to

- create a smoke-free generation, gradually ending the sale of tobacco products across the country and breaking the cycle of addiction and disadvantage.
- strengthen the existing powers to ban smoking in public places to reduce harms of passive smoking, particularly around children and vulnerable people.
- ban vapes and nicotine products from being deliberately branded, promoted, and advertised to children to stop the next generation from becoming hooked on nicotine.
- provide powers to introduce a licensing scheme for the retail sale of tobacco, vapes and nicotine products, extend the retail registration scheme in Scotland, and strengthen enforcement activity to support the implementation of the above measures.
- the Bill sits alongside wider support across the health service to support smokers to quit

4.4 It is anticipated that the final legislation (which may be further amended) will have a significant impact on local activity (particularly around tobacco control services) which will need to be acted upon at the time of commencement of new legislation.

4.5 At the same time, there is additional legislation either in process or has been announced with local implications.

4.6 From 1 June 2025, it will be illegal for businesses to sell or supply, offer to sell or supply, or have in their possession for sale or supply all single-use or 'disposable' vapes. This applies to:

- sales online and in shops
- all vapes whether or not they contain nicotine

This includes both online and in-store sales.

4.7 Local authority Trading Standards will lead on enforcing the ban. In the first instance, enforcement authorities will apply civil sanctions (non-criminal penalties) such as a:

- stop notice
- compliance notice
- fine of £200

4.8 There has also been an announcement to introduce a vaping duty. The duty is designed to make vaping less accessible to young people and non-smokers, while also raising revenue for funding vital public services like the NHS and smoking initiatives supporting a smokefree generation. Recognising that vaping has a role in helping smokers give up tobacco, the government will also introduce a one-off increase in tobacco duty to ensure the duty on vaping does not make smoking more attractive.

5.0 FINANCIAL IMPLICATIONS

5.1 Funding for smoking cessation and tobacco control is funded via the public health ringfenced grant.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

As described above, smoking is the main preventable cause of death, disability, and ill health. Reducing the prevalence will have a significant impact on individual and population health.

6.2 Building a Strong, Sustainable Local Economy

Estimates as described above suggest that tobacco causes £89M costs to the economy. Reducing the prevalence of smoking would have a significant impact on the local economy.

6.3 **Supporting Children, Young People and Families**

Smoking affects both those who smoke and those who are forced to inhale second hand smoke. Reducing the prevalence would improve the health of those smoking and those living with them including children and young people.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**

Those living in the most deprived areas are some of the most likely to smoke and suffer the consequences of poor health as a result. Reducing the prevalence would help reduce the resulting health inequalities.

6.5 **Working Towards a Greener Future**

Tobacco is harmful to the environment through several mechanisms from production, usually in developing countries through to air pollution during their consumption and then the impact of the waste products. Cigarette butts are not considered biodegradable and can cause land and water pollution if not disposed correctly. A reduction in prevalence will have a positive effect on reducing the local environmental impact of smoking.

Vaping products, particularly disposable vapes can be difficult to recycle as made from multiple materials including lithium batteries. It is anticipated that the new legislation due to commence later this year will also have a positive local effect in reducing the volume of vapes thrown away as litter.

6.6 **Valuing and Appreciating Halton and Our Community**

None identified.

7.0 **RISK ANALYSIS**

7.1 None identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

None identified.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 It is complex to estimate the total impacts from the manufacture, consumption and residual waste from the tobacco industry.

9.2 One estimate, reported to the World Health Organisation suggests the following environmental impact of one person smoking a pack of 20 cigarettes every day for 50 years, would result in:

- A total carbon footprint of 5.1t CO2 equivalent emissions, which to offset, would require 132 tree seedlings planted and grown for 10 years.

- A water footprint of 1,355 m3, which is equivalent to almost 62 years' water supply for any three people's basic needs.

- Total fossil fuel depletion of 1.3 tonne oil equivalent, which is comparable to the electricity use of an average household in India for almost 15 years

9.3 A reduction in prevalence will have a positive effect on reducing the local and international environmental impact of smoking.

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

Statistics on Public Health, England 2021 - NHS England Digital

Fingertips | Department of Health and Social Care

Data and Cost Calculators - ASH

Minutes 15/01/2014, 13.00

All Together Smokefree | Champs Public Health Collaborative

Tobacco Scams

quit smoking

stop smoking services effectiveness 2024-25 v1

Chief Medical Officer for England on vaping - GOV.UK

Smoking, Drinking and Drug Use among Young People in England, 2023 - NHS England Digital

New Tobacco and Vapes Bill backed by public, health charities and politicians - ASH

240121en.pdf (Tobacco and Vapes Bill Explanatory Notes)

Nicotine vaping in England: 2022 evidence update - GOV.UK

Single-use vapes ban - GOV.UK

Vaping_Products_Duty_consultation_response.pdf

REPORT TO: Halton Health & Wellbeing Board

DATE: March 12th 2025

REPORTING OFFICER: Director of Integration – Mersey and West Lancashire Hospitals

PORTFOLIO: Health

SUBJECT: Health Inequalities Dashboard

WARD(S) All

1.0 PURPOSE OF THE REPORT

1.1 To demonstrate the Hospital Trust's Health Inequalities Dashboard and share the next steps of its development.

2.0 RECOMMENDED: That

1) **That Board members note the establishment of the Health Inequalities Dashboard and its capabilities.**

2) **That the Board endorse the collaboration with Warrington and Halton Hospitals FT so that a more complete picture of acute care across Halton is available.**

3.0 SUPPORTING INFORMATION

3.1 Mersey and West Lancashire Hospital Trust is committed to being an Anchor Institution. The Trust is a significant provider across six 'Places'. Within Halton the trust provides care for around 50% of the population with a particular focus around Widnes and the surrounds.

3.2 A recent Kings Fund Health Inequalities paper sited a number of uncomfortable statistics:

People in the most deprived areas are twice as likely to die prematurely from cardiovascular disease than people in the least deprived areas. 111 deaths per 100,000 in the most deprived areas of England compared with 55 in the least deprived areas as of 2022. Source: Office for Health Improvement and Disparities 2024.
People living in the most deprived parts of England are more than twice as likely to wait over a year for elective care than people living in the most affluent areas in 2022. Source: Robertson *et al* 2023.

The difference in life expectancy for people living in the most deprived areas of England compared with the least deprived areas is 9.7 years for males and 7.9 years for women.
2018- 2020
Source: Office for National Statistics 2022.

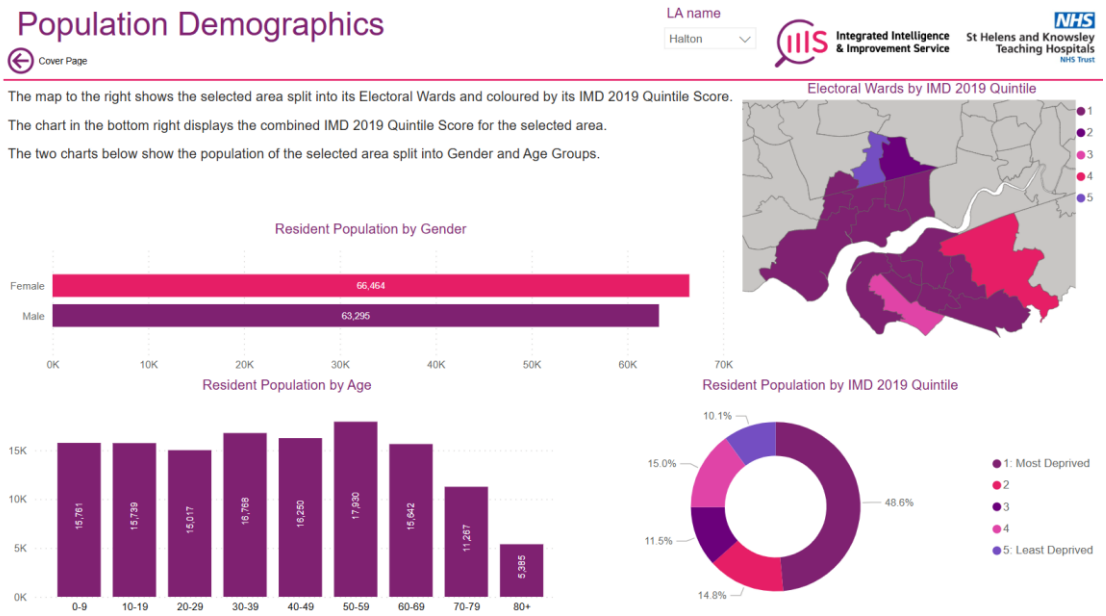
The Trust is committed to reducing health Inequalities and has developed a dashboard that uses near live data to support this journey. It is also interesting to see how well the statements above present themselves in the Trust's activities. The dashboard uses 'Power BI' as its platform and this provides a lens on the places serviced by the St Helens and Knowsley Hospitals.

3.3 The next steps in the development of the dashboard will be to complete the activity undertaken with in the wider Trust's footprint to include Sefton and West Lancashire.

3.4 The Trust has been in dialogue with Warrington and Halton Hospitals FT to explore the possibility of providing this system to their Trust. This would give a more complete picture of acute care in Halton.

3.5 The dashboard holds demographic data of local boroughs as well as elective and non-elective activity across the Trust. The next few sections illustrate the capability of the dashboard in the form of a few screen shots.

3.6 Demographics:



3.7 Non-Elective Care

Non-Elective Admissions per 1,000 Population

IMD 2019 Quintile	Non-Elective Admissions	Inpatient Admissions per 1000 population
1: Most Deprived	5,905	94
2	2,003	105
3	1,300	87
4	1,092	56
5: Least Deprived	1,335	102

Non-Elective Admissions per 1,000 Population

IMD 2019 Quintile	Non-Elective Admissions	Inpatient Admissions per 1000 population
1: Most Deprived	5,905	94
2	2,003	105
3	1,300	87
4	1,092	56
5: Least Deprived	1,335	102

3.8 Elective Care

First Outpatient Waiters per 1,000 Population

IMD 2019 Quintile	OP Waiters	OP Waiters per 1,000 Population
1: Most Deprived	2,463	39
2	845	44
3	655	44
4	648	33
5: Least Deprived	745	57

Inpatient Waiters per 10,000 Population (Gastroenterology Excluded)

IMD 2019 Quintile	Inpatient Waiters	Inpatient Waiters per 1,000 Population
1: Most Deprived	1,359	22
2	522	27
3	423	28
4	436	22
5: Least Deprived	506	39

IMD 2019 Quintile	Elective Admissions	Elective Admissions per 1,000 population
1: Most Deprived	3,344	53
2	1,308	68
3	1,131	76
4	1,169	60
5: Least Deprived	1,374	105

4.0 POLICY IMPLICATIONS

4.1 Mersey and West Lancashire Trust has developed a Health Inequalities Strategy and is developing a work programme to deliver its strategy.

4.2 Linking with Warrington and Halton Hospitals will enable a more complete picture of Acute Care in Halton, and it has the potential to be used across Cheshire and Merseyside.

4.3 The data from the dashboard along with insights from public health information should lead to changes in service provision and lead to a reduction in health inequalities.

5.0 FINANCIAL IMPLICATIONS

5.1 There are no direct financial implications from this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

Providing support for people to access services will improve the health and wellbeing of residents.

6.2 Building a Strong, Sustainable Local Economy

Prompt and appropriate care will support a healthier and more productive workforce that will enhance the local economy.

6.3 Supporting Children, Young People and Families

Children, Young People and families are a significant patient base of the trust. We do see high 'do not attends' in some paediatric services. Improving access is important to health.

6.4 Tackling Inequality and Helping Those Who Are Most In Need

This is the primary focus of the paper and presentation. We envisage working towards a significant reduction in health inequalities.

6.5 Working Towards a Greener Future

N/A

6.6 Valuing and Appreciating Halton and Our Community

N/A

6.7 Resilient and Reliable Organisation

N/A

7.0 **RISK ANALYSIS**

7.1 N/A

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 Further work is required include wider diversity data

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 None

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

All reports must contain this heading. Background papers are described as those upon which you have relied to write your report. They could for example be Government legislation, previous Board reports or Strategies. State the title of the document(s), where they can be inspected and a contact officer.

If there are none, include the following sentence:-

Tackling Health Inequalities | Seven Priorities For The NHS | The King's Fund

REPORT TO:	Health & Wellbeing Board
DATE:	12 March 2025
REPORTING OFFICER:	Sally Yeoman Chief Executive Officer – Halton and St Helens VCA Rebecca Taylor – Head of Operations – Community Mental Health
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Social Need Support for Secondary Care Mental Health Patients
WARD(S)	All

1.0 **PURPOSE OF THE REPORT**

1.1 To provide an update on the integrated offer between Mersey Care and Voluntary Community Faith and Social Enterprise (VCFSE) sector to address social needs of secondary care mental health patients to support delivery of the One Halton Living Well Strategic Priorities.

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

3.0 **SUPPORTING INFORMATION**

3.1 **Introduction & Background -** The NHS Mental Health Implementation Plan 2019/20 – 2023/24 identified the need for the Involvement of the VCFSE sector to help realise the identified patient benefits stating:

- The involvement of the VCFSE sector in the design and delivery of services can ensure that they are genuinely co-produced, recognising the local context.
- Systems, commissioners and mental health providers are asked to consider how the VCFSE sector could support local ambitions and whether the current commissioning approach encourages, or blocks, their involvement.

3.3 To support the delivery of the NHS Long Term Plan for Mental Health, NHS England and NHS Improvement (NHSE/I) provided an opportunity for trusts to bid for Community Mental Health transformation funding over a three-year period in line with the NHS Long Term Plan for Mental Health. The funding was for mental health in adults and older adults (not dementia care).

3.4 The funding was intended to support the interface between primary and secondary mental health care to transform delivery of care for those people who fall in the categories of severe and enduring mental illness and those with complex needs and their carers. The bid had to include specific care pathways for people with Personality Disorder, Eating Disorders and Community Rehabilitation.

3.5 Since late in 2020 Mersey Care (operating as NWB in Mid-Mersey) began discussions with the three Council for Voluntary Service (CVS) covering Halton, Knowsley, St Helens and Warrington to understand the role of the local VCFSE sector and the potential to include it as part of the transformation programme for Mid-Mersey.

3.6 In February 2021, an exploratory conversation hosted by the CVS network with local groups and organisations across the four places was held. More than 30 groups attended to hear an update on the work and to explore what role they might be able to play.

3.7 This has resulted in a new way of working with the local VCFSE sector and the adoption of a model led by the CVS network, supported and funded by Mersey Care. Although we know there are some similarities within each of the places and communities in Mid Mersey, the work with the VCFSE sector requires a Place-based approach and the programme has developed a specific offer for Halton to address local need using the unique Place community assets available. Due to the success of the Mid-Mersey work pilot the Trust has adopted this approach across it's whole footprint and implemented a strategic forum to lead the work.

3.8 Mental Health Care Navigators across the three places have been appointed with the skills, attributes and local experience to ensure they are able to support clients/carers on an individual need basis. It is expected users will be supported for up to 6 weeks to ensure they have been supported to access the most appropriate level of bespoke support within the community to meet their individual needs. The Mental Health Care Navigators work with users/carers to build up a good rapport and foster healthy and positive service user-care navigator relationships.

3.9 **Halton -** The work In Halton built on the ICB commissioned support that helped develop a Mental Health Alliance in the local VCFSE sector and tested out a link worker approach. What has evolved is the creation of two VCFSE Mental Health Navigator roles, managed by Halton & St Helens VCA, but embedded in the secondary care community teams and Mental Health in-patient Units. The service:

- Act as a connector/sign-poster between health care professionals, VCFSE groups and local people
- Facilitates a Voluntary Sector Mental Health forum and builds an alliance of local VCFSE sector providers that support

engagement between mental health professionals and the sector

3.10 **Capacity Building Support for Peer-support and Third Sector Crisis Prevention groups.** The service has built upon Halton & St Helens VCA's (VCA hereafter) existing programme of Third Sector support. VCA are Halton's Council for Voluntary Sector (CVS) and have a membership of over 500 Halton based VCFSE Sector organisations. VCA offer a tailored programme of support, training and networking opportunities that are aimed at both existing VCFSE sector mental health organisations and the development of new ones.

3.11 **Core Outcomes / Benefits:**

- The provision of a point of contact for mental health improvement, allowing for greater cross-sector working between NHS, Council and VCFSE partners.
- Being based with VCA allows for joined up offers of support, as a central location with several Third Sector partners already based there.
- Service users accessing the site will have opportunities to engage with other services and projects, increasing the range and type of support available.
- The Navigators offer a varied range of support for groups that support people with protected characteristics such as veterans, disabled people and carers
- An investment fund that has supported the development of capacity within the sector to achieve the ambitions of the transformation programme.

3.12 **What we have delivered:** Since inception the whole programme has provided **£64k investment into 14 VCSE projects and programmes.** These programmes have supported individuals living with a Serious Mental Illness including 4 short term winter crisis interventions from December to January 24 / 25.

3.13 **Quarterly Mental Health Alliance** - bringing together representatives of local VCFSE, working in partnership with the statutory and clinical mental health services, creating an interface between them. Sharing knowledge and good practice and identifying opportunities that ensure residents of Halton get the right mental health support at the right time. Key goals set out by VCSE alliance members include:

- Increasing investment and growth in the sector to support increase in demand and create preventative services and activities.
- Developing a recognised kite mark for trusted providers that isn't onerous but gives a level of assurance around service

and support expectations.

- Identifying, sourcing and / or developing relevant training to support alliance members specifically around mental health support.
- aligning services to an appropriate directory that highlights trusted providers

3.14 **Mental Health Care Navigator Team have:**

- Received 179 referrals (end of January 2025) with identified needs covering:
- reducing anxiety and social isolation
- increasing activities in the community, increased learning, engaging in volunteering.
- Discharged 65% of referrals
- engaged individuals with over 40 different activities
- Worked closely with referring teams to improve communication, quality of information and reduce referrals where individual isn't ready.
- supported individuals to share their lived experience.

3.15 **Strategic Development** – Identifying needs and gaps in and around the sector and supporting collaboration of new services including:

- Runcorn Deaf Club with Deafness Resource Centre
- Photography sessions with Hazelhurst Studios
- Developing Crisis intervention support offer with Sean Bailey Wellness and Space Runcorn

4.0 POLICY IMPLICATIONS

4.1 None

5.0 FINANCIAL IMPLICATIONS

5.1 Service is funded from NHSE via Community Mental Health Transformation monies and a three-year contract is in place with the option to extend for a further two.

5.2 Further work will be undertaken to determine if cost savings are achieved via a reduction in length of stay in community teams and a reduction in crisis presentations from this cohort.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

This integrated service offer contributes to the delivery of this priority

by facilitating access for secondary Mental Health patients to community assets to reduce dependence on statutory services.

6.2 **Building a Strong, Sustainable Local Economy**

This investment has created two additional jobs for local people.

6.3 **Supporting Children, Young People and Families**

The families of Secondary Care mental health patients who receive this service benefit from the improved wellbeing of their relative and the additional safeguarding support provided by the additional resource.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**

Research indicates that people with mental health conditions often experience worse physical health outcomes. This includes higher rates of chronic diseases and lower life expectancy (Kings Fund 2024) and this service seeks to address this by working directly with the most vulnerable secondary Care mental health patients and connecting them to community assets that can help prevent poor health.

6.5 **Working Towards a Greener Future**

By connecting secondary care mental health patients to the local community offer this has reduced unnecessary travel.

6.6 **Valuing and Appreciating Halton and Our Community**

This model was co-produced with the sector and therefore embraces the strength that communities can play in the recovery journey of secondary care mental health patients.

7.0 **RISK ANALYSIS**

7.1 Financial challenges in the VCFSE sector from changes to National Insurance may mean a reduction in the local community offer. An example of this financial pressure is the recent closure of the MIND service in Halton. Halton & St Helens VCA are working with partners including Mersey Care to manage and mitigate this risk.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified. Service intends to address equality and diversity challenges aced by Halton Secondary Care mental health patients by connecting them with community assets.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 This service will positively impact climate change by reducing unnecessary travel by ensuring patients are connected to the local community offer.

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

One Halton Health and Wellbeing Strategy 2022-27 – Director of Public Halton Metropolitan Borough Council

NHS Mental Health Implementation Plan 2019/20 – 2023/24 – Claire Murdoch - National Mental Health Director and Senior Responsible Officer, NHS England and NHS Improvement

Mental Health 360 | Inequalities | The King's Fund - Helen Gilburt Saoirse Mallorie

Halton & St Helens
Voluntary and Community Action

NHS
Mersey Care
NHS Foundation Trust

Integrated offer to provide Social Need Support for Community Mental Health Patients

Sally Yeoman | CEO Halton & St Helens VCA
Rebecca Taylor | Head of Operations Head of Operations Mersey Care

Overview

Halton & St Helens Voluntary and Community Action

NHS Mersey Care NHS Foundation Trust

- To support the NHS Long Term Plan for Mental Health, trusts can bid for Community Mental Health transformation funding
- The funding was for mental health in adults and older adults (not dementia care)
- Focus on severe and enduring mental illness and those with complex needs and their carers
- In February 2021, CVS network hosted a workshop consisting of 30 local groups and organisations across the four places.

VCFSE Governance

Alliance Group

- Meets Quarterly
- Forward thinking Agenda items
- Strategic Priorities
- State of the Sector
- Barriers/ Challenges to delivery
- Summary of other meetings

Operational Group

- Meets every month
- Relationship Building
- Vignettes/ Good News Stories
- Operational Issues
- Shared Training

Contract Meeting

- Meets every month
- Formal Standard Quality Assurance Agenda/Contracts

Halton Care Navigators

Halton & St Helens Voluntary and Community Action

NHS Mersey Care NHS Foundation Trust

2 x Mental Health Care Navigators supporting patients with SMI and complex needs

Hosted by VCA, embedded in secondary care community teams and in-patient units

Health Care Navigator Team have received 179 referrals including:

Reducing anxiety and social isolation increasing activities in the community, increased learning, engaging in volunteering

Discharged 65% of referrals engaged with over 40 different activities

Worked closely with referring teams to improve communication, quality of information and reduce inappropriate referrals

Halton Care Navigators

Halton & St Helens Voluntary and Community Action

NHS Mersey Care NHS Foundation Trust

Performance and Activity Reports

Indicator	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
[HVA1] Number of referrals received	4	21	14	13	11	5	12	9	6	95
[HVA2] Number of F2F contacts	16	13	9	6	6	3	7	3	2	65
[HVA3] Number of Non-F2F contacts	24	34	23	23	20	6	27	8	17	182

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Total
8	4	5	9	6	12	7	16	5	99
13	12	4	0	1	14	7	12	1	76
42	16	9	6	0	27	17	30	4	203

Contract Requirements: The service will support safer transitions and community engagement both in Inpatient and Community settings. There will be two Care Navigators for each Borough. With a range of populations of between 88,000 and 209, 547 for each Borough and many wards according to council Websites. This role has the potential to further enhance each Boroughs population's current mental health services through a joined-up partnership working approach.

Since the teasm have had access to Rio the data pulling through our systems is as below:

Indicator	Feb-24	Mar-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Total
[HSH1] Number of referrals received	1	1	1	1	1	1	11	11	19	4	51
[HSH2] Number of F2F contacts									50	57	107
[HSH3] Number of Non-F2F contacts								1	31	38	70
[HSH4] Number of meetings achieved								1	81	95	177

Service User Stories

Background of patient/ reason for referral:

- Suicidal ideations (thoughts of hanging herself) and overdoses
- Isolating at home as signed off work due to being unwell
- Feels unsupported by work, too anxious to go outside, lacks motivation, disinterested, loss of confidence and gets overwhelmed easily

Intervention/ support received

- Referral to Care Navigator for introduction to services/ cafe
- Regular telephone contact and weekly meets at the community café
- Using Motivational Interviewing and Graded exposure to support

Outcome

- Going to the community café on her own, attended classes
- Linking in with IPS to look at getting a different job that will support her
- Registered with volunteer centre and exploring volunteering/ peer support
- Active role as a grandparent, feels a lot better than she did.

Service User Stories

Halton & St Helens Voluntary and Community Action

NHS Mersey Care NHS Foundation Trust

Background of patient/ reason for referral:

- Deaf client referred from Brooker centre, who has mental health problems
- Feeling isolated and lonely, especially through communication barriers
- Safeguarding issues, social needs and demonstrably vulnerable

Intervention/ support received

- Accompanied to Weaver Arts Centre at Grangeway Community Centre
- Helped communication with sign language cards and BSL tools
- Linking with Deafness Resource Centre to support social needs

Outcome

- Socially connected with arts groups who greet her in BSL
- Managed safeguarding issue with appropriate support form agencies
- Enabled improvements to the home for security and accessibility
- Feeling more confident and connected, improved wellbeing, reduced low mood and depressive episodes

Service User Feedback

Halton & St Helens Voluntary and Community Action

NHS Mersey Care NHS Foundation Trust

"Shirley is my Care Navigator and has been helping and supporting me. She has helped me re-connect with people."

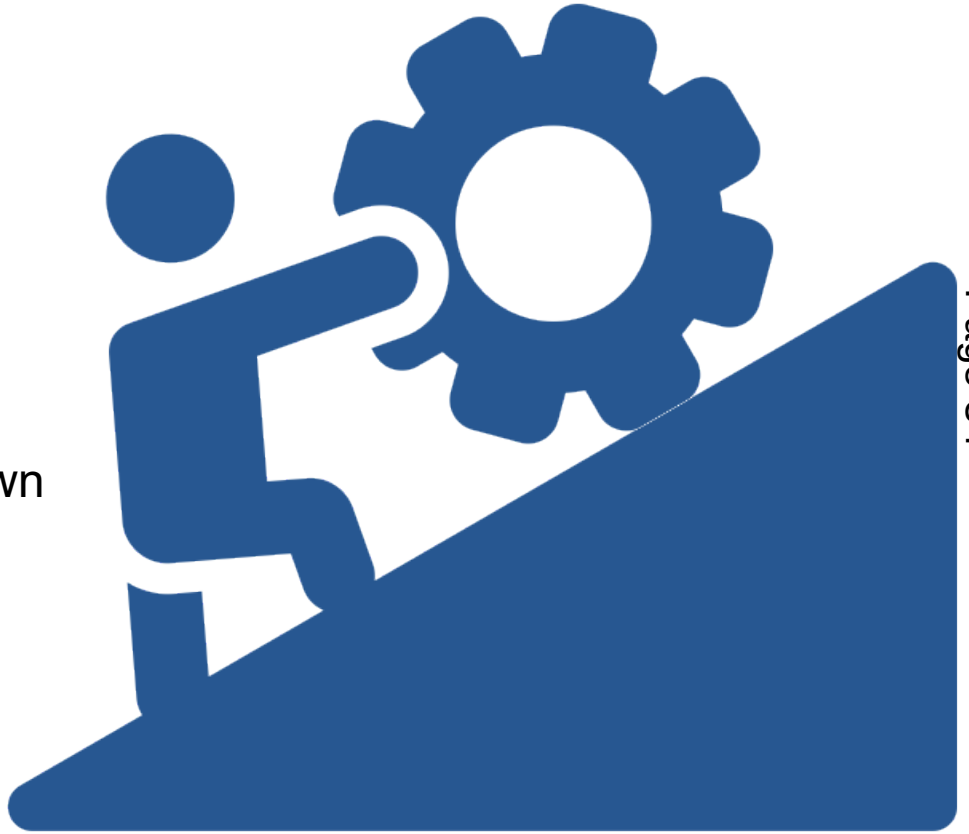
"She is/ has been an absolute angel to me, she listens, advises and never judges me. Without her in my life I wouldn't want to have carried on living. She has encouraged me to focus on what is important. She's amazing and I wouldn't be here without her"

"The Mental Health Care Navigator, supported and encouraged me through every step of the process. I felt valued and validated. Through talking with her, she instantly knew my strengths and where best to apply them, by tailoring her service to my needs"

"Without the help of Fran and the service, I believe I would still be lying in that bed with no purpose and no reason to leave my flat."

Challenges Identified

- Access to information
- Ongoing maintaining/ referrals to VCSFE
- Training for VCSFE- addressed through training programme
- Data flow – ongoing access to Rio now addressed and services have access
- Access back to services when stepped down
- Timely discharge from VCSFE
- Managing expectations of patients/ service users



Halton & St Helens
Voluntary and Community Action

NHS
Mersey Care
NHS Foundation Trust

Questions

Sally Yeoman | CEO Halton & St Helens VCA
Rebecca Taylor | Head of Operations Mersey Care

REPORT TO:	Health & Wellbeing Board
DATE:	12 March 2025
REPORTING OFFICER:	Executive Director, Adult Social Care
PORTFOLIO:	Adult Social Care
SUBJECT:	Adults Principal Social Worker - Annual Report (October 2024)
WARD(S):	Borough wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of this report is to provide an annual progress report from the Adults Principal Social Worker, (APSW), to discuss how the role of social work, supports Halton Borough Council to meet its priorities and objectives.

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

3.0 **SUPPORTING INFORMATION**

3.1 **Background**

3.1.1 The APSW is a statutory requirement under The Care Act 2014. The national guidance on the role and responsibilities has evolved and been updated and clarified over recent years. The Principal Social Workers, has a key role in representing and promoting the social work profession. Principal Social Workers should in brief:

- Lead and oversee excellent social work practice
- Oversee quality assurance and improvement of social work practice
- Support the development of creative and person centred support to Halton residents
- Link in with the monthly regional and National ADASS PSW Networks
- Advise the Director of Adult Social Services (DASS), SMT, Management Team and/or wider Council in complex or controversial cases and on case or other law relating to social work practice.

3.2 **Strengths Based Approaches and Practice**

3.2.1 Halton Borough Council Social Workers in ASC are skilled and committed to their personal development, as well as ensuring we provide an excellent service to people who are in receipt of support and their carers. Over the past twelve months, Halton has commissioned Helen Sanderson Associates to provide Strengths based training across adult social care, initially gaining feedback from people with lived experience on the new social care documentation. We have completed 2 Cohort's for 250 staff and 2 Train the Trainers as part of the on-going roll out of Strengths based Training

for staff in the future as well as recent dedicated management training.
This has aided staff in supporting an individual to identify their strengths and abilities, wishes, feelings, hopes and aspirations.

3.3 **Specialist Training**

3.3.1 As part of the national roll out of the Oliver McGowan training, Halton now has the eLearning available to all staff , with 390 staff , having accessed it this year . We are working in partnership with the Clinical Advisor for Learning Disability and Autism Programme, NHS England North West, Training for Tier 1 webinars with 12 people completing and tier two , 'Train the trainer ' have been trained here from in-house/external care provider 's in Halton . We are now promoting opportunities for potential local experts with Learning Disabilities and Autism to train as trainers. We have met with our colleagues in HR and we are looking at how we can best support and recruit expert trainers in order to roll out the training in house.

3.4 **Workforce**

3.4.1 As part of HBC commitment to our present and future workforce development, we are supporting Community Care Workers, (Unqualified Social Work Practitioners) in accessing the Social Work degree programme, via the Apprenticeship Scheme across LJMU & Chester University . We currently have a total of eight staff training on the SWDA We have also utilised funding from HCPC to explore the new MA Social Work Degree Apprenticeship offered by UCLAN and have a successful candidate who started on that course in September 2024. In 2024 we also created the opportunity to offer an Occupational Therapy apprenticeship and have recruited an existing unqualified OT worker onto the course ran at University of Huddersfield. The APSW is working alongside social care and corporate colleagues in order to maximise the use of the apprenticeship levy for our future workforce.

3.5 **Mental Health: Think Ahead Programme**

3.5.1 This year Halton successfully partnered up with the national 'Think Ahead' programme and Mersey Care to offer the opportunity for graduates to experience both community and secure mental health services while fast tracking to a social work master's degree. This will benefit Halton's workforce plans by having the opportunity to recruit from the participants and has presented development opportunities for current Social Workers to experience the role of Consultant Social Worker and complete Practice Educator training.

3.6 **Standards For Employers**

3.6.1 In supporting our social work staff, we are using "The Standards for Employers of Social Workers in England", which states, *"Good social work can transform people's lives and protect them from harm"*

3.6.2 The Standards for Employers of Social Workers, published by the Local Government Association (LGA), set out the shared core expectations of employers which will enable social workers in all employment settings to work effectively and safely. Under the umbrella of the standards, there is a range of work taking place locally to ensure

that the social work profession is supported, including:

3.7 **The Organisational Health Check**

3.7.1 One of the requirements under Standard 1 is for employers to "ensure that mechanisms are in place to listen to and respond to the views of social work practitioners on a regular basis, in Halton we regularly undertake an annual "Organisational Health Check" to ensure the organisation remains a place where the right environment and conditions exist to support best social work practice".

3.7.2 An annual **Health Check Survey** is conducted by the LGA at a national level. Halton Social Workers have taken part in the survey in 2020, 2021, 2022, 2023 and 2024. The purpose of the health check survey is to better understand the experiences of Social Workers. It is intended to help support and deliver effective social work and means that issues can be identified an addressed and allows social workers to feel listened to.

3.7.3 Some key points to note from the attached summary of results from the 2024 survey are:

- Our average overall responses to standard 1 to 8 is higher at a score of 80, to the Northwest at 77 and nationally at 76.
- Our average overall responses workplace experiences is also higher at a score of 75, to the Northwest at 69 and nationally at 67.
- When looking at Adult social workers, there are no standards in the amber zone, they are all in the green zone, whereas last year there was one standard in the amber zone, which was CPD
- 7 of the standards have increased from last year. There is only standard 2, Effective workforce planning systems which has remained the same as last year with a score of 83. The national average response to this standard is 78.
- Standard 6, Continuing professional development (CPD) has had the biggest increase from a score of 66 last year to a score of 85 this year. This is then followed by Standard 3, Safe workloads and case allocation with a score of 70 last year to a score of 82 this year. This is then closely followed by Standard 5, Supervision with a score of 74 last year to a score of 85 this year.
- When looking more closely at the individual questions under the safe workloads and case allocation standard, last year, of particular concern was the responses to the statement "I am usually able to balance the demands of case work and the resources needed to fulfil my responsibilities." This was a score of 50 last year and this has increased to a score of 71 this year.
- Last year, in relation to the supervision standard, the lowest scoring statement was "I have uninterrupted, scheduled supervision at a suitable frequency with an appropriately skilled social work supervisor." It fell in the amber zone but it is green this year with a score of 78.
- In previous years, CPD has scored low, in particular the following statements – "My organisation provides regular/annual appraisals (or performance reviews) that are relevant for social workers" and "Within my organisation, I have an up to date plan of my professional development needs and how I and my employer will contribute to them." These were red scoring statements. There has been an increase this year for both statements. "My organisation provides regular/annual appraisals (or performance reviews) that are relevant for social

workers" has increased from a score of 47 last year to a score of 67 this year. "Within my organisation, I have an up to date plan of my professional development needs and how I and my employer will contribute to them" has increased from a score of 43 last year to a score of 68 this year.

3.8 **Quality Assurance**

3.8.1 Peer Review; Skills for Care

3.8.1.1 In February 2024, Skills for Care completed a Peer Review of Halton's ASYE Programme. This included the requirement that Halton have a robust Quality Assurance (QA) process in place and a continuous improvement cycle. The aim was to improve ASYE consistency and standards across the country. They also provide feedback to the Department of Health and Social Care and the Department for Education. The APSW & ASYE Coordinator prepared for the visit by sending through a comprehensive overview of the programme and this was acknowledge by the lead reviewer on behalf of Skills for Care. The Director for Care management, the Principal Social Worker and the ASYE coordinator , six of Halton's Newly Qualified Social Workers and three of the ASYE assessors were interviewed separately. The feedback was very positive. There was acknowledgement of the positive impact of the Practice Manager post for Adult Social Care training and development had, enabling Adult Social Care to provide a structured ASYE programme, with strong involvement from the APSW and senior management, The feedback was that the interviews with the NQSWs and the Assessors feedback on the programme was positive, with Halton placing a strong commitment to the recruitment, retention and development of social workers in Halton.

3.9 **Case File Audits**

3.9.1 The APSW worked with Managers to recently update The Case File Audits policy, following 12 months of dedicated Case file audits sessions, supporting managers to ringfence time to allow team managers time away from the teams to enable case file audits to take place. There has been a steady improvement in the quality of the audits and an understanding of the themes, which have fed into Social Work Matters agenda and Service Planning events. The themes arising recently have been, Documents were person centred, Evidence of effective partnership working, Excellent documentation of person wishes , Excellent use of MCA ,Evidence of independence being focused on within the intervention , Clear outcomes set, One case highlighted a case were a person challenged the support plan. This showed good feedback mechanisms within the team and management oversight. Evidenced the Prevention & Wellbeing Service (PWS), impact at the front door of social care.

3.10 **Culture & Practice**

3.10.1 Since the appointment of the Practice Manager for Training & Social Work Professional Development, back in February 2022, who has supported the APSW supporting overall training and development and recruitment and retention of Social Work Staff and students in a number of areas:

- Forging a positive working relationship with the Cheshire and Merseyside Social Work Teaching Partnership (CMSWTP),

- Social Work Degree Apprenticeship Programme has expanded
- A relationship with the FEI providers has been strengthened and a presentation on Social Work as a career choice has taken place with more to follow. This work has strengthen the pipeline of Social Work training, development and recruitment in Halton.
- Regular monthly support sessions have been set up for Newly Qualified Social Workers (NQSWs).
- The Continued Professional Development (CPD) of Social Workers has continued to be supported by the Social Work Matters (SWM) forums. Particular themes that have been covered are support to carers, Prevention & Wellbeing, hoarding, working with people who have complex needs.
- A monthly Social Work Matters roundup newsletter goes out, highlighting, new Government guidance, Legislation updates, and articles of interest from Social Work England, BASW, SCIE, NICE, RIPFA etc., with CPD opportunities for Adult Social Care staff
- Staff Action Leaning sets, Journal clubs and dedicated time to
- uphold their CPD requirements to uphold their registration for social work England.

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 Improving Health, Promoting Wellbeing and Supporting Greater Independence
The activity outlined in this report contributes to the attainment of this Council priority.

6.2 Building a Strong, Sustainable Local Economy
None identified.

6.3 Supporting Children, Young People and Families
None identified.

6.4 Tackling Inequality and Helping Those Who Are Most In Need
The activity outlined in this report contributes to the attainment of this Council priority.

6.5 Working Towards a Greener Future
None.

6.6 Valuing and Appreciating Halton and Our Community
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**

10.1 None under the meaning of the Act.

REPORT TO: Health & Wellbeing Board

DATE: 12 March 2025

REPORTING OFFICER: Executive Director, Adult Social Care

PORTFOLIO: Adult Social Care

SUBJECT: Principal Occupational Therapist - Annual Report

WARD(S): Borough wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of this report is to provide an annual report from the Principal Occupational Therapist (POT), to update on the role of Occupational Therapy within the Local Authority.

2.0 **RECOMMENDED: That the Board note the contents of the report and associated appendix.**

3.0 **SUPPORTING INFORMATION**

3.1 **Background**

3.1.1 The Adults Principal Social Worker, (APSW) is statutory requirement under The Care Act 2014, however at present there is no requirement in place for local authorities to have a Principal Occupational Therapist. There has been a POT in post in Halton since January 2024, with the permanent appointment being made in June 2024.

The Association of Directors of Adult Social Services (ADASS) acknowledge that having a POT to work alongside the APSW is of value and that having a diverse leadership within adult social care has a positive impact on local populations.

3.1.2 The national guidance on the role and responsibilities of the post have been detailed in the Royal College of Occupational Therapists publication, “Principal occupational therapists in adult social care services in England: roles and responsibilities”

The Principal Occupational Therapist is key in representing and promoting the profession. Principal Occupational Therapists roles and responsibilities include:

- Lead and promote excellent occupational therapy practice using a whole-systems, strength-based approach.
- Facilitate learning and development actively engage in regional and national Principal OT networks.
- Lead and advocate for the role of occupational therapy
- Advise the Director of Adult Social Services (DASS) and/or wider Council in

complex or controversial cases and on case or other law relating to occupational therapy.
- Work closely with the Principal Social Worker looking at evidence-based best practice and areas for improvement.

3.1.3 Our Occupational Therapists (OTs) work alongside social workers as the key professions in social care, enabling people who use services to live the lives they want. OTs are at the forefront of the Prevention and Wellbeing agenda empowering people to prevent, reduce or delay the need for formal services. They complete holistic assessments focussing on wellbeing and occupation and the environmental barriers within the home which impact their daily living.

Occupational Therapist's promote choice and control and positive risk taking, co-producing with the individual and those that they want involved in their lives, utilising strengths-based approaches and anti-discriminatory practice (See case study at ***Appendix 1***).

3.2 **The Role of Occupational Therapy**

3.2.1 Occupational Therapy is a regulated profession governed by the Health Care Professions Council (HCPC). Qualification involves the undertaking of an intensive programme of training at degree/masters level, and ongoing post-qualification professional development and audit undertaken by HCPC.

3.2.2 It is the POT's responsibility to promote the value of occupational therapists as key professionals who drive the prevention and wellbeing agenda through a personalised place-based approach. Occupational Therapists have the qualifications, knowledge and skills to support people to participate fully in their own lives working with complexity, risk and conflict.

3.2.3 Occupational Therapy is well placed to support the Health and Wellbeing Strategy's underlying themes, particularly:

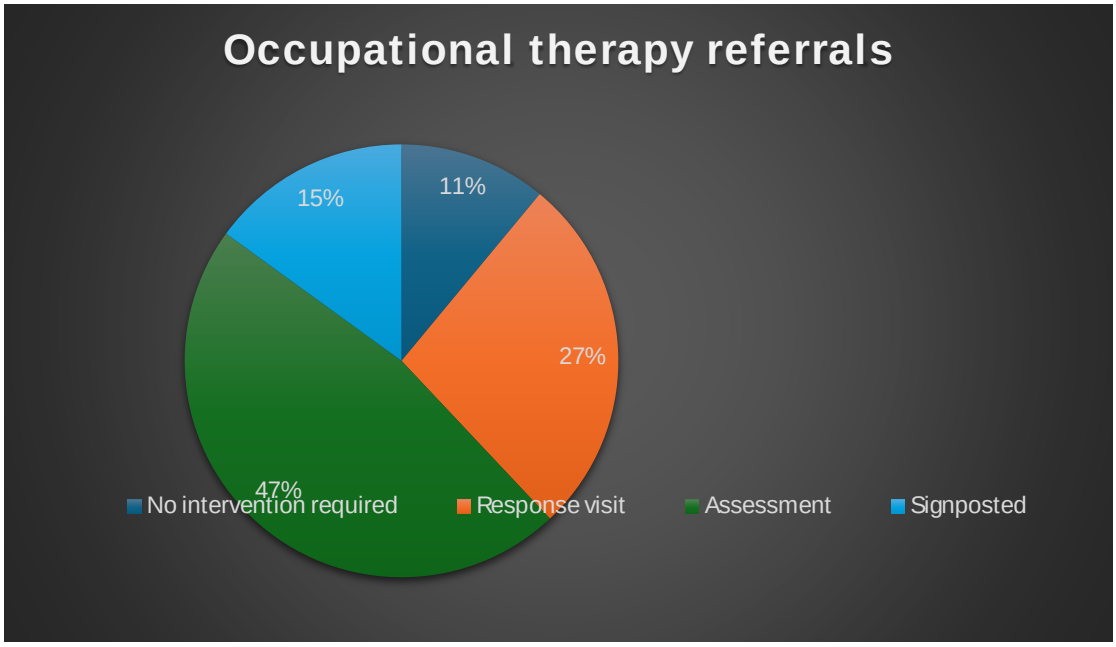
• *Support our community in Living Well*
• *Support our community in Ageing Well*

3.2.4 The Care Act 2014 is the key legislative framework along with the Housing Grants, Construction and Regeneration Act 1996. The focus for Occupational Therapy in line with this in Halton, is on:

- Prevention- timely intervention to prevent deterioration in the person's abilities or level of support required
- Independence- promoting independence and engagement in outcomes that matter to the individual
- Wellbeing- this is a subjective context to each individual but is central to occupational therapy practice
- Joining up the local authority, health and housing around the individual when appropriate

3.2.5 In February the Initial Assessment Team became the Prevention & Wellbeing

Service, with occupational therapy being a key part of the “front door” service. The changes made have renewed the focus on signposting and prevention and there has a been a very positive shift in the number of referrals requiring full assessment. On average 47% of referrals are going onto the appropriate waiting list, with the other 53% having their needs met at the point of referral or via signposting. The wait for assessment is also significantly reducing, with individuals requiring an OTCCW visit, being seen within 3 months. The wait for complex assessment from an OT is within 6 months, owing to absences.



3.3 Challenges

3.3.1 There are many challenges ahead for Occupational Therapy. There is a recruitment issue with it proving to be a national challenge to entice occupational therapists into social care from the NHS and therefore vacancies are commonplace. There is also more demand for flexible working patterns and short working weeks. There remains a high demand for occupational therapy services in Halton, including assessments in the home environment, moving and handling and blue badges.

We have utilised waiting list funding to gain additional capacity however this has been with Community Care Workers (CCW) and along with the new working practices in PWS, the number of people waiting for an OTCCW assessment has significantly reduced. However the demand for an Occupational Therapist (complex) assessment remains high.

3.4 Culture and Practice

3.4.1 The POT should encourage a culture of openness and critical reflection, promoting equity, equality, inclusivity and diversity. They will lead on embedding theory and practice principals in line with the prevention and wellbeing agendas.

3.5 **Workforce**

3.5.1 The Occupational Therapists must always adhere to the standards of practice upheld by the Royal College of Occupational Therapists (RCOT) and Health Care Professions Council (HCPC).

3.5.2 The Standards for Employers of Occupational Therapists, published by the Local Government Association (LGA), set out the shared expectations of employers. *"Employers should have a strong, clear accountability and assurance framework that promotes safe and effective occupational therapy practice, delivering positive and for filling outcomes for people; flexible, safe, effective, caring, responsive and well-led (ADASS, 2022)".*

Each standard has a detailed list of the things that employers should do in order to meet the standards – full details can be found at LGA Standards for Employers of Occupational Therapists 2022.

3.5.3 The POT and OT Practice Manager have attended a Skills for Care OT Leaders Programme funded by the Cheshire and Merseyside Allied Health Professions Faculty between April and September 2024. Leadership Impact Posters were devised (based around PWS) and the implementation of PWS and figures achieved were of great interest to the other LA's present.

3.5.4 Following the appointment of the permanent POT, the vacant Practice Manager position has been filled by the Advanced Practitioner Occupational Therapist (APOT). The APOT vacancy is awaiting approval to advertise, and once appointed to, will form a structure that mirrors social work and will enable workforce priorities to be further explored and actioned, whilst also providing a career progression pathway.

3.6 **The Organisational Health Check**

3.6.1 One of the requirements under Standard 1 is for employers to "ensure that mechanisms are in place to listen to and respond to the views of Occupational Therapists on a regular basis". In Halton we regularly undertake an annual "Organisational Health Check" to ensure these views are obtained and contribute towards the optimum working environment and conditions to promote best Occupational Therapy practice.

3.6.2 An annual **Health Check Survey** is conducted by the LGA at a national level. HBC Occupational Therapists are invited to take part in this. The purpose of the health check survey is to better understand the experiences of the social care workforce. It is intended to help support and deliver effective practice and allow Occupational Therapists an opportunity to feedback.

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 Improving Health, Promoting Wellbeing and Supporting Greater Independence
Occupational Therapy delivered by the Local Authority is key in the delivery of the Prevention agenda as set out in the Care Act 2014. Occupational Therapists are vital in promoting wellbeing and maximising independence, and this is core to their role in social care.

6.2 Building a Strong, Sustainable Local Economy
None identified.

6.3 Supporting Children, Young People and Families
None identified.

6.4 Tackling Inequality and Helping Those Who Are Most In Need
None identified.

6.5 Working Towards a Greener Future
None identified.

6.6 Valuing and Appreciating Halton and Our Community
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**

10.1 None under the meaning of the Act.

Appendix 1

Case Study

Note: Case Study has either been anonymised or pseudonyms have been used.

Case Study Title	Prevention and Wellbeing Service – Moving and Handling - Peter
Date of Case Study	January 2024

Context

Peter was referred by his care staff for a moving and handling assessment on 11th January 2024. Peter would always become more anxious if he had more than one person to support with transfers, however was beginning to struggle more using the stand aid in situ. Having to require a second person due to his difficulties was becoming a concern for Peter and the staff members.

Prior to this referral, at his last moving and handling assessment it was discussed with Peter that any further deterioration in his transfer ability would lead to hoisting to ensure safety for himself and also his support team. However Peter remains of the opinion that he does not want to be hoisted.

Action

Taking Peter's wishes into account, other equipment was explored when he was assessed. However, an alternative method or piece of equipment could not be found that maintained safe transfers. Peter did then agree to be assessed in a hoist.
Reasoning and face to face discussion were paramount to help Peter understand the reasoning and implications and agree to this change. Peter's input was key in terms of determining which types of slings would be required and for which tasks.

Peter has hearing loss and chooses not to wear hearing aids so this can be a barrier in terms of clear communication. Verbal prompts and physical gestures need to be used and he also requires physical and verbal assistance to orientate to the situation at times. Peter's initial reluctance to be hoisted was an initial barrier however this was overcome with clear communication and reasoning for recommendations made.

Outcome

In sourcing appropriate slings and supporting Peter to accept hoisting, a proportionate response to care could be achieved meaning he can continue to be transferred with just the assistance of one. This prevented the need for a second staff member's input as per Peter's wishes as well as promoting his dignity and wellbeing.

Learning

We were able to work with the support staff to ensure they could use proportionate methods and staff in order to promote Peter's wishes and wellbeing, whilst also ensuring that staff's safety from a moving and handling perspective was maintained.

Although a lot of work has been done in previous years to promote single handed or proportionate care techniques, there may still be groups that have not been trained in this. As a result this could be a future area for further development in reaching people working in small group settings and shared accommodation.

REPORT TO: Health & Wellbeing Board

DATE: 12 March 2025

REPORTING OFFICER: Executive Director - Adults

PORTFOLIO: Adult Social Care

SUBJECT: Better Care Fund (BCF) Plan 2024/25 – Quarter 2 Update

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To update the Health and Wellbeing Board on the Quarter 2 (Q2) BCF Plan 2024/25 following its submission to the National BCF Team.

2.0 RECOMMENDATION

RECOMMENDED: That the Board note the report and associated appendix.

3.0 SUPPORTING INFORMATION

3.1 Following submission of the BCF Updated Plan for 2024/25 in June 2024[1], quarterly monitoring has been mandated for 2024/25. Attached is a copy of the Q2 report which was submitted in line with the national requirements.

As at the end of Q2, there are no areas of concern being highlighted to the Board.

3.2 **Tab 3 – National Conditions**
In addition to confirming that we have a Section 75 agreement in place to support the BCF Plan, there are four national conditions which we have confirmed we are meeting, as follows: -

- That we have a jointly agreed plan in place;
- We are implementing the BCF Policy Objective in respect to enabling people to stay well, safe and independent at home for longer;
- We are implementing the BCF Policy Objective in respect to providing the right care in the right place at the right time; and
- We are maintaining the NHS's contribution to Adult Social Care and investment in NHS commissioned out of hospital services.

[1] Letter received from NHS England on 23rd August 2024, confirming approval of the Plan following the regional assurance process.

3.3 **Tab 4 – Metrics**

There are four national metrics that are assessed, linked to: -

- Avoidable admissions;
- Discharge to normal place of residence;
- Falls; and
- Residential admissions

As at the end of Q2, we are on track to meet the targets set.

NB. Tab 2 (Cover Page) has a 'red' error stating the Metrics Tab (Tab 4) is not complete. The national team confirmed that this was an error on the spreadsheet and could be ignored.

3.4 **Tabs 5.1 & 5.2 Capacity and Demand**

Capacity and demand over the first 6 months of 2024/25 has generally been in line with the estimates made in our BCF Plan. Where demand exceeds capacity, additional resources would be secured via agency staff, although this hasn't been required over this period.

3.5 **Tab 6b Expenditure**

For Q2, we have had to report on spend and activity linked to all the schemes within the plan. Information has been completed outlining incurred expenditure and actual numbers of outputs delivered to the end of the second quarter (1st April 2024 – 30th September 2024).

Spend and activity will continue to be monitored via the Better Care Commissioning Advisory Group, as part of the joint working arrangements between the Local Authority and NHS Cheshire & Merseyside (Halton Place).

As at the end of this quarter no areas of concern have been identified.

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 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 continues to support effective resource utilisation.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**

Developing integration further between Halton Borough Council and the NHS Cheshire & Merseyside will have a direct impact on improving the health of people living in Halton. The BCF Plan 2024/25 that has been developed is linked to the priorities identified for the borough by the Health and Wellbeing Board.

6.2 **Building a Strong, Sustainable Local Economy**
None identified.

6.3 **Supporting Children, Young People and Families**
None identified.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**
None identified.

6.5 **Working Towards a Greener Future**
None identified.

6.6 **Valuing and Appreciating Halton and Our Community**
None identified.

6.7 **Resilient and Reliable Organisation**
None identified.

7.0 RISK ANALYSIS

7.1 Management of risks associated with the BCF Plan and associated funding is through the governance structures outlined within the Joint Working Agreement.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified at this stage.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 None identified at this stage.

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

10.1 None under the meaning of the Act.

Better Care Fund 2024-25 Q2 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.
The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS

Note on entering information into this template

Please do not copy and paste into the template

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

Data needs inputting in the cell
Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require
Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values

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

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Templa
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and

Better Care Fund 2024-25 Q2 Reporting Template

2. Cover

Version 3.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. 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:	Louise Wilson
E-mail:	louise.wilson@halton.gov.uk
Contact number:	0151 511 8861
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 report is expected to be signed off:	

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2024-25 Q2 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Halton

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		Yes

Confirmation of Nation Conditions			
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:**	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2024-25 Q2 Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Halton

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning Q1	Q2	Q3	Q4	For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs *Please: - describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans - **ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	249.0	258.0	263.0	262.0	213.3	On track to meet target	Halton has achieved the planned rate of ACS reduction	Halton Intermediate Care and Frailty Service, providing a 2hr response, is able to meet the needs of more patients in the community	The position is a positive variation from plan	No further mitigation is required	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	95.5%	95.5%	95.5%	95.5%	94.89%	On track to meet target	The target set is a stretch target and the highest in Cheshire and Merseyside, and actual performance remains in the top decile in the ICB.	April actual 95.2% May actual 94.1% June actual 95.5% July actual 95.0% August acutal 95.4%	The variance between the plan and actuals over the first quarter is 22 cases out of 3,227 discharges	The borough continues to promote home first principles and new discharge to access models are being introduced	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,648.0	479.7	On track to meet target	The number of falls in Q1 has decreased from Q3 & Q4 from the previous year but is higher than Q1 in that period. NWAS no longer provides a dedicated falls car and has been challenged to meet response	Halton Intermediate Care and Frailty Service, providing a 2hr response, is able to meet the needs of more patients in the community. Care home falls management programme and reduce conveyance to ED.	The Q1 actual rate is on track to continue to improve and meet the annual plan	A falls group is being set up in Halton to consider additional opportunities to tackle falls and C&M collaborative arrangements are in place for develop a strategy and to consider falls pick up options	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				600	not applicable	On track to meet target	Halton has maintained its home/reablement first principles and has reduced pathway 3 discharges. Complex care home placement remains a challenge for all areas within C&M	Halton has not had to increase the care home bed capacity	Maintaining admission rates in line with the planned capacity levels	No mitigation is required	Yes

Better Care Fund 2024-25 Q2 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Halton

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include any learnings from the last 6 months.	
Our estimates for capacity and demand haven't changed since the plan was submitted in June.	Yes
2. How have system wide discussions around winter readiness influenced any changes in capacity and demand as part of proactive management of winter surge capacity?	
As part of the Urgent and Emergency Care Recovery Plan, work is progressing on Hospital Discharge processes across Cheshire & Merseyside with the aims of improving the flow of discharges from hospital back to the community. Halton continues to be actively involved in this work and the revisions being made to discharge pathways will increase capacity to deal with potential surges during winter.	Yes
3. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
No.	Yes
4. Where actual demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
Where demand exceeds capacity, additional resources are secured when necessary via agency staff, although this hasn't been required over the past 6 months.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6 months of the year
- modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF.. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Complete:

Better Care Fund 2024-25 Q2 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Halton

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan						Actual activity (not including spot purchased capacity)						Actual activity through only spot purchasing (doesn't apply to time to service)						Checklist
Service Area	**Metric**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	Complete:
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	60	55	70	73	44	57	40	39	34	45	36	35	0	0	0	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	12	11	15	11	8	9	16	12	15	15	14	14							Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0							Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	17	16	19	16	21	18	12	11	11	17	17	9	0	0	0	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	5	8	10	12	12	13	12	11	12	11	12	11							Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	3	17	8	7	2	6	3	10	3	5	2	3	0	0	0	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	5	8	10	12	12	13	2	13	14	6	15	23							Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0							Yes

Actual activity - Community		Prepopulated demand from 2024-25 plan						Actual activity:						Checklist
Service Area	**Metric**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	Complete:
Social support (including VCS)	Monthly activity. Number of new clients.	17	17	17	17	17	17	10	16	10	1	7	5	Yes
Urgent Community Response	Monthly activity. Number of new clients.	165	165	165	165	165	165	168	167	158	194	180	166	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	2	2	2	2	2	2	2	4	3	2	0	1	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	1	1	1	1	1	1	0	0	0	1	0	0	Yes
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2024-25 Q2 Reporting Template

6. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: Halton

<< Link to summary sheet

Running Balances	2024-25 Income	Expenditure to date	Percentage spent	Balance
DFG	£2,175,723	£976,000	44.86%	£1,199,723
Minimum NHS Contribution	£13,484,478	£4,479,018	33.22%	£9,005,460
iBCF	£6,982,074	£3,795,730	54.36%	£3,186,344
Additional LA Contribution	£0	£0		£0
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£1,631,460	£696,804	42.71%	£934,656
ICB Discharge Funding	£1,281,956	£540,922	42.20%	£741,034
Total	**£25,555,691**	**£10,488,474**	**41.04%**	**£15,067,217**

Comments if income changed

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25 Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£3,831,907	£1,012,000	£2,819,907
Adult Social Care services spend from the minimum ICB allocations	£6,777,080	£3,462,357	£3,314,723

Checklist	Column complete:	Yes	Yes

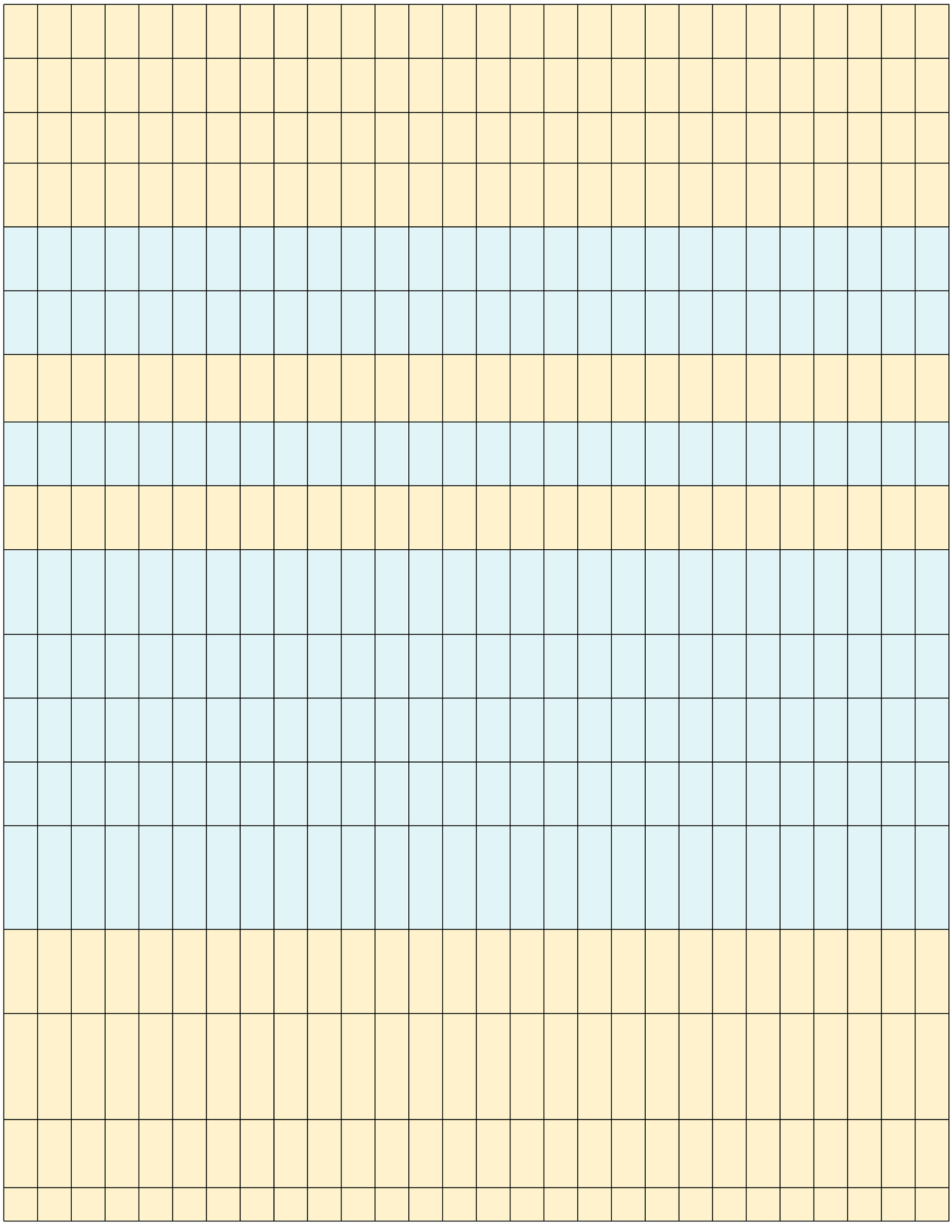
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Comments
3	Carers Centre	Carers Centre	Carers Services	Carer advice and support related to Care Act duties		6000	6000	Beneficiaries	Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£358,959	£0	Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
3	Halton Home Based Respite Service	Carers Breaks - Care at Home	Carers Services	Respite services		32	38	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	£124,740	£59,058	
4	Community Respiratorty Team (WHHFT)	WHHFT - Facilitating discharge & extending community offer	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£152,339	£0	Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
4	Respiratory - Out of Hospital Team	Extending Community Provision	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£353,571	£0	Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
4	Halton Support at Home Service	Support at Home Seervice - British Red Cross	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess		0	NA		Other	3rd Sector	LA			Charity / Voluntary Sector	Minimum NHS Contribution	£9,321	£4,661	
7	Hospital Discharge Team	Integrated Discharge Teams - Warrington & Whiston	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£734,740	£362,705	
7	ESD Stroke	Stroke Outreach Pathway	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£190,489	£0	Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
8	Domicilary Care Packages	Maintaining Domicilary Care Packages	Home Care or Domiciliary Care	Domiciliary care packages		132431	69596	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£2,929,396	£1,474,050	
8	Domicilary Care Packages	Maintaining Domicilary Care Packages	Home Care or Domiciliary Care	Domiciliary care packages		42305	28390	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	iBCF	£912,518	£601,310	
17	Residentail Care Home Placements	Maintaining Residential Care Home Placements	Residential Placements	Care home		37	18	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£1,399,467	£702,499	
17	Residential Care Home Placements	Maintaining Residential Care Home Placements	Residential Placements	Care home		155	75	Number of beds	Social Care		LA			Private Sector	iBCF	£5,702,916	£2,926,745	
11	Intermediate Care Bed Based Service	Oakmeadow - 19 Bedded Unit	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		28	19	Number of placements	Social Care		LA			Local Authority	Minimum NHS Contribution	£430,630	£215,315	
11	Intermediate Care Bed Based Service	Oakmeadow - 19 Bedded Unit	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		36	23	Number of placements	Social Care		LA			Local Authority	Local Authority Discharge	£544,586	£272,294	
12	Intermediate Care Community Services	Reablement/Rehab Services	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		330	258	Packages	Social Care		LA			Local Authority	ICB Discharge Funding	£943,601	£471,801	
12	Intermediate Care Community Services	Reablement/Rehab Services	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		180	123	Packages	Social Care		LA			Local Authority	Local Authority Discharge	£434,290	£217,145	

16	Warrington Therpay Staff	Warrington Therpay Staff	Prevention / Early Intervention	Other	Preventing admissions to acute setting	0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£197,674	£0	Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
16	Support to Intermediate Care	Bridgewater Community Therapies	Prevention / Early Intervention	Other	Preventing admissions to acute setting	0	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£162,195	£0	Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
16	High Intensity User	High Intensity User	Prevention / Early Intervention	Risk Stratification		0	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£61,163	£0	Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
5	DFG & Equipment Adaptations	DFG	DFG Related Schemes	Adaptations, including statutory DFG grants		1000	600	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	£2,175,723	£976,000	
12	Intermediate Care Community Services	Reablement/Rehab Services	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		87	100	Packages	Social Care		LA			Local Authority	iBCF	£366,640	£267,675	
8	Home First Support	Home First Support	Home Care or Domiciliary Care	Domiciliary care packages		98124	30629	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£2,111,215	£648,730	
7	Trusted Assessment	Trusted Asessor Role	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£59,537	£0	Posts not yet recruited to
6	Mental Health Commissioning	Mental Health Joint Commissioning Role	Enablers for Integration	Joint commissioning infrastructure		0	NA		Mental Health		LA			Local Authority	Minimum NHS Contribution	£71,408	£0	Posts not yet recruited to
19	Development Fund	Development - Other (New Service Developments)	Other			0	NA		Other	Community Health & Social Care	LA			Local Authority	Minimum NHS Contribution	£467,448	£0	Schemes in process of being identified
7	Care Home - Lead Nurse	Care Home - Lead Nurse	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes	0	0	NA		Social Care	0	LA	0.0%		NHS Acute Provider	Minimum NHS Contribution	£83,454	£0	Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
4	Mental Health Outreach Support	Mental Health Outreach Support	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as	0	0	NA		Mental Health	0	NHS	0.0%		NHS Acute Provider	Minimum NHS Contribution	£148,000	£74,000	
7	Trusted Assessment - Mental Health	Mental Health Trusted Assessor	High Impact Change Model for Managing Transfer of Care	Trusted Assessment	0	0	NA		Mental Health	0	NHS	0.0%		NHS Acute Provider	Minimum NHS Contribution	£20,000	£0	Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
12	HICAFS	Halton Intermediate Care & Frailty Service	Urgent Community Response	0	0	0	NA		Community Health	0	NHS	0.0%		NHS Community Provider	ICB Discharge Funding	£120,000	£0	Posts not yet recruited to
1	Halton Integrated Community Equipment	Joint Equipment Service	Assistive Technologies and Equipment	Community based equipment	0	4374	2483	Number of beneficiaries	Community Health	0	NHS	0.0%		NHS Community Provider	Local Authority Discharge	£652,584	£207,365	
1	Halton Integrated Community Equipment	Joint Equipment Service	Assistive Technologies and Equipment	Community based equipment	0	1458	828	Number of beneficiaries	Community Health	0	NHS	0.0%		NHS Community Provider	ICB Discharge Funding	£218,355	£69,121	
12	HICAFS	Halton Intermediate Care & Frailty Service	Urgent Community Response	0	0	0	NA		Community Health	0	NHS	0.0%		NHS Community Provider	Minimum NHS Contribution	£3,418,732	£938,000	

Back to top

Adding New Schemes:

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Outputs for 2024-25	Outputs delivered to date (Number)	Units (auto-populated)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding	Planned Expenditure (£)	Expenditure to date (£)
			<Please Select>														



REPORT TO: Health & Wellbeing Board

DATE: 12th March 2025

REPORTING OFFICER: Executive Director - Adults

PORTFOLIO: Adult Social Care

SUBJECT: Better Care Fund (BCF) Plan 2024/25 – Quarter 3 Update

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To update the Health and Wellbeing Board on the Quarter 3 (Q3) BCF Plan 2024/25 following its submission to the National BCF Team.

2.0 RECOMMENDATION

RECOMMENDED: That

a) **the report and associated appendix be noted.**

3.0 SUPPORTING INFORMATION

3.1 Following submission of the BCF Updated Plan for 2024/25 in June 2024[1], quarterly monitoring has been mandated for 2024/25. Attached is a copy of the Q3 report which was submitted in line with the national requirements.

3.2 **Tab 3 – National Conditions**
In addition to confirming that we have a Section 75 agreement in place to support the BCF Plan, there are four national conditions which we have confirmed we are meeting, as follows: -

- That we have a jointly agreed plan in place;
- We are implementing the BCF Policy Objective in respect to enabling people to stay well, safe and independent at home for longer;
- We are implementing the BCF Policy Objective in respect to providing the right care in the right place at the right time; and
- We are maintaining the NHS's contribution to Adult Social Care and investment in NHS commissioned out of hospital services.

3.3 **Tab 4 – Metrics**
There are four national metrics that are assessed, linked to: -

[1] Letter received from NHS England on 23rd August 2024, confirming approval of the Plan following the regional assurance process.

- Avoidable admissions;
- Discharge to normal place of residence;
- Falls; and
- Residential admissions

The Board should note that at the beginning of January 2025, we received information via the NHS Cheshire & Merseyside Network Intelligence Team which outlined that NHS England had revised the criteria for the Avoidable Admissions and Falls metrics to take account for the implementation of SDEC (Same Day Emergency Care - Type 5 attendance) recording, which involves a shift in short stay non-elective recording to Type 5 attendance recording. This change in effect renders plans submitted earlier this year incongruent with the latest activity data. Therefore, we were advised to reflect this in our submission; other areas within Cheshire & Merseyside were advised to do the same.

In respect to Discharge to Normal Place of Residence, as at the end of Q3, we are not on track to meet the target. Higher acuity and increased pressure to discharge early has resulted in lower discharges directly back to normal place of residence than planned; Halton remain in the top quartile within C&M. Overall for the year, the performance remains at 95% and the 0.5% variance against the target of 95.5% equates to 45 out of 8,902 discharges having not returned directly home.

In respect to Residential Admissions we remain on track to meet the target that has been set.

3.4 **Tabs 5.1 & 5.2 Capacity and Demand**

Capacity and demand over Q3 (October – December 2024) has generally been in line with the estimates made in our BCF Plan, apart from community admissions into the Urgent Community Response Team. However capacity has been available to meet the additional demand experienced within this area.

3.5 **Tab 6b Expenditure**

For Q3, we have reported on spend and activity linked to all the schemes within the plan. Information has been completed outlining incurred expenditure and actual numbers of outputs delivered to the end of the third quarter (1st April 2024 – 31st December 2024).

Spend and activity will continue to be monitored via the Better Care Commissioning Advisory Group, as part of the joint working arrangements between the Local Authority and NHS Cheshire & Merseyside (Halton Place).

As at the end of this quarter no areas of concern have been identified.

4.0 **POLICY IMPLICATIONS**

4.1 None identified at this stage.

5.0 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 continues to support effective resource utilisation.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**
Developing integration further between Halton Borough Council and the NHS Cheshire & Merseyside will have a direct impact on improving the health of people living in Halton. The BCF Plan 2024/25 that has been developed is linked to the priorities identified for the borough by the Health and Wellbeing Board.

6.2 **Building a Strong, Sustainable Local Economy**
None identified.

6.3 **Supporting Children, Young People and Families**
None identified.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**
None identified.

6.5 **Working Towards a Greener Future**
None identified.

6.6 **Valuing and Appreciating Halton and Our Community**
None identified.

6.7 **Resilient and Reliable Organisation**
None identified.

7.0 RISK ANALYSIS

7.1 Management of risks associated with the BCF Plan and associated funding is through the governance structures outlined within the Joint Working Agreement.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified at this stage.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 None identified at this stage.

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

10.1 None under the meaning of the Act.

Better Care Fund 2024-25 Q3 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS

Please submit this template by 14 February 2025

Note on entering information into this template

Please do not copy and paste into the template

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

Data needs inputting in the cell
Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values

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

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Templa
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2024-25 will pre-populate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each

Better Care Fund 2024-25 Q3 Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. 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:	Louise Wilson
E-mail:	Louise.wilson@halton.gov.uk
Contact number:	0151 511 8861
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 report is expected to be signed off:	

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D H1 Actual Activity	Yes
6b. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

<< Link to the Guidance sheet

Better Care Fund 2024-25 Q3 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Halton

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		Yes

Confirmation of Nation Conditions			
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:**	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2024-25 Q3 Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Halton

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	**Definition**	**For information - Your planned performance as reported in 2024-25 planning**				**For information - actual performance for Q2** **(For Q3 data,please refer to data pack on BCX)**	**Assessment of progress against the metric plan for the reporting period**	**Challenges and any Support Needs** *Please:* *- describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans* ***- ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan***	**Achievements - including where BCF funding is supporting improvements.** *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	**Variance from plan** *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	**Mitigation for recovery** *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
		Q1	**Q2**	**Q3**	**Q4**							
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	249.0	258.0	263.0	262.0	229.0	Data not available to assess progress	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	95.5%	95.5%	95.5%	95.5%	95.0%	Not on track to meet target	Higher acuity and increased pressure to discharge early has resulted lower discharges directly back to normal place of residence than plannned. Halton remain in the top quartile within C&M.	An increase in reablement support at home has allowed for an increase in the number of patients to receive ongoing care in their own home rather than admitting all to a community bed for rehabilitation	Overall for the year, the performance remains at 95% and the 0.5% variance equates to 45 out of 8902 discharges having not returned directly home.	New discharge to assess processes have been implemented nearing the end of Q3, to enhance the home first pathways.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,648.0	469.4	Data not available to assess progress	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Awaiting clarification from NHSE regarding metric criteria. Current plans are no longer comparable to actuals largely due to the implementation of SDEC (Type 5) this year, as well as updates to National criteria that systems need time to adopt and validate.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				600	not applicable	On track to meet target	The number of patients admitted to care homes remains in line with plan, but the acuity and complexity of the admissions has increased following deconditioning within the acute episode.	The care home market remains stable and there hasn't been any increased bed capacity requirements. Trusted assessor arrangements are in place to support placements being made.	Maintaining admission rates in line with the planned capacity levels.	No mitigation is required	Yes

Better Care Fund 2024-25 Q3 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Halton

5.1 Assumptions

	Checklist
1. How have your estimates for capacity and demand changed since the last reporting period? Please describe how you are building on your learning across the year where any changes were needed.	
Our estimates for capacity and demand haven't changed since the last reporting period.	Yes
2. Do you have any capacity concerns for Q4? Please consider both your community capacity and hospital discharge capacity.	
No concerns for Q4 have been identified with from a community or hospital discharge capacity.	Yes
3. Where actual demand exceeds capacity, what is your approach to ensuring that people are supported to avoid admission or to enable discharge? Please describe how this improves on your approach for the last reporting period.	
When or if demand exceeds capacity, additional resources are secured when necessary via agency staff to ensure that people are supported to avoid admission or to enable discharge - This remains the same approach as taken in the last reporting period.	Yes
4. Do you have any specific support needs to raise for Q4? Please consider any priorities for planning readiness for 25/26.	
None identified.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- Actual demand in the first 9 months of the year
- Modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Complete:

Better Care Fund 2024-25 Q3 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Halton

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan			Actual activity (not including spot purchased capacity)			Actual activity through only spot purchasing (doesn't apply to time to service)			Checklist
Service Area	Metric	Oct-24	Nov-24	Dec-24	Oct-24	Nov-24	Dec-24	Oct-24	Nov-24	Dec-24	Complete:
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	45	74	59	49	44	39	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	10	9	12	7	10	5				Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	0	0	0	0	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0				Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	24	23	19	12	11	16	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	10	4	10	9	6	17				Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	8	4	10	6	3	8	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	10	4	10	7	44	12				Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	0	0	0	0	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0				Yes

Actual activity - Community		Prepopulated demand from 2024-25 plan			Actual activity:			Checklist
Service Area	Metric	Oct-24	Nov-24	Dec-24	Oct-24	Nov-24	Dec-24	Complete:
Social support (including VCS)	Monthly activity. Number of new clients.	17	17	17	15	12	16	Yes
Urgent Community Response	Monthly activity. Number of new clients.	165	165	170	205	199	196	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	2	2	2	0	1	1	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	1	1	1	0	1	0	Yes
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2024-25 Q3 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: Halton

	2024-25			
Running Balances	Income	Expenditure to date	Percentage spent	Balance
DFG	£2,175,723	£1,520,710	69.89%	£655,013
Minimum NHS Contribution	£13,484,478	£7,785,744	57.74%	£5,698,734
iBCF	£6,982,074	£5,658,723	81.05%	£1,323,351
Additional LA Contribution	£0	£0		£0
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£1,631,460	£1,218,010	74.66%	£413,450
ICB Discharge Funding	£1,281,956	£896,822	69.96%	£385,134
Total	**£25,555,691**	**£17,080,009**	**66.83%**	**£8,475,682**

Comments if income changed
NB. Additonal in year DFG allocation 24/25 = £299,379 - Not reflected in the income

Required Spend

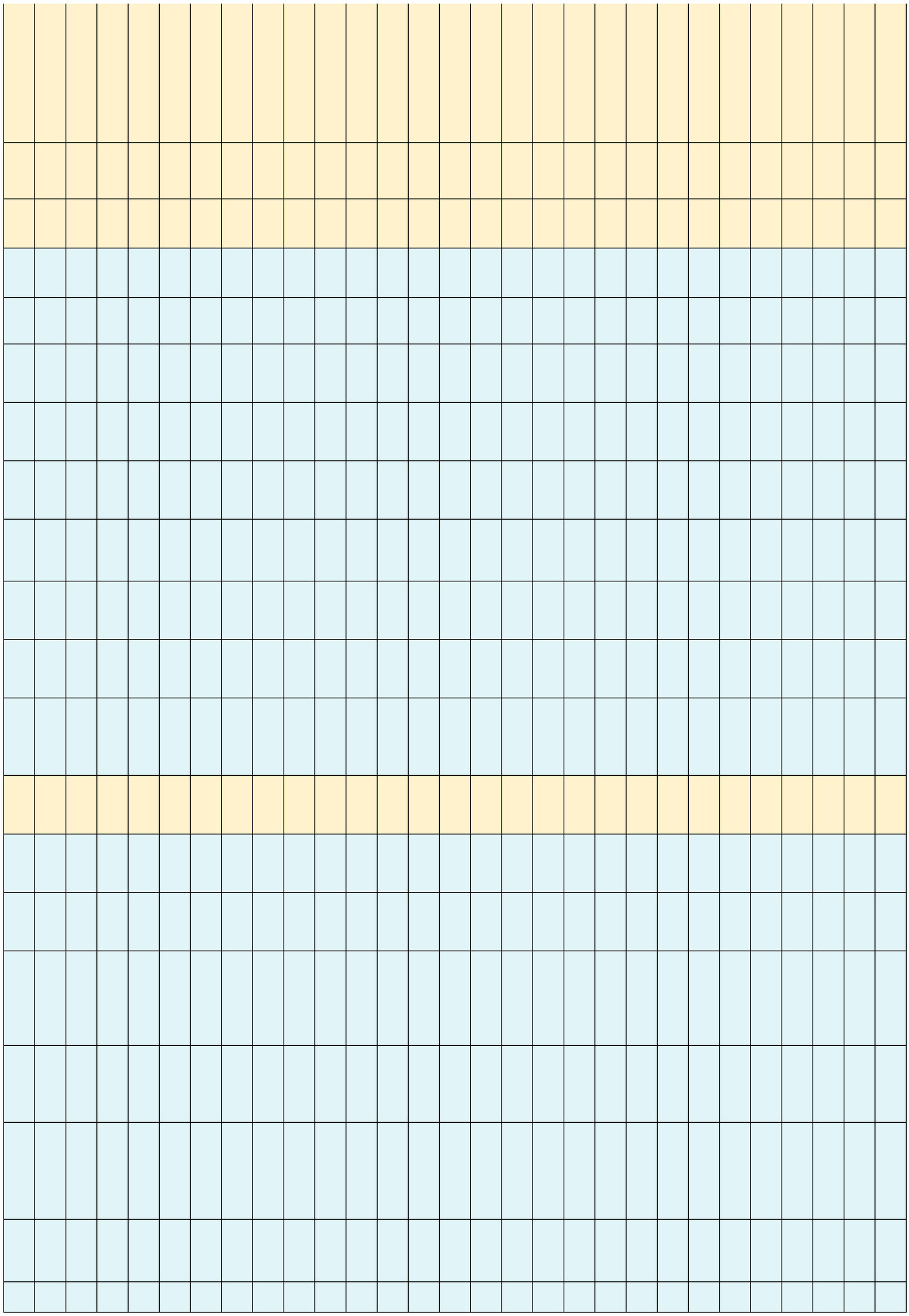
This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

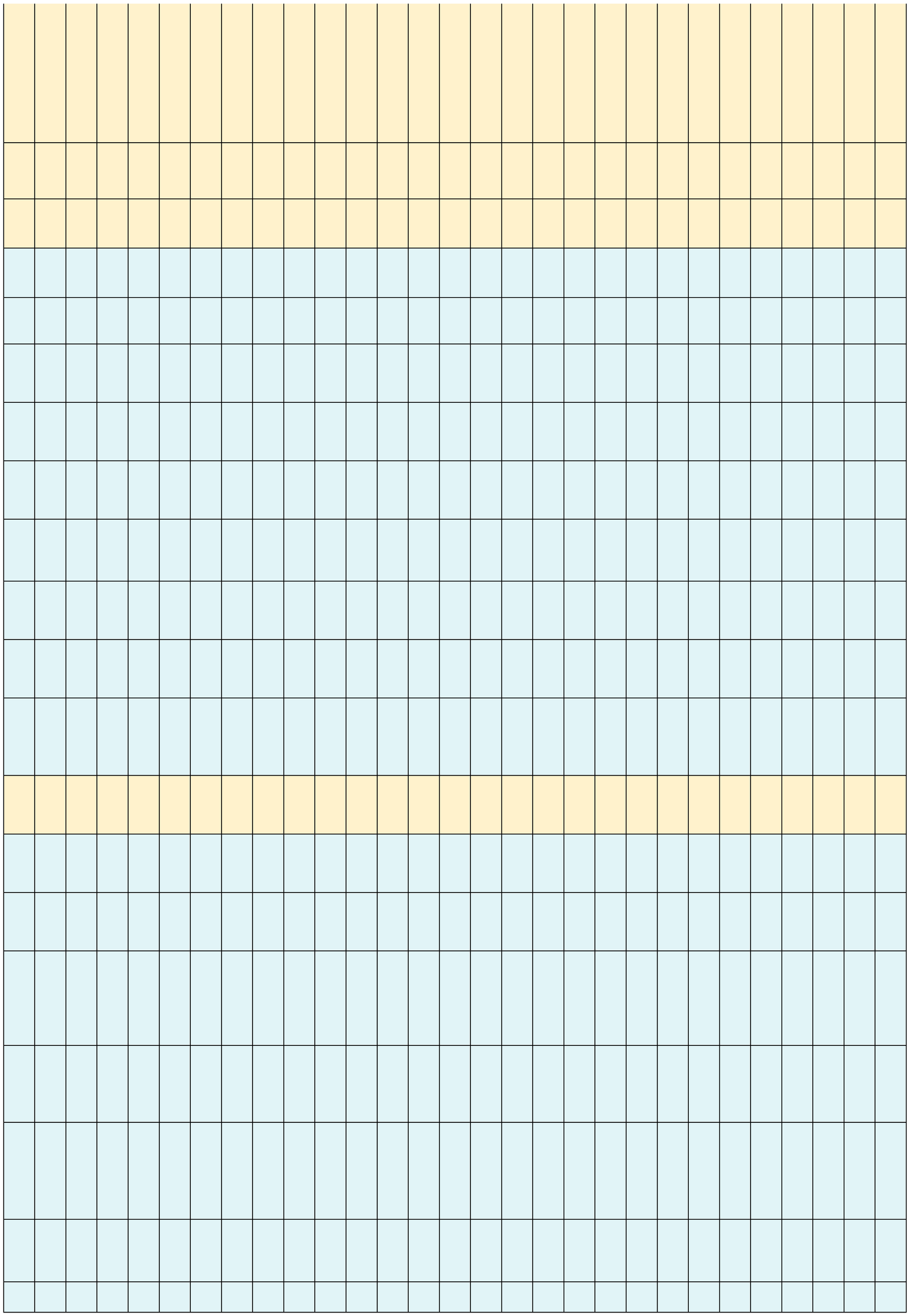
	2024-25		
	Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£3,831,907	£2,283,591	£1,548,316
Adult Social Care services spend from the minimum ICB allocations	£6,777,080	£5,834,698	£942,382

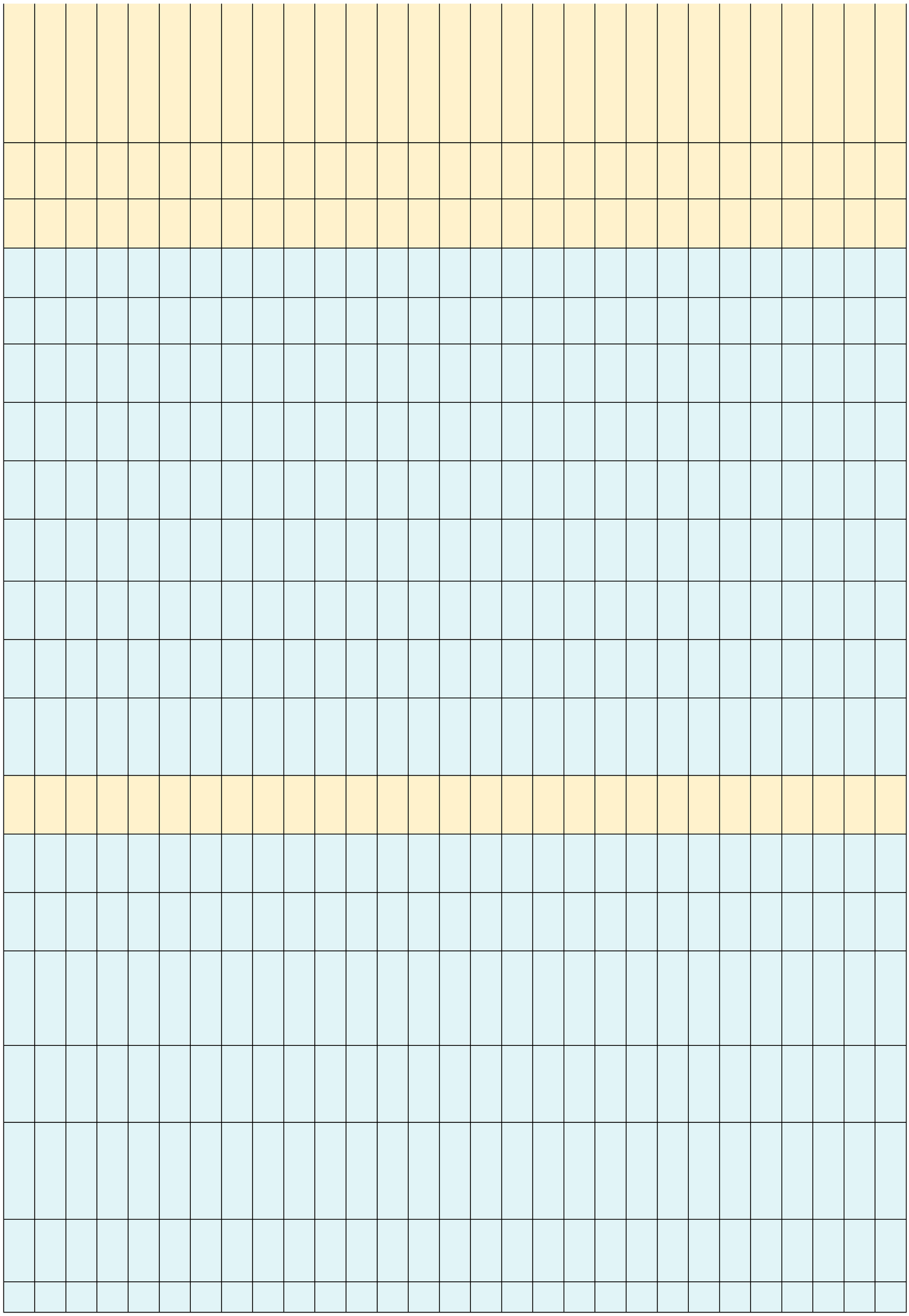
Checklist Column complete: Yes Yes

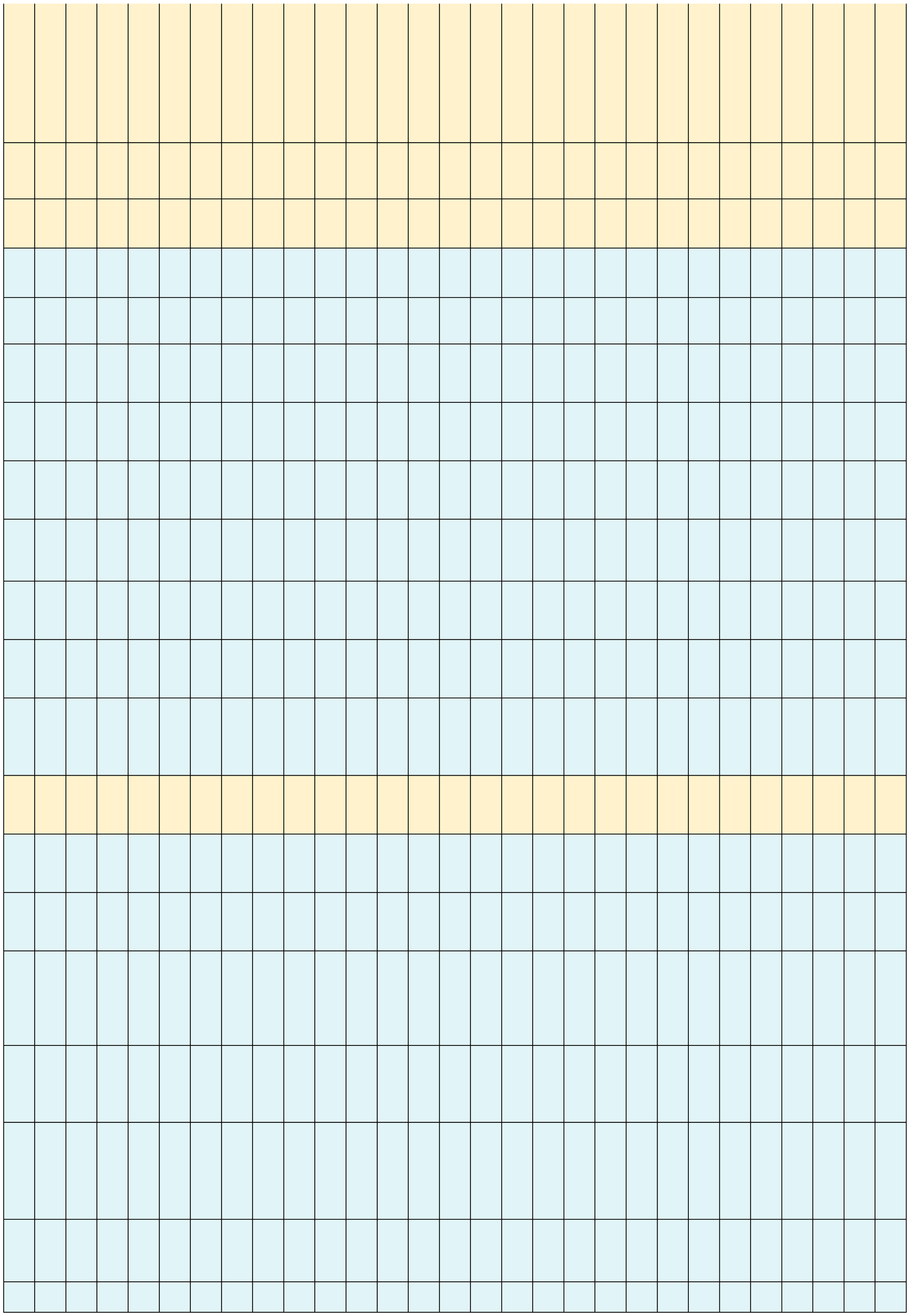
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Discontinue (if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent)	Comments
3	Carers Centre	Carers Centre	Carers Services	Carer advice and support related to Care Act duties		6000	6000	Beneficiaries	Social Care	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 358,959	£341,866		Paid upto the end March 2025
3	Halton Home Based Respite Service	Carers Breaks - Care at Home	Carers Services	Respite services		32	38	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 124,740	£90,243		Paid upto the end December 2024
4	Community Respiratorty Team (WHHFT)	WHHFT - Facilitating discharge & extending community offer	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 152,339	£0		Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
4	Respiratory - Out of Hospital Team	Extending Community Provision	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 353,571	£0		Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
4	Halton Support at Home Service	Support at Home Seervice - British Red Cross	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess		0	NA		Other	3rd Sector	LA			Charity / Voluntary Sector	Minimum NHS Contribution	£ 9,321	£9,321		
7	Hospital Discharge Team	Integrated Discharge Teams - Warrington & Whiston	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£ 734,740	£544,058		
7	ESD Stroke	Stroke Outreach Pathway	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 190,489	£133,982		
8	Domicilary Care Packages	Maintaining Domicilary Care Packages	Home Care or Domiciliary Care	Domiciliary care packages		132431	104394	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 2,929,396	£2,211,075		
8	Domicilary Care Packages	Maintaining Domicilary Care Packages	Home Care or Domiciliary Care	Domiciliary care packages		42305	42586	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	iBCF	£ 912,518	£901,965		
17	Residentail Care Home Placements	Maintaining Residential Care Home Placements	Residential Placements	Care home		37	27	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 1,399,467	£1,045,292		
17	Residential Care Home Placements	Maintaining Residential Care Home Placements	Residential Placements	Care home		155	113	Number of beds	Social Care		LA			Private Sector	iBCF	£ 5,702,916	£4,390,118		
11	Intermediate Care Bed Based Service	Oakmeadow - 19 Bedded Unit	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		28	28	Number of placements	Social Care		LA			Local Authority	Minimum NHS Contribution	£ 430,630	£322,973		
11	Intermediate Care Bed Based Service	Oakmeadow - 19 Bedded Unit	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		36	35	Number of placements	Social Care		LA			Local Authority	Local Authority Discharge	£ 544,586	£408,443		
12	Intermediate Care Community Services	Reablement/Rehab Services	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		330	407	Packages	Social Care		LA			Local Authority	ICB Discharge Funding	£ 943,601	£707,701		

12	Intermediate Care Community Services	Reablement/Rehab Services	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		180	185	Packages	Social Care		LA			Local Authority	Local Authority Discharge	£ 434,290	£325,718		
16	Warrington Therpay Staff	Warrington Therpay Staff	Prevention / Early Intervention	Other	Preventing admissions to acute setting	0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 197,674	£109,539		
16	Support to Intermediate Care	Bridgewater Community Therapies	Prevention / Early Intervention	Other	Preventing admissions to acute setting	0	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£ 162,195	£0		Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
16	High Intensity User	High Intensity User	Prevention / Early Intervention	Risk Stratification		0	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£ 61,163	£0		Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
5	DFG & Equipment Adaptations	DFG	DFG Related Schemes	Adaptations, including statutory DFG grants		1000	811	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	£ 2,175,723	£1,520,710		
12	Intermediate Care Community Services	Reablement/Rehab Services	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		87	157	Packages	Social Care		LA			Local Authority	iBCF	£ 366,640	£366,640		
8	Home First Support	Home First Support	Home Care or Domiciliary Care	Domiciliary care packages		98124	60145	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 2,111,215	£1,273,865		
7	Trusted Assessment	Trusted Asessor Role	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£ 59,537	£5,327		
6	Mental Health Commissioning	Mental Health Joint Commissioning Role	Enablers for Integration	Joint commissioning infrastructure		0	NA		Mental Health		LA			Local Authority	Minimum NHS Contribution	£ 71,408	£0		Posts not yet recruited to.
19	Development Fund	Development - Other (New Service Developments)	Other			0	NA		Other	Community Health & Social Care	LA			Local Authority	Minimum NHS Contribution	£ 467,448	£0		
7	Care Home - Lead Nurse	Care Home - Lead Nurse	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes	0	0	NA		Social Care	0	LA	0		NHS Acute Provider	Minimum NHS Contribution	£ 83,454	£0		Waiting for invoices to be submitted by Mersey & West Lancs Teaching Hospitals NHS Trust
4	Mental Health Outreach Support	Mental Health Outreach Support	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as	0	0	NA		Mental Health	0	NHS	0		NHS Acute Provider	Minimum NHS Contribution	£ 148,000	£74,000		
7	Trusted Assessment - Mental Health	Mental Health Trusted Assessor	High Impact Change Model for Managing Transfer of Care	Trusted Assessment	0	0	NA		Mental Health	0	NHS	0		NHS Acute Provider	Minimum NHS Contribution	£ 20,000	£0		Waiting for invoices to be submitted from NHS Cheshire & Merseyside (Halton Place)
12	HICAFS	Halton Intermediate Care & Frailty Service	Urgent Community Response	0	0	0	NA		Community Health	0	NHS	0		NHS Community Provider	ICB Discharge Funding	£ 120,000	£120,000		
1	Halton Integrated Community Equipment	Joint Equipment Service	Assistive Technologies and Equipment	Community based equipment	0	4374	3655	Number of beneficiaries	Community Health	0	NHS	0		NHS Community Provider	Local Authority Discharge	£ 652,584	£483,850		
1	Halton Integrated Community Equipment	Joint Equipment Service	Assistive Technologies and Equipment	Community based equipment	0	1458	1218	Number of beneficiaries	Community Health	0	NHS	0		NHS Community Provider	ICB Discharge Funding	£ 218,355	£69,121		
12	HICAFS	Halton Intermediate Care & Frailty Service	Urgent Community Response	0	0	0	NA		Community Health	0	NHS	0		NHS Community Provider	Minimum NHS Contribution	£ 3,418,732	£1,624,203		





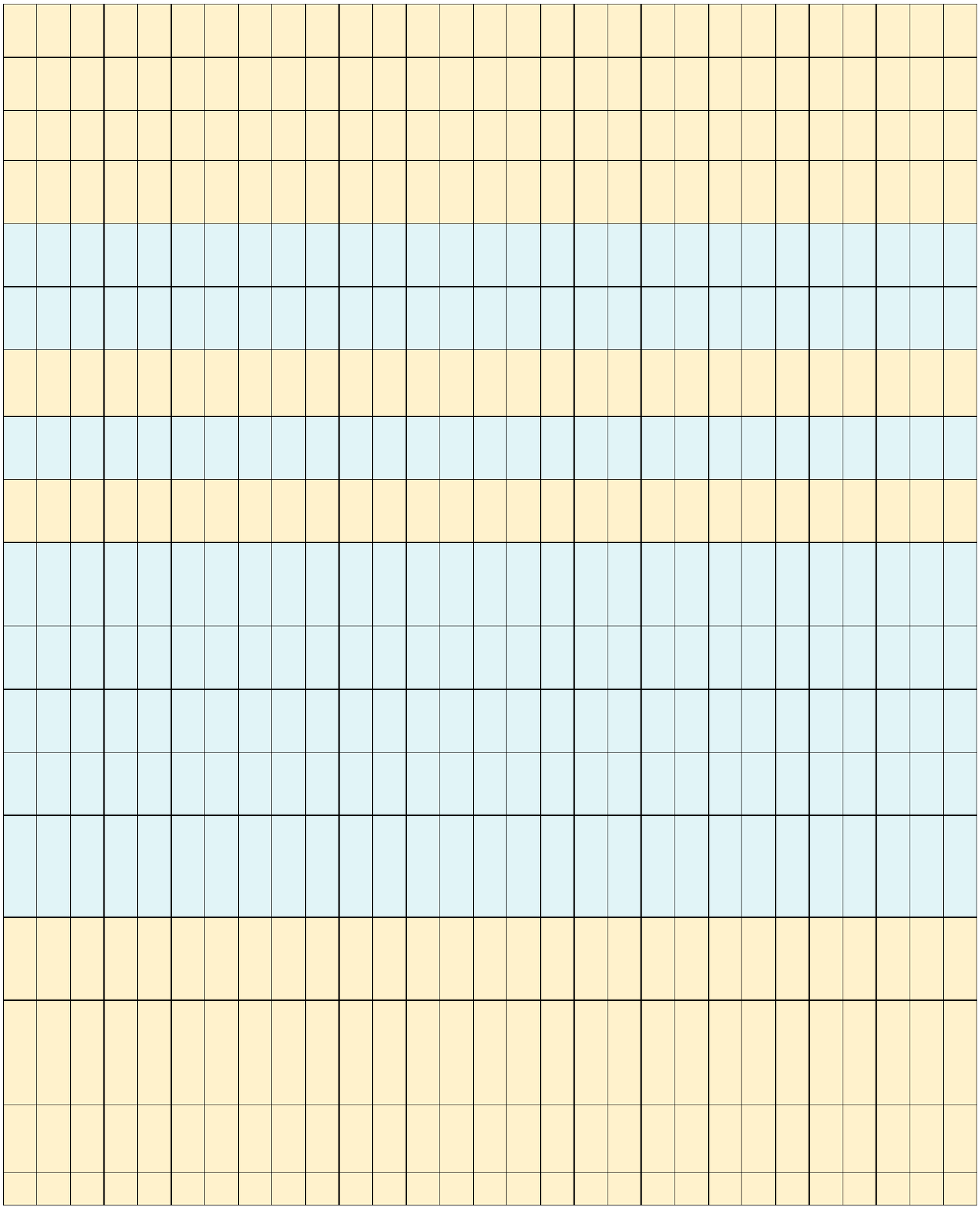


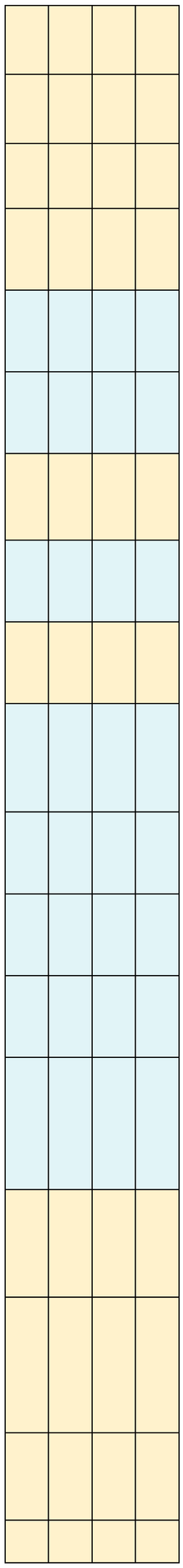


Adding New Schemes:

Back to top

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Outputs for 2024-25	Outputs delivered to date (Number)	Units (auto-populated)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding	Planned Expenditure (£)	Expenditure to date (£)

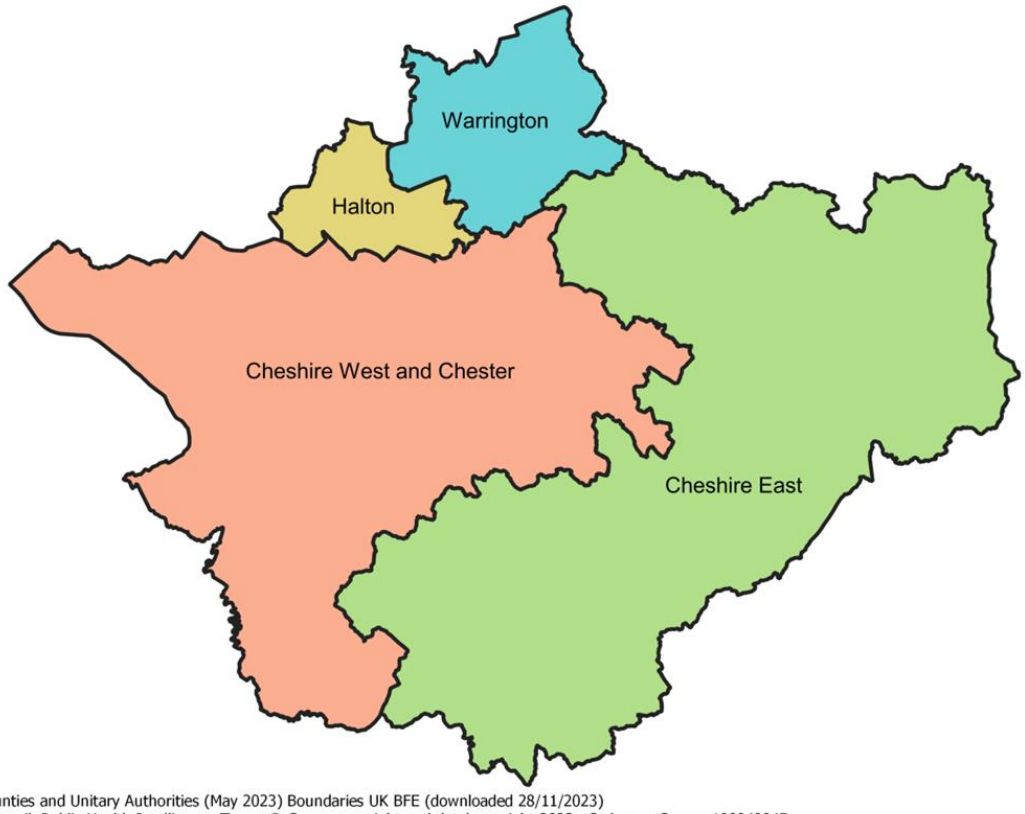




Annual Report of the

Pan Cheshire
Child Death Overview Panel

2023/24



Source: ONS Counties and Unitary Authorities (May 2023) Boundaries UK BFE (downloaded 28/11/2023)
Cheshire East Council, Public Health Intelligence Team, © Crown copyright and database right 2023. Ordnance Survey 100049045

Contents

Introduction

Each child death is a tragedy.

"The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child and know that people will learn from what happened. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths[1].

Child Death Overview Panels exist to ensure the independent and systematic review of the death of every child, so that lessons can be learned from these tragic events and shared effectively to prevent future deaths, wherever possible.

At the time of writing this most recent annual report, the live hearings at the public Thirlwall Inquiry have commenced. This inquiry has been set up to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital[2].

The Pan Cheshire Child Death Overview Panel continues to support partners contributing to the Thirlwall Inquiry. Once the Inquiry concludes, the Panel is committed to championing the recommendations that result.

This current report focuses on children whose deaths were either notified to the Pan Cheshire Child Death Overview Panel during 2023/24, or whose reviews concluded during 2023/24.

As a panel, we are dedicated to ensuring our families are supported following the death of their child, and that any learning from these heartbreaking losses is fully acknowledged and shared across our the Pan Cheshire area and beyond.

---

[1] HM Government (2023) Working Together to Safeguard Children 2023. A guide to multi-agency working
to help, protect and promote the welfare of children. Available from: Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk) (Accessed 24 June 2024).
[2] Thirlwall Inquiry. Available from: https://thirlwall.public-inquiry.uk/ © Crown Copyright 2024 (Accessed 13 September 2024).

The Pan Cheshire Child Death Overview Panel footprint and process

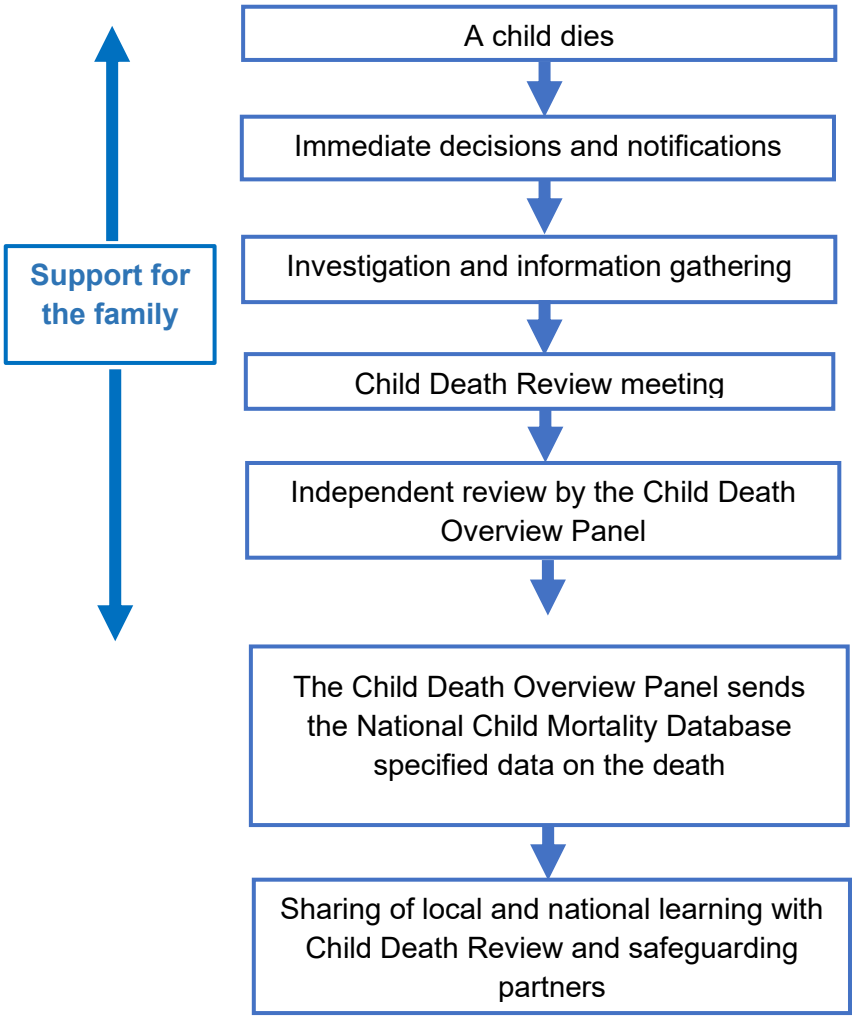
Child Death Review partners include the local authorities and the NHS Cheshire and Merseyside Integrated Care Board.

The Cheshire Child Death Overview Panel includes representatives from across:

- Cheshire East
- Cheshire West and Chester
- Halton
- Warrington

The child death review process is outlined in statutory guidance: Working Together to Safeguard Children 2023 and Child Death Review Statutory and Operational Guidance (England) 2018.

When a child dies, the process undertaken is illustrated in the figure below.



The review by the Child Death Overview Panel is intended to be the final, independent review of a child's death by senior professionals from different specialities and organisations with no responsibility for providing care to the child during their life. The information gathered may help identify factors that could be altered to prevent future deaths.

The Pan Cheshire Child Death Overview Panel consists of varied experts including: public health representatives, the Designated Doctor for Child Deaths for the local area; social services; police, the Designated Doctor or Nurse for Safeguarding; nursing and/or midwifery; and other professionals that Child Death Review partners consider should be involved. Additional professionals may be asked to contribute reports in relation to individual cases.

Supporting families with child bereavement

At the centre of every child death are families and friends experiencing devastating loss. An important role of the Child Death Overview Panel is to ensure they have the support and importantly, the compassion and sensitivity that is so greatly needed in such distressing circumstances. Child Bereavement UK has produced guidance to support professionals with this important role.

> "Working with families who are grieving can feel daunting…
>
> Nothing we can do or say can take away the pain of bereavement, but families tell us of the importance of sensitive care. Poor care can intensify and prolong a family's distress, whilst care that is sensitive and appropriate can help families in their grief. The effects of this are positive and long-lasting…
>
> Supporting bereaved families includes good communication, responding to their needs in a timely way, and being emotionally self-aware"[3].

The guidance states:

"Listening to others means using all our senses to pick up on what the person is communicating, and it involves much more than just what we are hearing.

[3] Child Bereavement UK. Supporting bereaved families. Available from: https://www.childbereavementuk.org/Listing/Category/working-with-bereaved-families (Accessed 15 July 2024

Good communication involves:

- Having the right environment, preferably where you will not be disturbed.
- Being compassionately clear about the time the person or family can have with you to talk. This creates a safe environment where they know what they can expect, and it avoids the interaction ending abruptly.
- Listening to the words, the tone of voice and the feelings being conveyed.
- Observing body language and facial expressions, and noticing what is not being said as well as what is said.
- Showing your interest and empathy through good eye contact, your tone of voice and body language.

Checking with the person that you have both heard and understood the key messages."[4]

Purpose of the Child Death Overview Panel Annual Report

As outlined in the statutory guidance, the purpose of the Annual Report is:

- To clarify and outline some of the Child Death Overview Panel processes directed by national guidance.
- To assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across the Pan Cheshire Child Death Overview Panel footprint.
- To provide an overview of information on trends and patterns in child deaths reviewed across the Pan Cheshire Child Death Overview Panel footprint during the last reporting year (2023/24) and highlight issues arising from the child deaths reviewed.
    - This could include deaths of children who were resident in the Pan Cheshire Child Death Overview Panel footprint, or who died in the footprint.
- To report on achievements and progress.
- To make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across the Pan Cheshire Child Death Overview Panel footprint.

[4] [4] Child Bereavement UK. Supporting bereaved families. Available from: https://www.childbereavementuk.org/Listing/Category/working-with-bereaved-families (Accessed 15 July 2024

Key trends in child death notifications

As described in the statutory guidance, when a child dies, a number of notifications should also be made, including: to the child's GP and other professionals; to the Child Health Information System; the relevant Child Death Review partners and the Child Death Overview Panel. This helps to guide how to support the family. It also helps to identify whether Joint Agency Reviews, NHS serious investigations, or referrals to the coroner are required. Across the Pan Cheshire footprint:

- Rates of child notifications were reasonably stable over the last three years.
- There were 52 child death notifications during 2023/24 compared to 55 during 2022/23.
- The rate of notifications across Pan Cheshire during 2023/24 was 2.35/10,000 0-17 year olds and 2.48/10,000 during 2022/23[5].
- The rate of notifications across England as a whole was 3.18/10,000 during 2022/23[6].
- The majority of notifications were in children under the age of 1 year (62%), this was a similar to the age distribution across England as a whole.

It is difficult to discern a pattern of seasonal variation due to the very small numbers involved.

Key trends in reviews of child deaths completed by the Child Death Overview Panel during 2023/24

Child deaths are reviewed by the Child Death Overview Panel only after all other review processes are undertaken. Therefore, a child death may be notified during one year and reviewed during another.

The length of time between notification and final review can vary considerably depending on circumstances and other review processes. The reasons for delays can include awaiting further investigation through neonatal reviews, post-mortems and inquests.

[5] Based on ONS 2022 mid-year population estimates. ONS (2024) Population estimates for the UK, England, Wales, Scotland, and Northern Ireland: mid-2022. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest (Accessed 14 June 2024

[6] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

The deaths of 57 children were reviewed by Pan Cheshire Child Death Overview Panel during 2023/24, the majority of which died during 2021/22 or 2022/23 (76%).

As at 31 March 2024, reviews of 63 children were ongoing (compared to 68 as at 31 March 2023) and therefore could not as yet be reviewed by the Child Death Overview Panel.

Key trends in modifiable factors during 2023/24

Each child death is reviewed to understand if there were any ways children, young people or their families could be supported differently, which may prevent future deaths. These are known as modifiable factors. Due to the small numbers of child deaths seen each year, it can be helpful to take a longer term view to understand common modifiable or vulnerability factors.

Between 1 April 2022 and 31 March 2024, the leading modifiable (or vulnerability) factors associated with reviews completed by the Pan Cheshire Child Death Overview Panel have included:

- Mental health issues in a co-habiting parent, care giver or other family member, in 39% of all completed reviews.
- Substance or alcohol misuse in a co-habiting parent, care giver or other family member, in 20% of all completed reviews.
- Obesity (body mass index ≥30), in 20% of all completed reviews.
- Smoking, in 16% of all completed reviews.
- Parental separation, in 16% of all completed reviews.
- Domestic abuse, in 15% of all completed reviews.

Certain causes of death are more frequently associated with modifiable factors that if addressed may prevent further deaths in the future.

- During 2023/24, 32 out of 57 competed reviews were linked to modifiable risk factors this represents 56% of all deaths reviewed and is higher than the percentage across England as a whole (43%)[7].
- During 2023/24, all completed reviews with a primary category of deliberately inflicted injury, abuse or neglect, and sudden unexpected, unexplained death involved modifiable risk factors.
- Modifiable factors were also linked to the majority of completed reviews with the following primary categories of death:

[7] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 23/05/2024. Quarter 4 2023/24

- Trauma and other external factors, including medical/surgical complications or error.
- Perinatal or neonatal events.
- Suicide or deliberate self-inflicted harm.

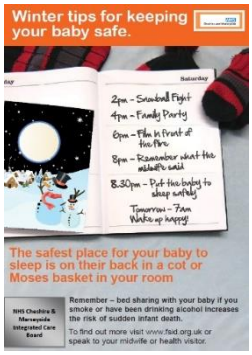
The same factors were highlighted as the most commonly identifiable factors across England as a whole during the most recent national data release (relating to 2022/23 child deaths)[8].

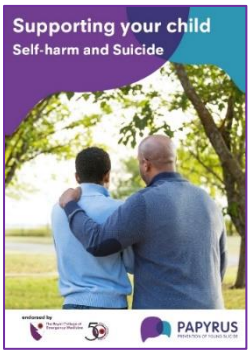
Progress during 2023/24 and achievements

Significant progress has been made against the recommendations in the 2022/23 Child Death Overview Panel Annual Report (see Progress against 2022/23 annual report recommendations during 2023/24) for further details.

Key achievements include:

- Awareness raising regarding:
  - Safe sleep
  - The ICON programme to provide information about infant crying including how to support parents/carers to cope, reduce stress and prevent injuries
  - Water safety
  - Button battery safety
  - Suicide prevention
  - Bereavement support
  - Child death processes
- Further development of child death review processes to reflect national guidelines and local learning.

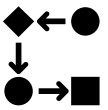




[8] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

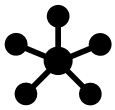
Priority recommendations for 2024/25

The priorities for 2024/25 include:



- Child Death Overview Panel reviews to promote greater reflection of the scrutiny of services provided by partner agencies and follow up on actions taken after learning has been identified through partner agency reviews.

- Further developing child death review processes to reflect national guidelines and local learning.
- To promote the findings from the Child Death Overview Panel Annual Report 2023/24 to wider partners.



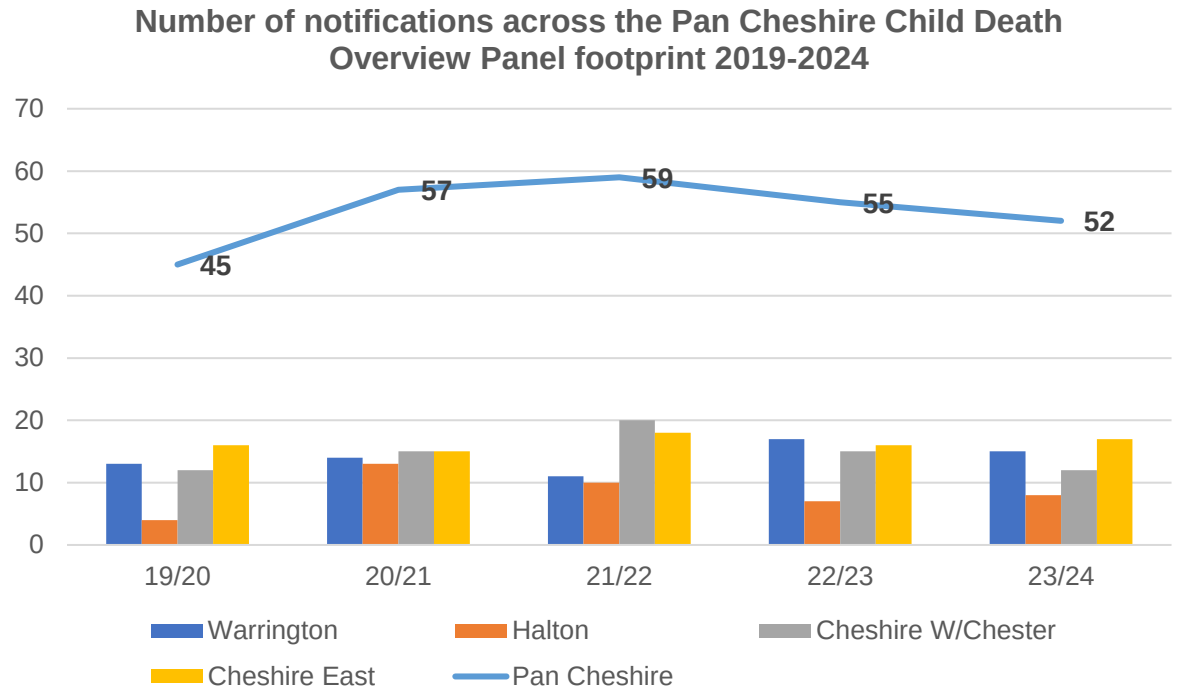
- To continue to support partners contributing to the Thirlwall Inquiry, await the recommendations from the Inquiry and to champion them amongst stakeholders.

A Child Death Overview Panel business plan has been developed for 2024/25 to facilitate progress against these priorities.

Appendices

Number of notifications to the Pan Cheshire Child Death Overview Panel

Natural variation in the number of deaths notified to Child Death Overview Panels is to be expected from year to year. Between 2019 and 2024, the number of child death notifications across the Pan Cheshire footprint has varied from 45 to 59. There were 52 notifications during 2023/24 across Pan Cheshire. This is 3 fewer than during 2022/23. During 2023/24, the highest numbers of death notifications were seen in Cheshire East and then Warrington.

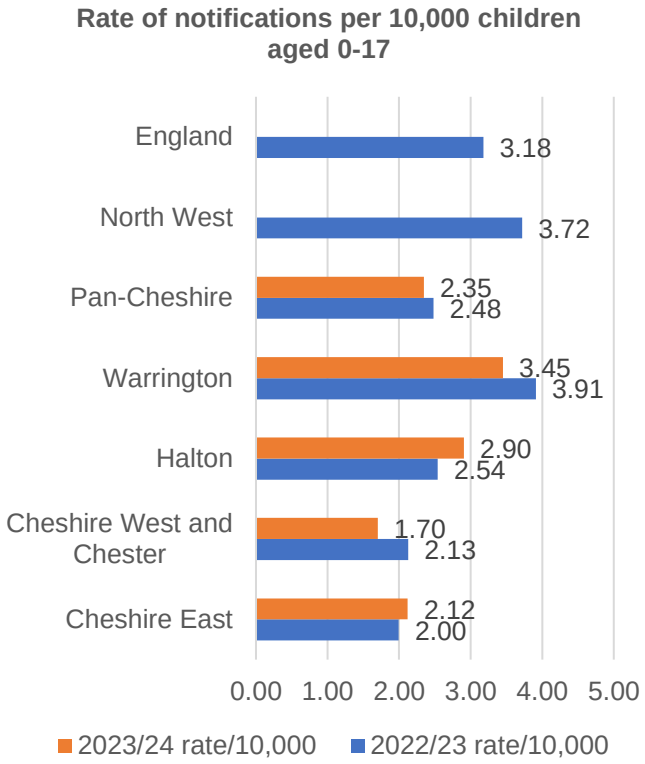


Rate of notifications to Pan Cheshire Child Death Overview Panel (per 10,000 children aged 0-17years)[9]

During 2023/24, the rate of notifications to the Pan Cheshire Child Death Overview Panel was 2.35/10,000 children aged 0-17 years. At time of writing, the national death notification rate for 2023/24 is not currently published. However, the death

[9] .Based on ONS 2022 mid-year population estimates. ONS (2024) Population estimates for the UK, England, Wales, Scotland, and Northern Ireland: mid-2022. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest (Accessed 14 June 2024).

notification rate across England for 2022/23 was 3.18/10,000 children aged 0-17. This was higher than the Pan Cheshire rate for 2022/23 (2.48/10,000)[10] (although the statistical significance of this difference has not been determined). The regional notification rates for 2022/23 ranged from 2.42/10,000 in the South West to 4.11/10,000 in the West Midlands[11]. The rate across the North West was 3.72/10,0004[11].



During 2023/24, the highest notification rate was seen in Warrington where there were 3.45 notifications/10,000 children aged 0-17 years. Warrington also had the highest rate during 2022/23. The rate for 2023/24 is lower than that for 2022/23. Single year rates are subject to significant random variation. Statistical analysis has determined that the Warrington rate of notifications for 2023/24 was not statistically significantly different to the rate of the other local authorities[11].

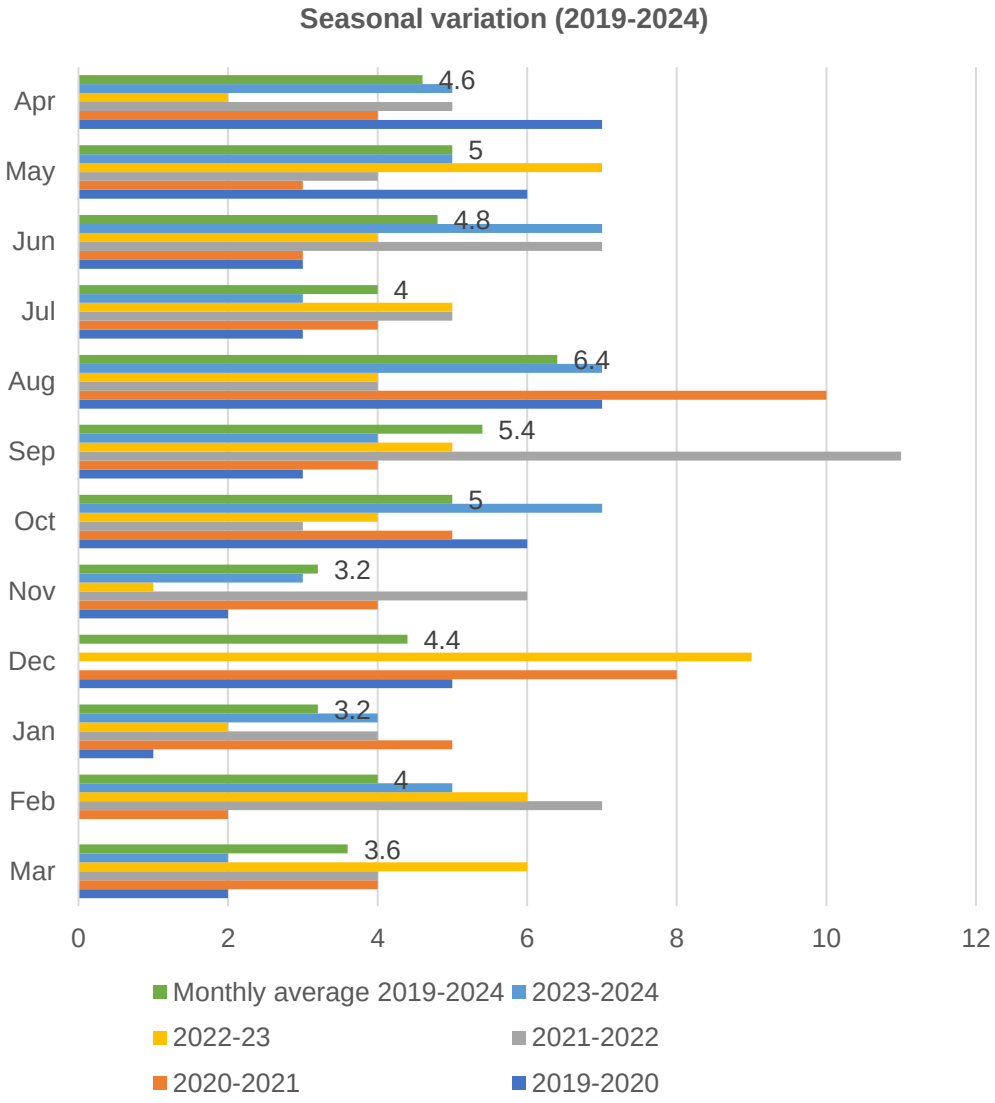
On reviewing rolling 3 year average rates of infant mortality in Warrington (2001-22) and of child mortality in Warrington (1-17 years old) (2010-2022), rates have been consistently similar to the England average[12]. In addition, the 3 year average child

[10] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).
[11] Cheshire East Council Public Health Intelligence Team (2024). Chi-squared testing was undertaken to determine whether there is a significant difference between the expected frequencies and the observed frequencies in one or more categories with null hypothesis that any differences are due to chance. Childhood deaths are similar across all Cheshire local authorities.
[12] Office for Health Improvement & Disparities. Public Health Profiles. (Accessed 14 June 2024) https://fingertips.phe.org.uk © Crown copyright (2024).

death notification rate (2021-2024) for Warrington (3.3/10,000) was more similar to Halton (3.1/10,000) than the single year rate for 2023/24.

Variation in notifications by month

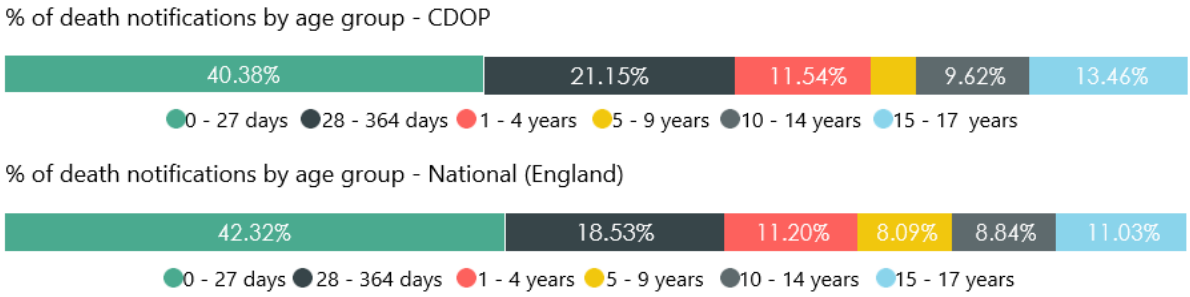
Seasonal variation in notifications to the Pan Cheshire Child Death Overview Panel are provided in the graph below. Monthly numbers of notifications varied from 0 in December to 7 in June, August and October. It is difficult to discern a pattern in terms of seasonal variation as the numbers for each given month vary from year to year. However, the month with the highest average rate over the last five years was August, followed by September[13]. The statistical significance of this finding has not been determined and this could be due to chance variation.



[13] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP. Report created on: 23/05/2024. Quarter 4 2023/24

Variation in notifications by age during 2023/24

The age distribution of notifications to Pan Cheshire Child Death Overview Panel was very similar to the England average, with the majority being deaths in the first year of life (62%) (see bar chart below)[14].



Numbers of reviews of child deaths completed by the Child Death Overview Panel

Child deaths are reviewed by the Child Death Overview Panel only when all information has been provided, and once all other review processes are completed. This is to ensure a final independent review by senior professionals to make sure all learning is identified and to ensure this learning will then be shared with wider relevant professionals to try and prevent future deaths, where possible.

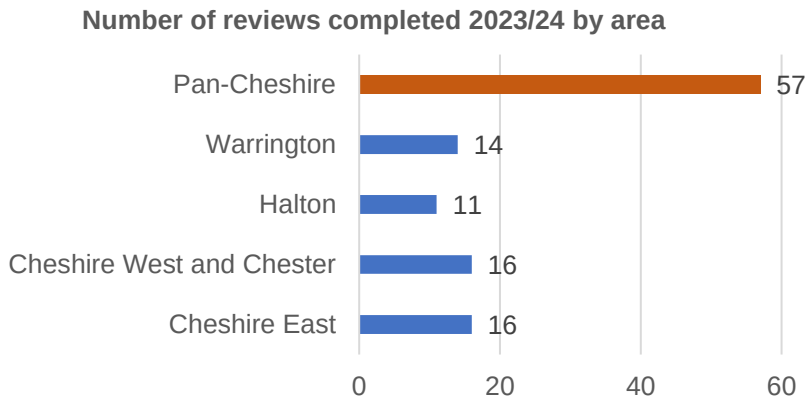
The length of time between notification and review can vary considerably depending on circumstances and other review processes. The reasons for delays can include awaiting further investigation through neonatal reviews, post-mortems and inquests.

57 reviews of child deaths were completed by the Child Death Overview Panel during 2023/24 (compared to 76 during 2022/23) The year of death of the cases reviewed ranged from 2016/17 to 2022/23:

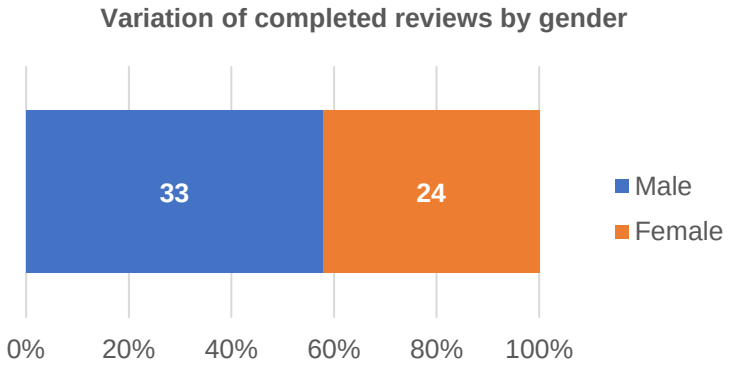
- 53% had died during 2022/23
- 23% had died during 2021/22

Of the reviews of child deaths completed, the highest numbers related to children resident in Cheshire East and Cheshire West and Chester, followed by Warrington. As at 31 March 2024, there were 63 cases with reviews ongoing (compared to 68 as at March 2023), and therefore could not as yet be reviewed by the Child Death Overview Panel. Cheshire East had 22 ongoing cases, Warrington 17, Cheshire West and Chester 14 and Halton 10.

[14] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP. Report created on: 23/05/2024. Quarter 4 2023/24

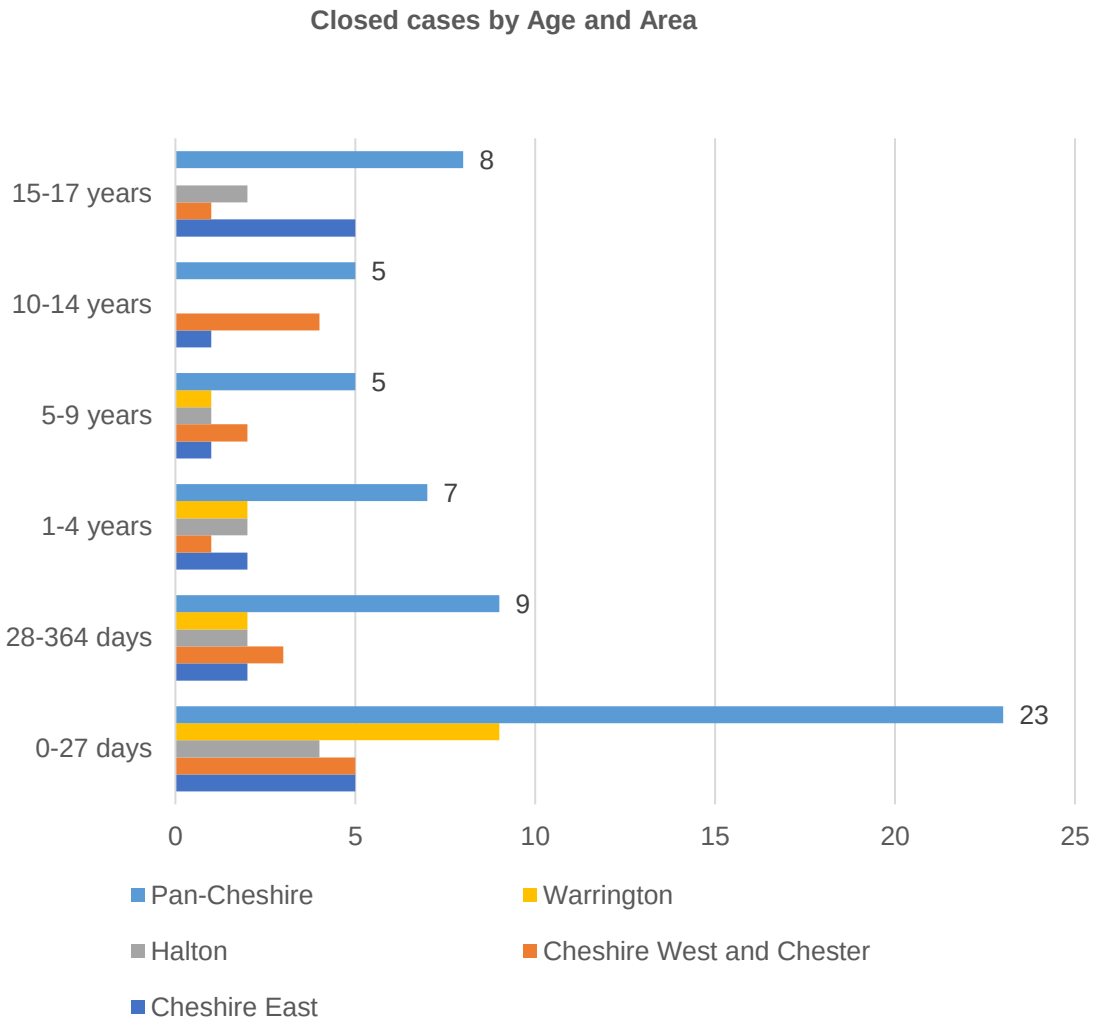


More males were reviewed than females.



Variation of reviews of child deaths completed by the Pan Cheshire Child Death Overview Panel by age and area (2023/24)

The highest numbers of child deaths reviewed related to death during the neonatal period (23/57,40%). 56% (32/57) of child deaths reviewed related to death within the first year. The next highest proportions of reviews related to 1-4 year olds (12%) and 15-17 year olds (14%) (see graph below).



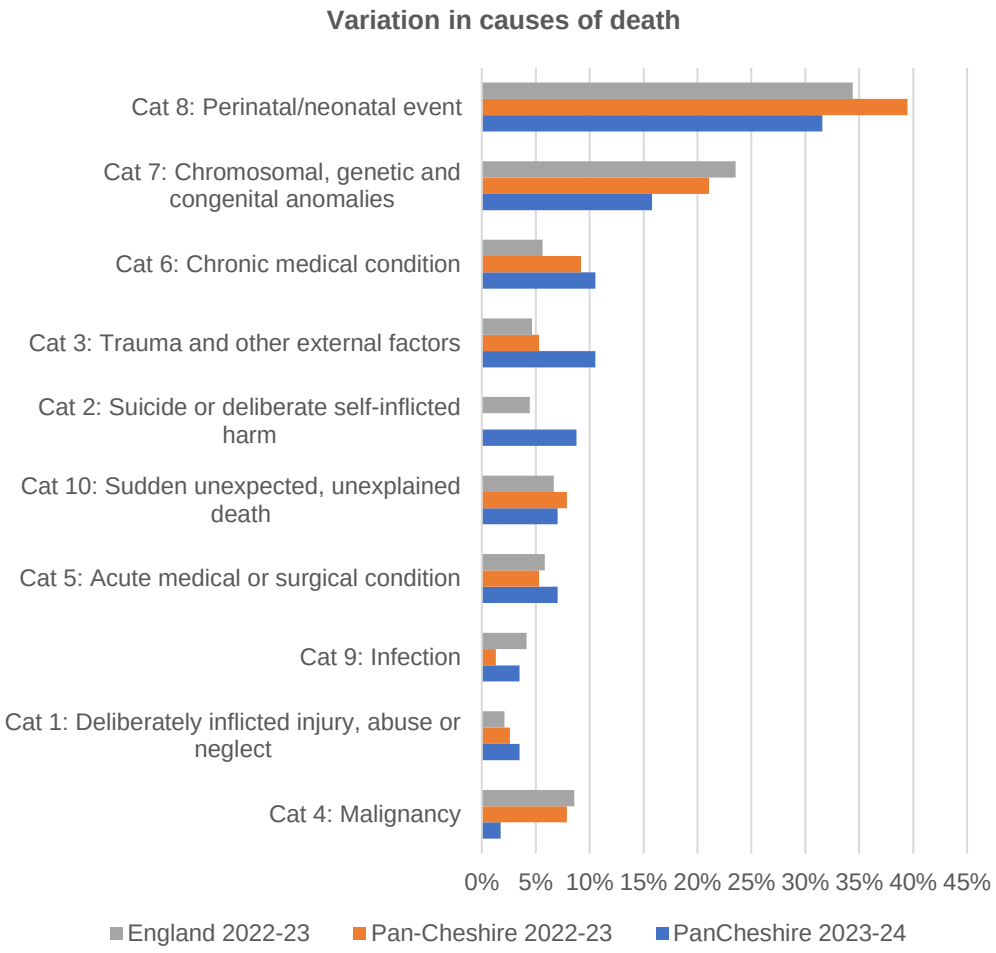
Causes or categories of death amongst reviews of child deaths completed by the Pan Cheshire Child Death Overview Panel (2023/24)

The most frequent causes of death amongst completed reviews were

- Perinatal/neonatal events (32%)
- This was followed by chromosomal, genetic and congenital anomalies (16%), chronic medical conditions (11%) and trauma and other external factors (11%)
- Suicide or deliberate self-inflicted harm was the category in 9% of cases (5/57)
- Sudden unexpected death was noted as a category of death in 7% of cases (4/57).

Whilst there is significant variation from year to year (due to the small numbers involved) and statistical significance has not been determined, the distribution of the

causes of death are fairly similar in the Pan Cheshire Child Death Overview Panel footprint to the England average[15].



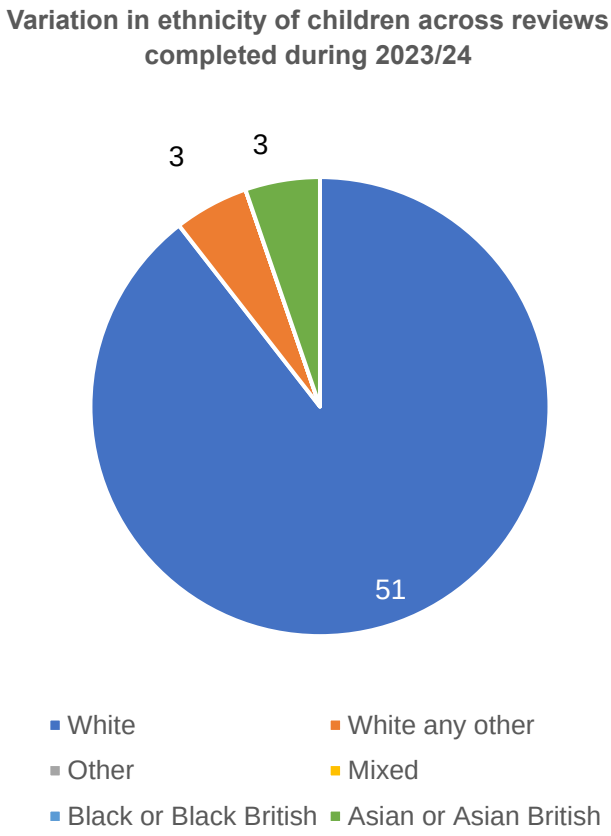
Variation in ethnicity of reviews of child deaths completed by the Pan Cheshire Child Death Overview Panel (2023/24)

The majority of closed cases were of “white” ethnicity (51/57, 89%), this was similar to 2022/23 where 87% of closed cases were of “white” ethnicity.

According to the School Census, 83% of children and young people were “White British” across the Pan Cheshire area. However, the classification of ethnicity may be slightly different. The numbers of closed cases are comparatively very small

[15] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

compared to the entire population. However, those from ethnicities other than White British do not appear to be significantly over represented[16].



Modifiable/vulnerability factors in reviews completed during 2022-24 across the Pan Cheshire Child Death Overview Panel footprint

Modifiable factors are factors across domains specific to the child, the social and physical environment, and service delivery that could be altered to prevent future deaths[17]. During 2022-24, the leading associated modifiable (or vulnerability) factors across the Cheshire Child Death Overview Panel area have included:

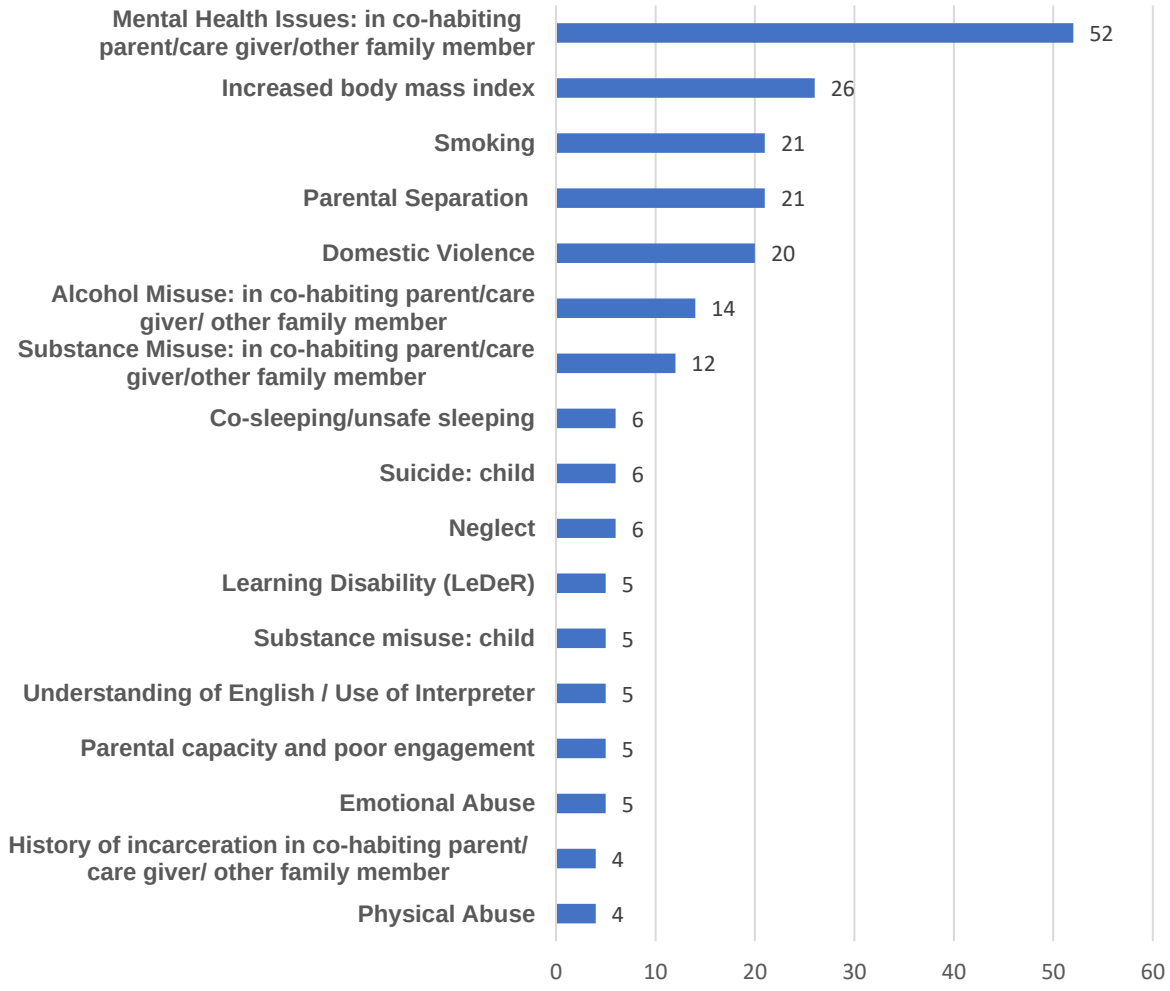
- Mental health issues in a co-habiting parent, care giver or other family member, in 39% of all completed reviews
- Substance or alcohol misuse in a co-habiting parent, care giver or other family member, in 20% of all completed reviews

[16] Gov.uk (2024) Academic year 2023/24. Schools, pupils and their characteristics. Available from: https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics (Accessed 14 June 2024).
[17] Gov.uk (2018) Child death review: statutory and operational guidance (England). Available from: Child death review: statutory and operational guidance (England) - GOV.UK (www.gov.uk) (Accessed 13 September 2024).

- Obesity (Body mass index ≥30), in 20% of all completed reviews
- Smoking, in 16% of all completed reviews
- Parental separation, in 16% of all completed reviews
- Domestic abuse, in 15% of all completed reviews

As well as child death data, other sources of data demonstrate the wider public health challenges of smoking and obesity across the Pan Cheshire population. According to the most recently available data, Halton and Warrington had significantly worse rates of mothers smoking at time of the birth of their babies than the England average. Cheshire West and Chester and Halton had a significantly higher prevalence of excess weight (people experiencing overweight or obesity) than the England average[18]

Variation in identified modifiable or vulnerability factors in completed reviews of child deaths (2022-24)



[18] Office for Health Improvement & Disparities. Public Health Profiles. Available from: https://fingertips.phe.org.uk © Crown copyright [2024].(Accessed 18 June 2024).

In addition to the modifiable and vulnerability factors that were recorded as part of a systematic framework, for 2023/4, some additional comments were recorded as more free-form text, including relating to the following themes:

- Equipment safety issues (2)
- Service development/provision issues (7).

Variation of modifiable risk factors across pan Cheshire Child Death Overview Panel by cause of death

During 2023/24, 32 out of 57 completed reviews were linked to modifiable risk factors. This represents 56% of all completed reviews and is higher than the percentage across England as a whole (43%).

During 2023/24, all completed reviews with a primary category of deliberately inflicted injury, abuse or neglect, and sudden unexpected, unexplained death had modifiable risk factors.

Modifiable factors were also linked to the majority of closed cases with the following primary categories of death.

- Trauma and other external factors, including medical/surgical complications or error.
- Perinatal or neonatal events.
- Suicide or deliberate self-inflicted harm.

The category of deaths with the highest numbers of cases with modifiable factors identified was for perinatal/neonatal events (see table on next page). These findings are similar to the national picture presented for child deaths during 2022-23, similar analysis for 2023-24 is not yet available[19].

[19] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

Primary category of death (CDOP)	Modifiable Factors Identified (%)	Modifiable Factors Identified (absolute numbers)
Malignancy	0%	0
Chronic medical condition	0%	0
Acute medical or surgical condition	0%	0
Chromosomal, genetic and congenital anomalies	33%	3
Infection	50%	1
Suicide or deliberate self-inflicted harm	60%	3
Perinatal/neonatal event	78%	14
Trauma and other external factors, including medical/surgical complications/error	83%	5
Deliberately inflicted injury, abuse or neglect	100%	2
Sudden unexpected, unexplained death	100%	4

Variation in modifiable risk factors by cause of death across England (2022-23)

The picture in Pan Cheshire during 2023/24 was similar to the England picture during 2022/23[20].

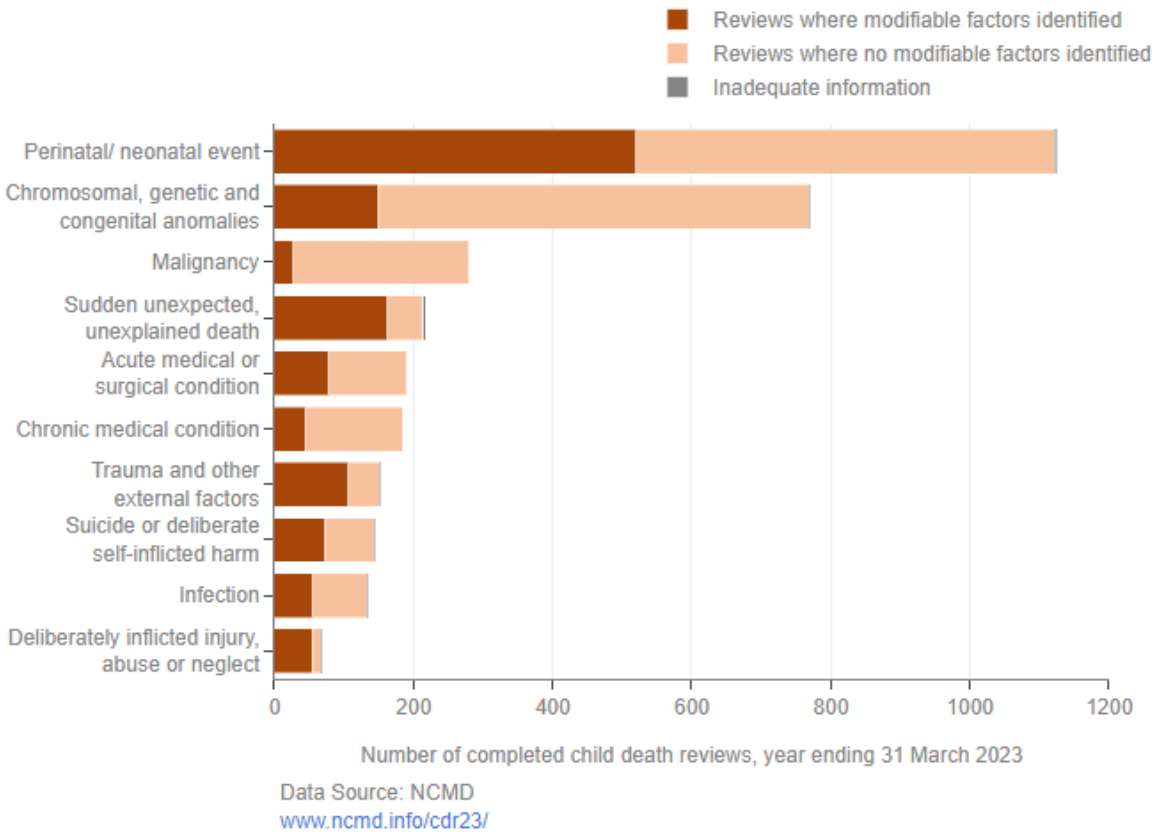
Categories of death where modifiable factors were most frequently identified in child deaths across England included:

- Deliberately inflicted injury, abuse or neglect (81%).
- Sudden unexpected and unexplained death (76%).
- Trauma or other external factors (71%).
- Suicide or deliberate self-inflicted harm (50%).

(See graph on next page).

[20] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

Number of reviews completed by the Child Death Overview Panel by primary category of death and whether modifiable factors were identified, year ending 31 March 2023



Adverse childhood experiences in cases of child death

Adverse Childhood Experiences (ACEs) are a set of adverse events or environmental factors occurring in a person's life under the age of 18. It has been shown that ACEs can negatively affect people's health and opportunities throughout their life, however in many cases ACEs are preventable[21].

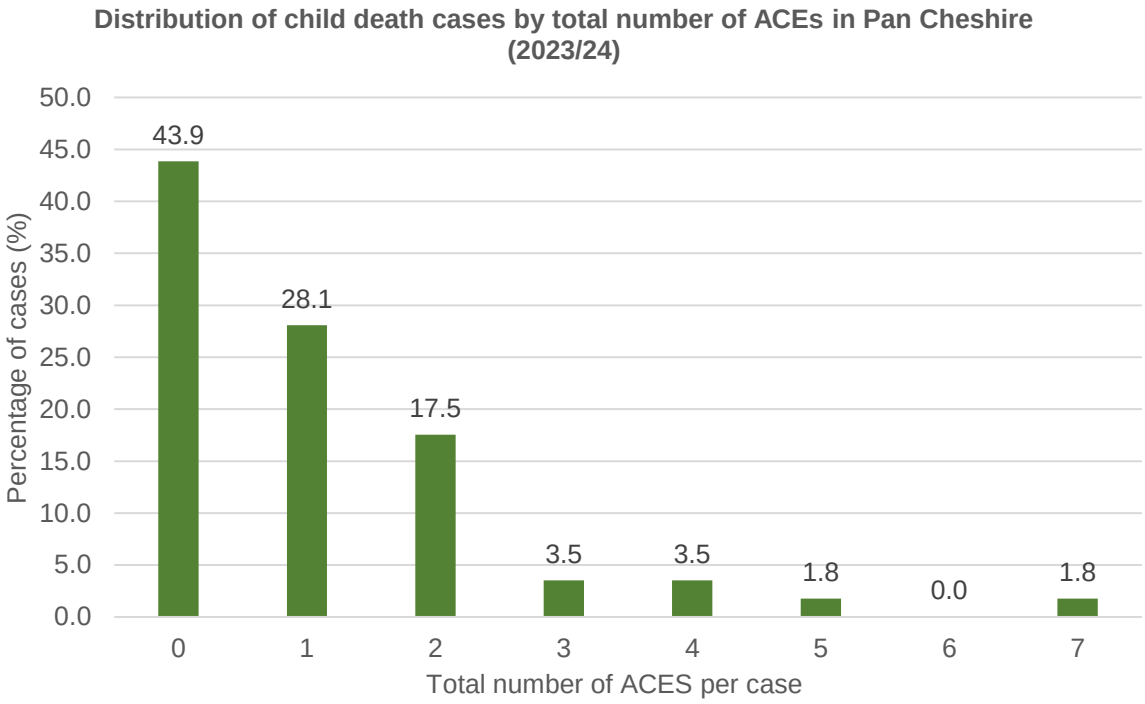
Across the Pan Cheshire Child Death Overview Panel area between 2019/20 and 2022/23 the most common ACEs present in child death cases were:

- Household mental health issues (present in 41 cases)
- Parental separation (present in 25 cases)
- Household domestic violence (present in 24 cases).

[21] CDC (2024) Adverse Childhood Experiences. Available from: https://www.cdc.gov/aces/about/index.html?CDC_AAref_Val=https://www.cdc.gov/violenceprevention/aces/preventingace-datatoaction.html (Accessed 13 September 2024).

However, children experiencing neglect have the highest mortality rates of all the ACEs (245 per 100,000 children experiencing neglect).

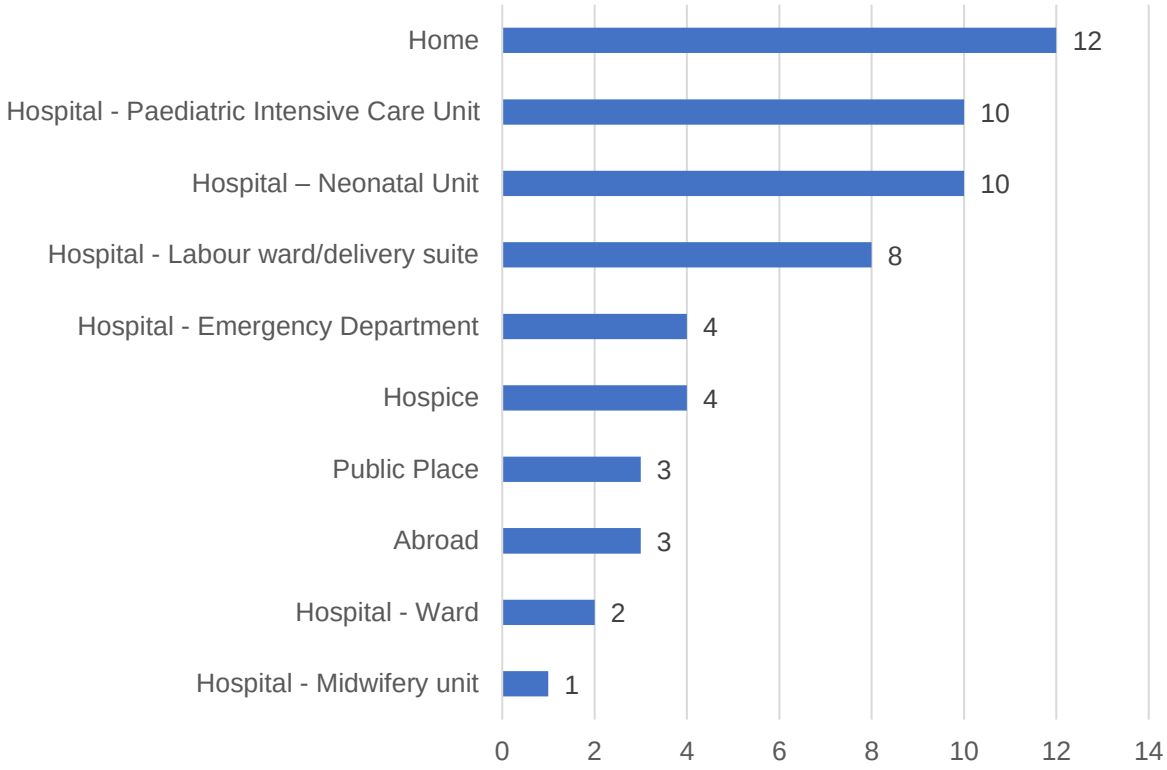
Just over 4 in 10 child deaths (25) in Pan Cheshire in 2022/23 had zero associated ACEs, and the number of ACEs for each child ranged between zero and seven of a possible ten. There were four children with four or more ACEs identified (7%).



Place of death of the reviews completed by the Pan Cheshire Child Death Overview Panel (2023/24)

49% (28/57) of deaths took place in either the hospital neonatal units, paediatric intensive care units, labour wards or delivery suites. 21% (12/57) of deaths were at home (see graph on next page).

Variation in place of death in completed reviews of child deaths (2023/24)



Achievements during 2023/24

Non-accidental injury prevention

A national learning event took place regarding The Infant Crying You Can Cope (ICON) programme: 25th - 29th of September 2023

The ICON programme is being implemented by health and social care organisations in the UK to provide information about infant crying. It includes how to support parents/carers cope, reduce stress and prevent 'Abusive Infant Head Trauma'.

Resources, toolkits, newsletters, and information on daily webinars were shared to all agencies in Cheshire via the communication teams.

ICON Week

25 - 29 September 2023

WEBINAR PROGRAMME

Monday 25 September	
10:30-10:35	Sue Anslow, ICON Programme Manager - Welcome to ICON Week
10:35-10:50	Dr Suzanne Smith PhD ICON Founder & Programme Advisor - Introduction
10:50-11:00	Jane Scattergood – A few words from our Chair
11:00-11:15	Sue Anslow - Feedback from Audit
13:00-13:30	Joanna Garstang – Birmingham Videos
14:30-15:00	Laura Kefford and Monica Davis - Raising awareness of ICON and abusive head trauma within the multi-agency
Tuesday 26 September	
10:00-10:30	Craig Johnson – SCPHN/Clinical Advisor for School Health for SSAFA, based in British Forces Cyprus Delivering ICON to the teenage audience
11:00-11:30	Tilly Pillay and Vijay Jobanputra STORK Programme and ICON
13:30-14:00	Eleanor Marchant - Team Leader 0-19 service Locala's approach to ICON and male inclusivity
15:00-15:30	Fran Acharya – ReachDeck - An accessible website for all
Wednesday 27 September	
10:00-10:30	James Foottit Account Director, Bauer Media - Get Our Message Heard
11:00-11:30	Lois Fisher Deputy Clinical Lead- ICON - Update from 0-19 HCP across Cambridgeshire and Peterborough
13:30-14:00	Dr Giles Haythornthwaite - Consultant Paediatrician - Why the Major Trauma network in the UK are stakeholders in parent advice at birth and support the ICON message
15:00-15:30	Deborah Gibbons - Safeguarding Midwife, Carla Clarke – Named Midwife Safeguarding, and Karen Turnbull - Clinical Practice Lead ICON Developments in Lancashire
Thursday 28 September	
10:30-11:00	Kristoper Sawyerwoo and Professor Anna Tarrant - Rethinking Dads
12:00-12:30	Emma Davis - Senior Probation Officer Warrington - Probation and ICON
13:00-13:30	Jonathan Hill Brown, Karen Tyson-Lee and Monica Davis - MECSH and ICON in Harrow Health Visiting
14:30-15:00	Dr Rachael Jolley - ICON in General Practice
Friday 29 September	
10:00-10:30	Kieran Anders - Dad Matters and ICON
10:45-11:30	Parents Ambassadors
11:30-12:00	Final thoughts and close from Dr Suzanne Smith

All webinars are on Microsoft Teams and available at this link www.iconcope.org/webinar-iconweek2023

Full details are available on our website: www.iconcope.org/iconweek2023

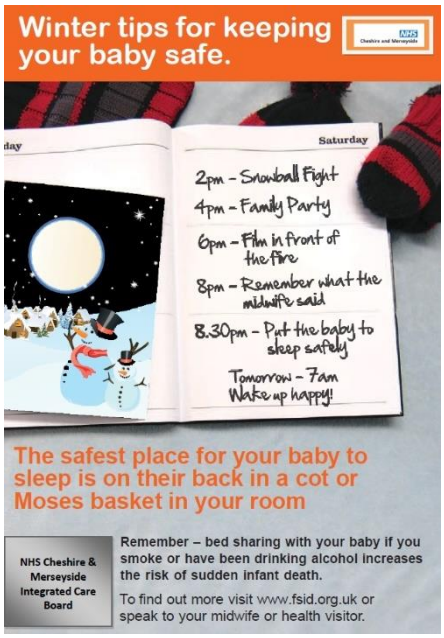
Safe sleep: Winter tips for keeping your baby safe (December 2023)

Christmas is often a period when infants are more exposed to situational risks as often a safe sleep plan for baby has not been considered by parents/carers when 'out of routine', for example, staying at relatives or friends, consuming excessive alcohol.

Regional promotional material on safe sleep was widely circulated across Pan Cheshire Child Death Overview Panel professional networks during the lead up to Christmas.

A leaflet was designed by Designated Nurse for West Place Integrated Care Board as the Christmas festive season was approaching.

The leaflet also contained tips on the infant safer sleep during the winter months, as parents/carers



may choose unsafe infant sleep techniques/methods as their decisions are compounded by deprivation and prevailing fuel poverty.

The leaflet was shared complete with QR codes for further reading to all multi agencies in Cheshire via the communication teams, safeguarding nurse teams and by the Pan Cheshire Child Death Overview Panel members.

There were no child death notifications during December 2023.

Accident prevention

A Christmas Button Battery Safety Message Poster was developed and disseminated following Concerns Raised by UKHSA about ingestion by children of button batteries.

As the Christmas festive period was approaching, a poster was developed for professionals to alert parents/carers of the dangers, symptoms of ingestion and to seek immediate medical help if it is suspected a child has swallowed a button battery.

This poster was shared to agencies throughout Cheshire and Merseyside via the communications teams.

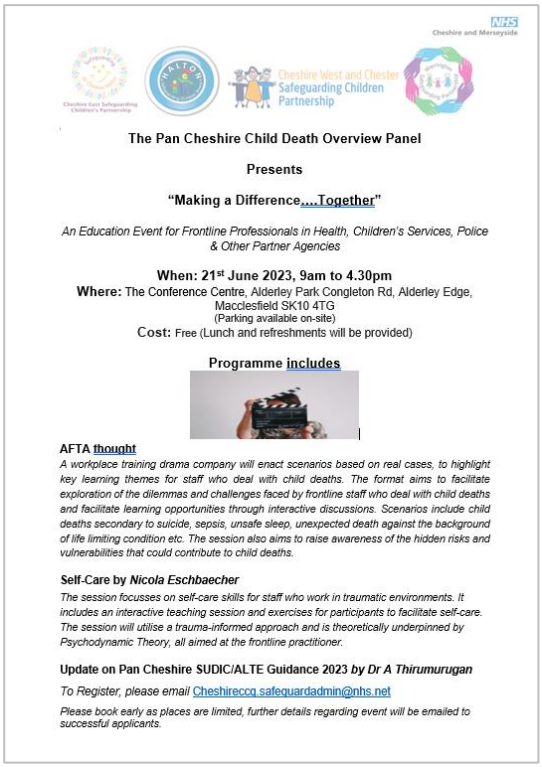
Enhancements of the child death review process

Plans were confirmed to move the administrative function of the Child Death Overview Panel to Mid Cheshire Hospitals NHS Foundation Trust and to expand capacity

The intention of moving the administrative function was to increase capacity for preparing cases for the panel and to increase resilience and pastoral support to those involved in the process.

Pan Cheshire Child Death Overview Panel Education Event, 21 June 2023

Making a Difference together-This was an interactive learning event for agencies held at Alderley Park Conference Centre. There was an update of the Pan Cheshire Sudden Infant and Child Death/ Acute Life-Threatening Event Guidance, learning through case scenarios delivered by the acting company 'AFTA thought', 'Trauma Informed Self Care' session followed by interactive reflections. The case scenarios were developed to highlight some of the issues identified by the Pan Cheshire Child Death Overview Panel. Over 100 professionals attended. Feedback was positive.



NHS
Cheshire and Merseyside

Cheshire West and Chester Safeguarding Children Partnership

The Pan Cheshire Child Death Overview Panel

Presents

"Making a Difference....Together"

An Education Event for Frontline Professionals in Health, Children's Services, Police & Other Partner Agencies

When: 21st June 2023, 9am to 4.30pm
Where: The Conference Centre, Alderley Park Congleton Rd, Alderley Edge, Macclesfield SK10 4TG
(Parking available on-site)
Cost: Free (Lunch and refreshments will be provided)

Programme includes

AFTA thought
A workplace training drama company will enact scenarios based on real cases, to highlight key learning themes for staff who deal with child deaths. The format aims to facilitate exploration of the dilemmas and challenges faced by frontline staff who deal with child deaths and facilitate learning opportunities through interactive discussions. Scenarios include child deaths secondary to suicide, sepsis, unsafe sleep, unexpected death against the background of life limiting condition etc. The session also aims to raise awareness of the hidden risks and vulnerabilities that could contribute to child deaths.

Self-Care by *Nicola Eschbaecher*
The session focusses on self-care skills for staff who work in traumatic environments. It includes an interactive teaching session and exercises for participants to facilitate self-care. The session will utilise a trauma-informed approach and is theoretically underpinned by Psychodynamic Theory, all aimed at the frontline practitioner.

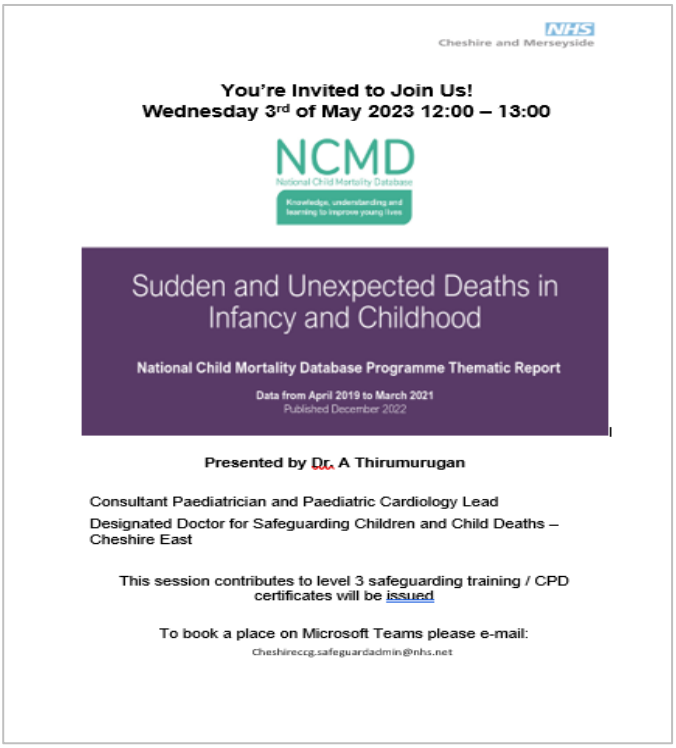
Update on Pan Cheshire SUDIC/ALTE Guidance 2023 *by Dr A Thirumurugan*

To Register, please email Cheshireccg.safeguardadmin@nhs.net

Please book early as places are limited, further details regarding event will be emailed to successful applicants.

The NCMD Sudden and Unexpected Deaths in Infancy and Childhood Thematic Report (virtual lunch and learn professional development session)

This session was presented by Dr Thirumurugan (Designated Dr for Child Deaths) on behalf of the Pan Cheshire Child Death Overview Panel to Multi agencies in Cheshire and Merseyside. Over 171 professionals attended. This report looked at vulnerabilities increasing susceptibility of sudden and unexpected deaths, modifiable factors and key learning points associated with the impact of the Covid -19 Pandemic and poor communication and information sharing, challenges in the child death response. It also affirmed the suspected risks associated with sudden and unexpected deaths infancy and the increased prevalence of convulsions in sudden and unexpected deaths in childhood.



NHS
Cheshire and Merseyside

You're Invited to Join Us!
Wednesday 3rd of May 2023 12:00 – 13:00

NCMD
National Child Mortality Database
Knowledge, understanding and learning to improve young lives

Sudden and Unexpected Deaths in Infancy and Childhood

National Child Mortality Database Programme Thematic Report

Data from April 2019 to March 2021
Published December 2022

Presented by Dr. A Thirumurugan

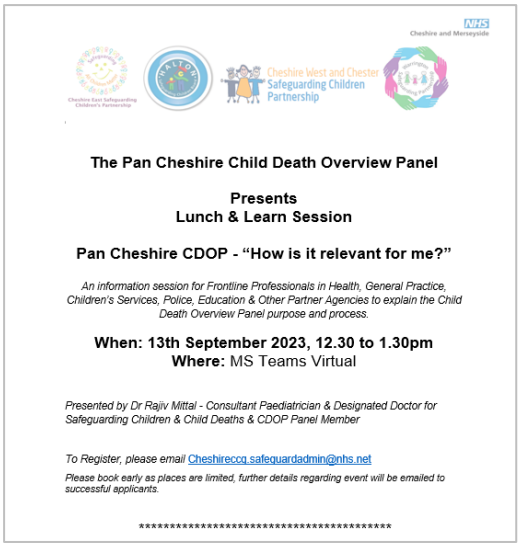
Consultant Paediatrician and Paediatric Cardiology Lead
Designated Doctor for Safeguarding Children and Child Deaths – Cheshire East

This session contributes to level 3 safeguarding training / CPD certificates will be issued

To book a place on Microsoft Teams please e-mail:
Cheshireccg.safeguardadmin@nhs.net

'How is it relevant for me?' (virtual lunch and learn professional development session), 13 September 2023

This session was presented by Dr Mittal (Designated Doctor for Child Deaths) to Multi agencies in Pan Cheshire, over 66 professionals attended. This event was to raise professional awareness of the Child Overview Panel purpose and processes for both unexpected and expected deaths of children who are resident within the Cheshire locality.



The Pan Cheshire Child Death Overview Panel

Presents
Lunch & Learn Session

Pan Cheshire CDOP - "How is it relevant for me?"

An information session for Frontline Professionals in Health, General Practice, Children's Services, Police, Education & Other Partner Agencies to explain the Child Death Overview Panel purpose and process.

When: 13th September 2023, 12.30 to 1.30pm
Where: MS Teams Virtual

Presented by Dr Rajiv Mittal - Consultant Paediatrician & Designated Doctor for Safeguarding Children & Child Deaths & CDOP Panel Member

To Register, please email Cheshireccg.safeguardadmin@nhs.net
Please book early as places are limited, further details regarding event will be emailed to successful applicants.

****

Progress against 2022/23 annual report recommendations during 2023/24

Recommendation	Progress during 2023/24	Next steps
1. Continue to share the Sudden Unexplained Death in Children processes within neonatal and maternity units for unexpected or unexplained collapses in hospital leading to deaths within them.	Agreed to re-circulate the individual Self Assessment Frameworks to Trusts to update.	To work with partners to promote further awareness, particularly in hospital trusts. To seek assurance that this activity has occurred.
2. Establish a system for monitoring notifications by hospital providers of neonatal and maternity care.	A spreadsheet has been established that identifies death notifications by month and unit; unexpected/ expected.	To ensure this is a standing agenda item in Child Death Overview Panel business meetings.
3. Develop stronger relationships with the Coroner's office, particularly in relation to information sharing, post-mortem reports and child death review meetings.	A coroner's office representative now attends Pan Cheshire Child Death Overview Panel meetings where feasible. A discussion with the Coroner took place during Autumn 2023 to discuss ways of strengthening relationships, which resulted in an agreement to a regular annual meeting.	Annual meetings with the coroner to become part of routine Child Death Overview Panel business.

4. Strengthen the Child Death Overview Panel business support functions through additional investment and funding arrangements.	Mid Cheshire Hospitals NHS Foundation Trust have taken over employment of the administrative function of the Child Death Overview Panel and funding has been confirmed for 1.2 administrators.	A second part-time administrator to be recruited. To explore strengthening resilience of business administration across Cheshire and Merseyside.
5. Maintain Pan Cheshire Child Death Overview Panel compliance with the National Child Mortality Database Report Key Performance indicators.	Compliance with key performance indicators has been demonstrated in the quarter four 2023/24 National Child Mortality Database report which highlighted “good” levels of completeness for all indicators.	To maintain this good standard of completeness of reporting.
6. Ensure that all parents whose child has died continue to have access to appropriate bereavement services.	Bereavement support is monitored at panel and followed up if bereavement support is not recorded; work by a Child Death Overview Panel representative has been quite instrumental in ensuring bereavement support remains at the fore front of professionals. Anecdotally, the number of analysis forms being returned without information regarding bereavement support is limited.	Sustain this support and continue to monitor as part of business as usual.
7. Ensure that all parents whose child has died are offered the opportunity to contribute to Child Death Review process.	Parents are contacted by the Child Death Overview Panel administrator.	To audit this and utilise national resources to support parental involvement.
8. Raise the profile of Child Death Overview Panel and the Child Death Review processes, and highlight impacts, with Health and Wellbeing Boards, and children’s safeguarding partners.	A development day was delivered involving a wide range of professionals; circulating national reports; annual report presentations; circulation of National Child Mortality Database quarter 4 report; annual report; quarterly reporting to Integrated Care Board safeguarding; Reports were also taken to the Integrated Care Board.	Further delivery of development days for a wide range of audiences. Adapt the format of Child Death Overview Panel reports to optimise their use and ability to influence.
9. Explore more alternative ways of presenting annual data to strategic partners.		To establish and contribute to a Cheshire and

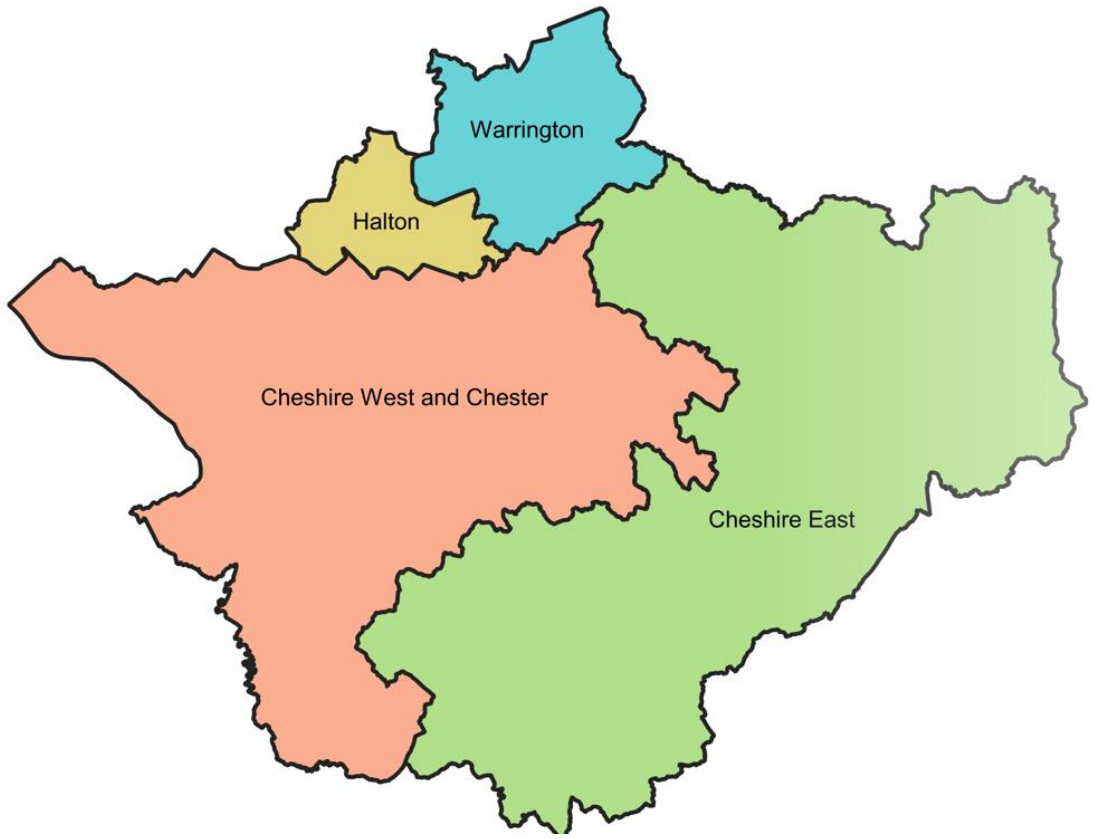
		Merseyside wide strategic group.
10. Reduce the number of outstanding deaths ready for review by the Child Death Overview Panel through additional meetings if required.	There has been a slight reduction in the number of outstanding reviews.	To continue with two monthly Child Death Overview Panel case review sessions and to extend sessions as needed.
11. Analyse trends and themes that will inform awareness raising/ training sessions as required.	Longer-term analysis of modifiable factors has been included in the 2023/24 annual report along with an in-depth review of adverse childhood experiences associated with child deaths. Circulate National Child Mortality Database quarterly reports; monitor themes emerging from panels and national reports, and provide recommendations; develop 7-minute briefings.	Exploration of the eCDOP system in relation to more comprehensive analysis of longer term trends.
12. Cooperate and contribute as required to the Thirlwall Inquiry.	All partners who have been asked to provide information for the Inquiry have complied.	To continue to support the public inquiry as required.
13. Clearing the backlog of cases pending Child Death Overview Panel review.	An open cases tracker has been developed and is a standing item on all business meeting agendas; modifiable reasons for delay are identified and followed up.	To continue with two monthly, rather than quarterly, case review meetings.
14. Promote greater participation by partner agencies at Child Death Review Meetings (CDRM) in cases where there has been prior involvement during life.	Invitation lists have been extended with regards to Sudden Unexplained Death in Children.	To seek assurance from partners in the case of expected deaths.
15. Promote greater reflection and scrutiny of services provided by partner agencies and any identified learning following child deaths from partner agencies' perspective,	Delivery of educational events and additional support from charities has been provided.	To continue with this provision and to explore obtaining further early years provision input.

at Child Death Overview Panel reviews.		
16. Evidence how the functions of the Child Death Overview Panel has influenced policy and practice within the local health economy and its impact.	We have explored alternative ways of presenting annual data to strategic partners; develop 7-minute briefings	To explore utilisation of the eCDOP system as part of this.

Contributors to the report

This report was produced through a collaborative multi-agency team including:

- Dr Susan Roberts, Consultant in Public Health, Cheshire East Council
- Janice Bleasdale, Specialist Child Death Review Nurse, Cheshire East Place & Cheshire West Place, NHS Cheshire and Merseyside Integrated Care Board
- Sue Pilkington, Designated Nurse Safeguarding Children and Children in Care, Cheshire West Place, NHS Cheshire and Merseyside Integrated Care Board
- Dr Rajiv Mittal, Designated doctor for Safeguarding and Child deaths, Countess of Chester Hospital
- Anne Barber, Senior Administrator, Pan Cheshire Child Death Overview Panel, Mid Cheshire Hospitals NHS Foundation Trust
- Jack Chedotal and Sara Deakin, Public Health Intelligence, Cheshire East Council
- The wider Pan Cheshire Child Death Overview Panel



Annual Report of the

Pan Cheshire Child Death Overview Panel

2023/24

November 2024

Contents

1. Introduction

Each child death is a tragedy.

"The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child and know that people will learn from what happened. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths"[1].

Child Death Overview Panels exist to ensure the independent and systematic review of the death of every child, so that lessons can be learned from these tragic events and shared effectively to prevent future deaths, wherever possible.

At the time of writing this most recent annual report, the live hearings at the public Thirlwall Inquiry have commenced. This inquiry has been set up to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital.

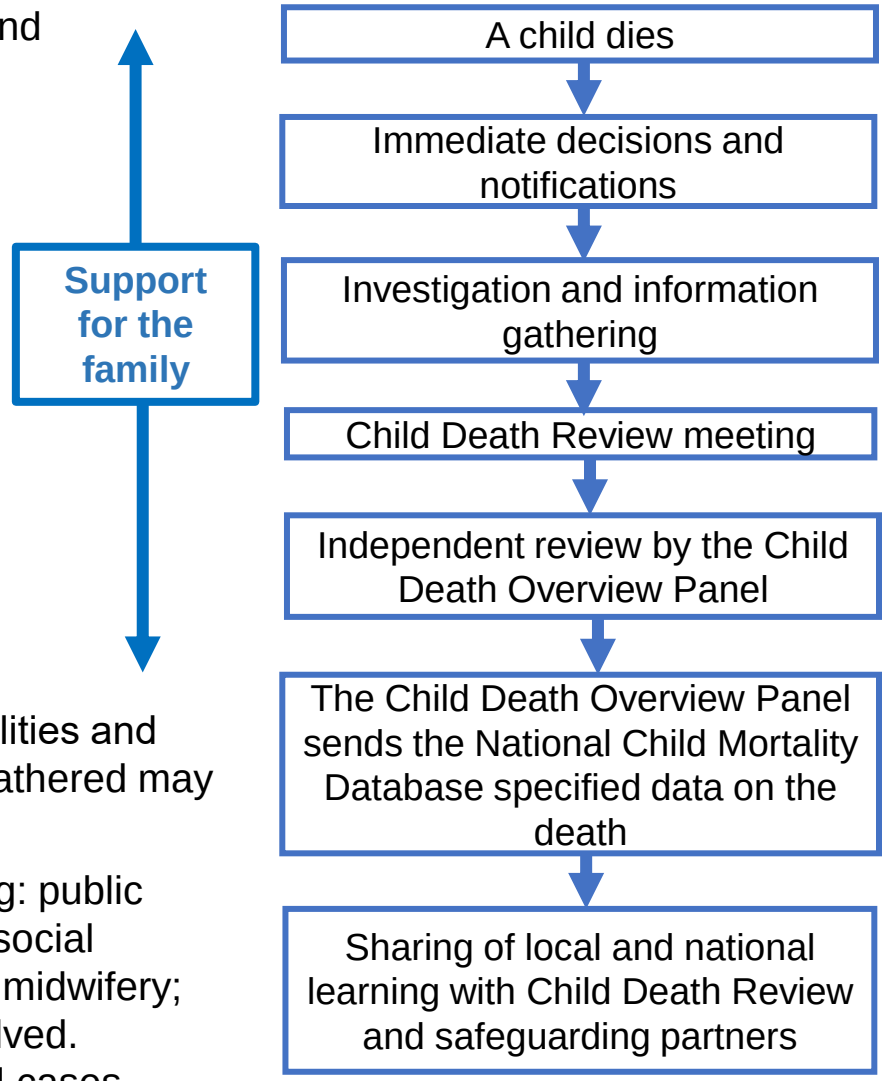
The Pan Cheshire Child Death Overview Panel continues to support partners contributing to the Thirlwall Inquiry. Once the Inquiry concludes, the Panel is committed to championing the recommendations that result.

This current report focuses on children whose deaths were either notified to the Pan Cheshire Child Death Overview Panel during 2023/24, or whose reviews concluded during 2023/24.

As a panel, we are dedicated to ensuring our families are supported following the death of their child, and that any learning from these heartbreaking losses is fully acknowledged and shared across the Pan Cheshire area and beyond.

2. The Pan Cheshire Child Death Overview Panel footprint and process

- Child Death Review partners include the local authorities and the NHS Cheshire and Merseyside Integrated Care Board.
- The Cheshire Child Death Overview Panel includes representatives from across:
  - **Cheshire East**
  - **Cheshire West and Chester**
  - **Halton**
  - **Warrington**
- The child death review process is outlined in statutory guidance: *Working Together to Safeguard Children 2023* and *Child Death Review Statutory and Operational Guidance (England) 2018*.
- When a child dies, the process described in the figure to the right is undertaken. More detail is provided in the statutory guidance.
- The review by the Child Death Overview Panel is intended to be the final, independent review of a child's death by senior professionals from different specialities and organisations with no responsibility for the child during their life. The information gathered may help identify factors that could be altered to prevent future deaths.
- The Pan Cheshire Child Death Overview Panel consists of varied experts including: public health representatives, the Designated Doctor for Child Deaths for the local area; social services; police, the Designated Doctor or Nurse for Safeguarding; nursing and/or midwifery; and other professionals that Child Death Review partners consider should be involved. Additional professionals may be asked to contribute reports in relation to individual cases.



3. Supporting families with child bereavement

At the centre of every child death are families and friends experiencing devastating loss.

An important role of the Child Death Overview Panel is to ensure families have the support and importantly, compassion and sensitivity that is so greatly needed in such distressing circumstances. Child Bereavement UK has produced guidance to support professionals with this important role.

"Working with families who are grieving can feel daunting…

Nothing we can do or say can take away the pain of bereavement, but families tell us of the importance of sensitive care. Poor care can intensify and prolong a family's distress, whilst care that is sensitive and appropriate can help families in their grief. The effects of this are positive and long-lasting…

Supporting bereaved families includes good communication, responding to their needs in a timely way, and being emotionally self-aware"[1]

4. Purpose of the Child Death Overview Panel Annual Report

As outlined in the statutory guidance, the purpose of the Annual Report is:

- To clarify and outline some of the Child Death Overview Panel processes directed by national guidance.
- To assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across the Pan Cheshire Child Death Overview Panel footprint.
- To provide an overview of information on trends and patterns in child deaths reviewed across the Pan Cheshire Child Death Overview Panel footprint during the last reporting year (2023/24) and highlight issues arising from the child deaths reviewed.
    - This could include deaths of children who were resident in the Pan Cheshire Child Death Overview Panel footprint, or who died in the footprint.
- To report on achievements and progress.
- To make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across the Pan Cheshire Child Death Overview Panel footprint.

5. Key trends in child death notifications

As described in the statutory guidance, when a child dies, a number of notifications should also be made, including: to the child's GP and other professionals; to the Child Health Information System; the relevant Child Death Review partners and the Child Death Overview Panel. This helps to guide how to support the family. It also helps to identify whether Joint Agency Reviews, NHS serious investigations, or referrals to the coroner are required. Across Pan Cheshire:

- **Rates of child notifications were reasonably stable over the last three years.**
- **There were 52 child death notifications during 2023/24 compared to 55 during 2022/23.**
- The rate of notifications across Pan-Cheshire during 2023/24 was 2.35/10,000 0-17 year olds and 2.48/10,000 during 2022/23*.
    - The rate of notifications across England as a whole was 3.18/10,000 during 2022/23[1].
- **The majority of notifications were in children under the age of 1 year** (62%), this was a similar to the age distribution across England as a whole.
- It is difficult to discern a pattern of seasonal variation due to the very small numbers involved.

*Based on ONS 2022 mid-year population estimates. ONS (2024) Population estimates for the UK, England, Wales, Scotland, and Northern Ireland: mid-2022. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest (Accessed 14 June 2024).

6. Key trends in reviews of child deaths completed by the Child Death Overview Panel during 2023/24

Child deaths are reviewed by the Child Death Overview Panel only after all other review processes are undertaken. Therefore, a child death may be notified in during one year and reviewed in another.

- The length of time between notification and review can vary considerably depending on circumstances and other review processes.
- The reasons for delays can include awaiting further investigation through neonatal reviews, post-mortems and inquests.

The deaths of 57 children were reviewed by Cheshire Child Death Overview Panel during 2023/24, the majority of which died during 2021/22 or 2022/23 (76%).

As at 31 March 2024, reviews of 63 children were ongoing (compared to 68 as at 31 March 2023) and therefore could not as yet be reviewed by the Child Death Overview Panel.

7. Key trends in modifiable or vulnerability factors from 2022 to 2024

Each child death case is reviewed to understand if there were any ways children, young people or their families could be supported differently that may prevent future deaths. These are known as modifiable factors. Due to the small numbers of child deaths seen each year, it can be helpful to take a longer term view to understand common modifiable or vulnerability factors.

Between 1 April 2022 and 31 March 2024, the leading modifiable (or vulnerability) factors associated with reviews completed by the Pan Cheshire Child Death Overview Panel area have included:

- **Mental health issues** in a co-habiting parent, care giver or other family member
- **Substance or alcohol misuse** in a co-habiting parent, care giver or other family member
- **Obesity** (body mass index ≥30)
- **Smoking**
- **Parental separation**
- **Domestic abuse**

More information on modifiable factors is provided on the next slide.

8. Causes of death associated with modifiable factors during 2023/24

Certain causes of death are more frequently associated with modifiable factors that if addressed may prevent further deaths in the future.

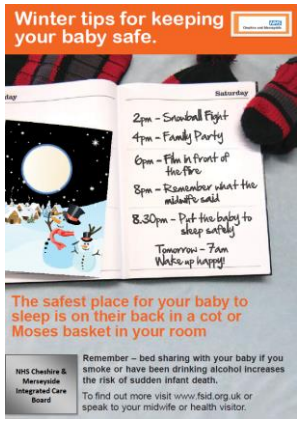
- **During 2023/24, 32 out of 57 competed reviews were linked to modifiable risk factors this represents 56%** of all deaths reviewed and is higher than the percentage across England as a whole (43%)*.
- **During 2023/24, all completed reviews with a primary category of deliberately inflicted injury, abuse or neglect, and sudden unexpected, unexplained death involved modifiable risk factors.**
- Modifiable factors were also linked to the majority of completed reviews with the following primary categories of death
  - **Trauma and other external factors, including medical/surgical complications or error**
  - **Perinatal or neonatal events**
  - **Suicide or deliberate self-inflicted harm.**
- **The same factors were highlighted as the most commonly identifiable factors across England** as a whole during the most recent national data release (relating to 2022/23 child deaths)[1].

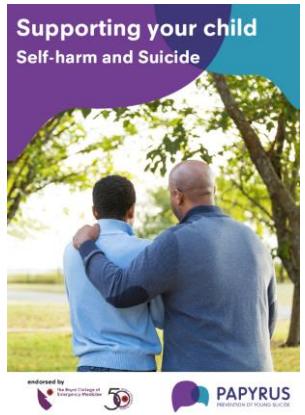
*NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP. Report created on: 23/05/2024. Quarter 4 2023/24

9. Progress during 2023/24 and achievements

Significant progress has been made against the recommendations in the 2022/23 Child Death Overview Panel Annual Report (please see the full annual report document for further details). Key achievements include:

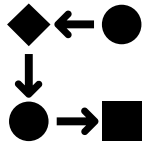
- Awareness raising regarding
  - **Safe sleep**
  - **The ICON programme** to provide information about infant crying including how to support parents/carers to cope, reduce stress and prevent injuries
  - **Water safety**
  - **Button battery safety**
  - **Suicide prevention**
  - **Bereavement support**
  - **Child death processes**
- Further development of child death review processes to reflect national guidelines and local learning





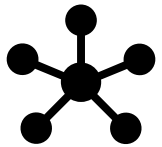
10. Priority recommendations for 2024/25

The priorities for 2024/25 include:



- Child Death Overview Panel reviews to promote greater reflection of the scrutiny of services provided by partner agencies and follow up on actions taken after learning has been identified through partner agency reviews.

- Further developing child death review processes to reflect national guidelines and local learning.
- To promote the findings from the Child Death Overview Panel Annual Report 2023/24 to wider partners.



- To continue to support partners contributing to the Thirlwall Inquiry, await the recommendations from the Inquiry and to champion them amongst stakeholders.

A Child Death Overview Panel business plan has been developed for 2024/25 to facilitate progress against these priorities.

Contributors to the report

This report was produced through a collaborative multi-agency team including

- Dr Susan Roberts, Consultant in Public Health, Cheshire East Council
- Janice Bleasdale, Specialist Child Death Review Nurse, Cheshire East Place & Cheshire West Place, NHS Cheshire and Merseyside Integrated Care Board
- Sue Pilkington, Designated Nurse Safeguarding Children and Children in Care, Cheshire West Place, NHS Cheshire and Merseyside Integrated Care Board
- Dr Rajiv Mittal, Designated doctor for Safeguarding and Child deaths, Countess of Chester Hospital
- Anne Barber, Senior Administrator, Pan Cheshire CDOP, Mid Cheshire Hospitals NHS Foundation Trust
- Jack Chedotal and Sara Deakin, Public Health Intelligence, Cheshire East Council