Public Document Pack

Health and Social Care Policy and Performance Board

Tuesday, 23 September 2025 at 6.30 p.m.
Council Chamber, Runcorn Town Hall

Interim Chief Executive

BOARD MEMBERSHIP

Councillor Eddie Dourley (Chair)	Labour
Councillor Sandra Baker (Vice-Chair)	Labour
Councillor Sian Davidson	Reform UK
Councillor Louise Goodall	Labour
Councillor Stan Hill	Labour
Councillor Colin Hughes	Labour
Councillor Alan Lowe	Labour
Councillor Katy McDonough	Labour
Councillor Norman Plumpton Walsh	Labour
Councillor Aimee Skinner	Labour
Councillor Tom Stretch	Labour
David Wilson	Healthwatch Co-optee

Please contact Kim Butler on 0151 511 7496 or email kim.butler@halton.gov.uk for further information.

The next meeting of the Board is on Tuesday, 25 November 2025

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

Part I

6. COUNCILWIDE SPENDING AS AT 31 MAY 2025 | **337 - 399**

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

HEALTH AND SOCIAL CARE POLICY AND PERFORMANCE BOARD

At a meeting of the Health and Social Care Policy and Performance Board held on Tuesday, 24 June 2025 at Council Chamber, Runcorn Town Hall

Present: Councillors Dourley (Chair), Baker (Vice-Chair), Davidson, Goodall, S. Hill, A. Lowe and N. Plumpton Walsh

Apologies for Absence: Councillor Hughes and McDonough

Absence declared on Council business: None

Officers present: K. Butler, H. Moir, S. Wallace-Bonner and L. Wilson

Also in attendance: T. Leo – Halton Place, NHS Cheshire & Merseyside

ITEMS DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HEA1 MINUTES

The Minutes of the meeting held on 11 February 2025 were signed as a correct record.

HEA2 PUBLIC QUESTION TIME

It was confirmed that no public questions had been received.

HEA3 HEALTH AND WELLBEING MINUTES

The minutes from the Health and Wellbeing Board meeting held on 12 March 2025, were submitted to the Board for information.

HEA4 HPPB ANNUAL REPORT 2024 25

The Chair presented the Health Policy and Performance Board's (PPB) Annual Report for April 2024 to March 2025.

During this period the Health PPB examined in detail many of Halton's Health and Social Care priorities. Details of the work undertaken by the Board was outlined in the

Annual Report.

The Chair thanked his Board Member colleagues and Officers for their input and support throughout the year.

RESOLVED: That the Annual Report be received.

HEA5 CONSULTATION ON PROPOSED CHANGES TO FERTILITY TREATMENT POLICIES ACROSS CHESHIRE AND MERSEYSIDE

The Board received a report from the Integrated Care Board (ICB) Place Director which outlined the proposals by NHS Cheshire and Merseyside ICB to harmonise the existing 10 Fertility Policies in place across the 9 Local Authority Place areas in Cheshire and Merseyside into a single policy for Cheshire. This would result in some changes to existing access for patients registered with a GP practice in Halton. The proposals incorporated changes to:

- the number of NHS funded IVF cycles available to patients;
- changes to eligibility with regards Body Mass Index and Smoking;
- changes to definition of childlessness;
- changes to Intra Uterine Insemination commissioning; and
- wording on the lower and upper ages for fertility treatment.

A number of other options regarding IVF cycles were considered and the pros and cons of each were outlined in table 4 of the report.

A six week public consultation went live on 3 June 2025 and was due to finish on 15 July 2025. Following a period of consideration of the findings of the consultation, the recommendations for approval regarding the single Fertility Policy for Cheshire and Merseyside would be presented to the ICB Board at its meeting on 25 September 2025.

Members of the Board noted the report and shared some of their personal experiences. Following discussions, Members confirmed that they did not endorse the proposals outlined in the report and formally requested a Joint Scrutiny Board for further consideration on this topic.

The importance and sensitivity of the topic was acknowledged and Members were thanked for their

comments. They were also encouraged to participate in the consultation and make their views known. The comments regarding the impact on individual's physical and mental health were taken on board. Members were advised, that should the policy be adopted, it would only be until National Institute for Health and Care Excellence (NICE) guidance was published (no expected date) and then the policy would be reviewed again.

The Chair agreed to email Board Members about participating in the consultation; two Members would be required to sit on a Joint Scrutiny Board.

RESOLVED: That the Board:

1) confirms that the proposal represents a substantial development or variation and Halton would participate in a Joint Scrutiny Board in line with the agreed protocol for establishment of joint health scrutiny arrangements for Cheshire & Merseyside; and

2) agree two Members of the Health Policy and Performance Board would be sought to participate in the Joint Scrutiny Board.

HEA6 HPPB SCRUTINY TOPIC 2025 26

The Board considered a report which presented the topic brief for the Health Policy and Performance Board's 2025-26 scrutiny review.

It was noted that at the February meeting it was agreed that '*Mental Health Support'* would be the focus of the 2025-26 scrutiny review. Appendix 1 set out the remit and areas of focus that would be considered as part of the Scrutiny Review.

It was confirmed that the first meeting of the topic group would take place in July and thereafter on a monthly basis. Members would be presented with information regarding the areas covered in the Topic Brief to scrutinise service delivery, emerging issues and opportunities in order to develop a set of recommendations for a report, which would be presented to the Board in February 2026. The Chair invited all Members of the Board to participate.

RESOLVED: That

1) the report be noted; and

2) the Board approves the topic brief as outlined in Appendix 1.

HEA7 MINOR AND MAJOR ADAPTATIONS PERFORMANCE UPDATE

The Board received a report from the Executive Director – Adults, which provided an update on performance relating to Minor and Major Adaptations funded through the Council's Disabled Facilities Grant (DFG).

A minor adaptations contract was in place for people in owner occupied or private rentals and work was undertaken by Upholland Property Services (UPS). Major adaptations, which required a DFG, were managed through Halton's Home Improvement Agency.

A home adaptation was delivered in 4 key stages and during April 2024 to March 2025 the following works were completed:

Minor adaptations (by UPS)	1515
DFG	35 (44 cancelled)
Registered Social Landlord/DFG	110
Stairlifts	9 (20 cancelled)

Members noted a number of challenges within the provision of minor and major adaptations and these were described in section 3.3 of the report.

RESOLVED: That the report is noted.

HEA8 PERFORMANCE MANAGEMENT REPORTS QUARTER 4 2024/25

The Board received the Performance Management Reports for quarter four of 2024/25.

Members were advised that the report introduced, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in quarter three of 2024/25. This included a description of factors, which were affecting the service.

The Board was requested to consider the progress and performance information; raise any questions or points for clarification; and highlight any areas of interest or concern for reporting at future meetings of the Board.

RESOLVED: That the Performance Management report for quarter four of 2024/25 be received.

HEA9 COUNCILWIDE SPENDING AS AT 31 JANUARY 2025

The Board received a copy of a report, which was presented to the Council's Executive Board on 13 March 2025. The report outlined the Council's overall revenue and capital spending position as at 31 January 2025, together with the latest 2024/25 outturn forecast. The report also described the reasons for key variances from budget.

The Executive Board had requested that a copy of the report be shared with each Policy and Performance Board for information, to ensure that all Members had a full appreciation of the Councilwide financial position, in addition to their specific areas of responsibility.

It was noted that some work had been undertaken to reduce agency costs which has resulted in some improvements, however, it was still too early to realise any significant savings.

A Member of the Board asked whether the Council was exploring any opportunities to share services and it was agreed that this would be confirmed in due course.

RESOLVED: That the Councilwide financial position as at 31 January 2025, as outlined in the report, be noted.

Executive Director of Adult Services

Meeting ended at 7.41 p.m.

REPORT TO: Health & Adult Social Care Policy & Performance Board

DATE: 23 September 2025

REPORTING OFFICER: Chief Executive

SUBJECT: Public Question Time

WARD(S) Boroughwide

1.0 **PURPOSE OF THE REPORT**

1.1 To consider any questions submitted by the Public in accordance with Standing Order 34(9).

1.2 Details of any questions received will be circulated at the meeting.

2.0 **RECOMMENDATION: That any questions received be dealt with.**

3.0 **SUPPORTING INFORMATION**

3.1 Standing Order 34(9) states that Public Questions shall be dealt with as follows:-

(i) A total of 30 minutes will be allocated for dealing with questions from members of the public who are residents of the Borough, to ask questions at meetings of the Policy and Performance Boards.

(ii) Members of the public can ask questions on any matter relating to the agenda.

(iii) Members of the public can ask questions. Written notice of questions must be given by 4.00 pm on the working day prior to the date of the meeting to the Committee Services Manager. At any one meeting no person/organisation may submit more than one question.

(iv) One supplementary question (relating to the original question) may be asked by the questioner, which may or may not be answered at the meeting.

(v) The Chair or proper officer may reject a question if it:-

- Is not about a matter for which the local authority has a responsibility or which affects the Borough;
- Is defamatory, frivolous, offensive, abusive or racist;
- Is substantially the same as a question which has been put at a meeting of the Council in the past six months; or

- Requires the disclosure of confidential or exempt information.

(vi) In the interests of natural justice, public questions cannot relate to a planning or licensing application or to any matter which is not dealt with in the public part of a meeting.

(vii) The Chair will ask for people to indicate that they wish to ask a question.

(viii) **PLEASE NOTE** that the maximum amount of time each questioner will be allowed is 3 minutes.

(ix) If you do not receive a response at the meeting, a Council Officer will ask for your name and address and make sure that you receive a written response.

Please bear in mind that public question time lasts for a maximum of 30 minutes. To help in making the most of this opportunity to speak:-

- Please keep your questions as concise as possible.
- Please do not repeat or make statements on earlier questions as this reduces the time available for other issues to be raised.
- Please note public question time is not intended for debate – issues raised will be responded to either at the meeting or in writing at a later date.

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**

None identified.

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.

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 and Social Care Policy & Performance Board

DATE: 23 September 2025

REPORTING OFFICER: NHS Director – Halton

PORTFOLIO: NHS

SUBJECT: One Halton Partnership - Update

WARD(S): Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Board with an update on One Halton Partnership.

2.0 **RECOMMENDATION: That the Board:**

i) That a presentation is received and noted.

3.0 **SUPPORTING INFORMATION**

3.1 The attached presentation provides an update on One Halton Partnership activities and builds on previous reports which have been shared with the Health Policy and Performance Board.

3.2 One Halton Partnership Board comprises a wide-range of members including NHS bodies, local authority (including children's, adults, public health services), and non-NHS/non-statutory bodies. This Partnership Board is the vehicle for delivery of national priorities, local priorities and Halton's Joint Health and Wellbeing Strategy. Achieving One Halton's ambitions is the responsibility of all partners working together to achieve a set of shared strategic objectives for Halton Place.

The presentation sets out the context and provides the latest overview of progress.

4.0 **POLICY IMPLICATIONS**

4.1 The original White Paper, Joining Up Care for People, Places and Populations, February 2022 set out the future ambition for shared outcomes with shared accountability and a single person accountable at place level. This means that as One Halton Place-Based Partnership further evolves and develops there will be a need to understand the potential impact on policies of all of the partner organisations, including the Council.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 One Halton is a partnership arrangement as described above and therefore

a collaborative of statutory and non-statutory organisations serving residents and patients within Halton. As One Halton further develops partners will need to understand more fully the resourcing and financial impacts on a collective basis at Place. This work is being progressed with partners.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

6.1 Children & Young People in Halton

One Halton supports the Council's Health & Wellbeing Board's priority of improving levels of early child development. One of the system thematic priorities is Start Well.

6.2 Employment, Learning & Skills in Halton

One Halton shares the Council's priorities for employment, learning and skills in Halton. One of the system thematic priorities is Wider Determinants which encompasses employment, education and opportunities as priorities.

6.3 A Healthy Halton

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

6.4 A Safer Halton

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

6.5 Halton's Urban Renewal

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

There will be a One Halton work stream around assets to understand the public estate that supports delivery (in the widest sense) in Halton and work towards collaborative planning of the public estate.

It is also imperative to plan appropriately for healthy communities utilising Public Health ensuring an evidence-led approach to meeting the future needs of Halton's population. One Halton will link into future regeneration schemes and developments in the Borough to ensure appropriate planning and system partner involvement. There are recent examples of

joint working with the delivery of a Hospital Hub in Shopping City and the development of the Town Deal for Runcorn Old Town.

7.0 RISK ANALYSIS

7.1 This will require further work to be undertaken when One Halton understands the range of services and activity that will be delivered at scale (Cheshire & Merseyside footprint) and those delegated to place (One Halton) provided by the different partners.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 In developing One Halton and health delivery moving over to NHS Cheshire & Merseyside, all services will continue to require equality impact assessments for any fundamental changes to service delivery to ensure equality and access to services is considered.

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

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 This report is for information only, therefore there are no environmental or climate implications as a result of this report.

NHS Cheshire and Merseyside

One Halton - Update

September 2025

Place-Based Partnerships - Recap

NHS
Cheshire and Merseyside

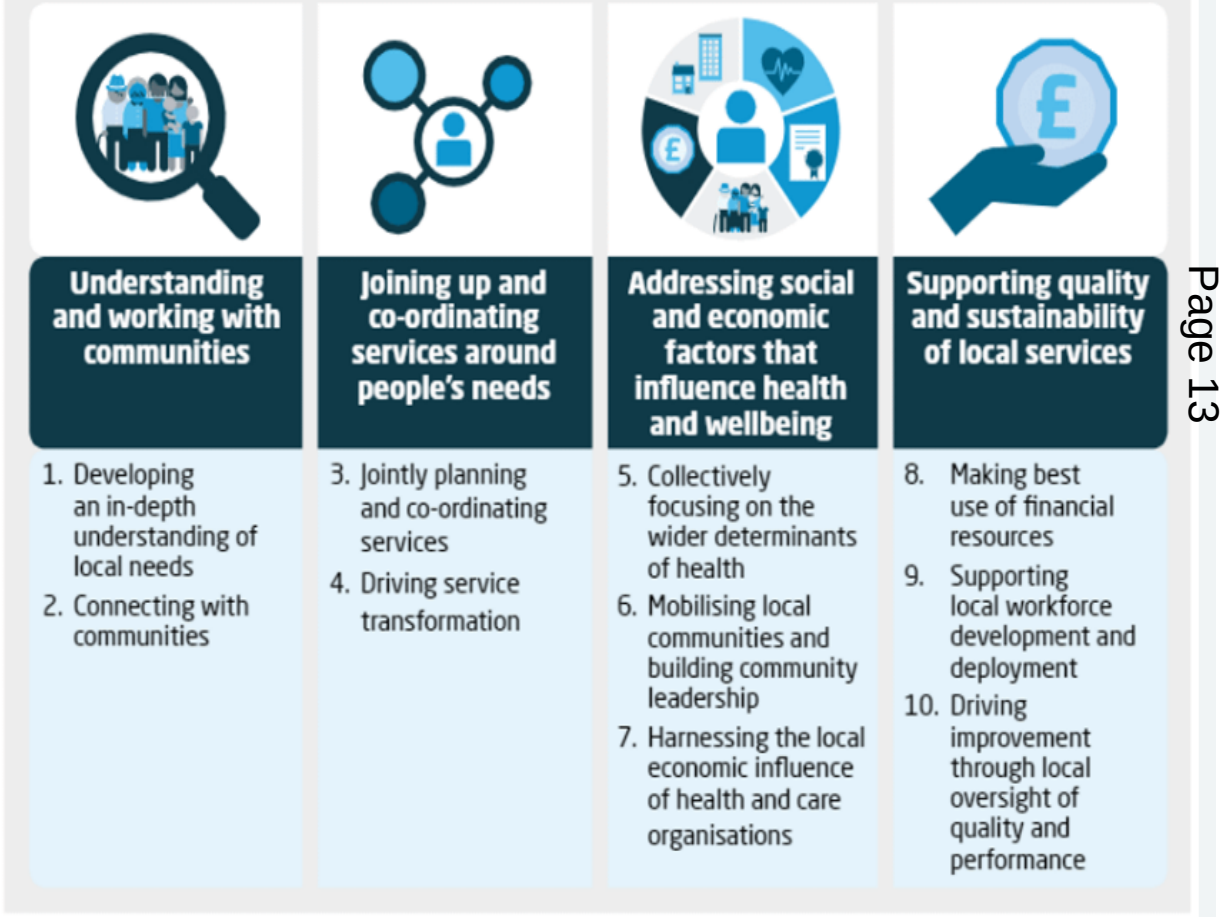
Place-based partnerships

NHS Cheshire and Merseyside will arrange for some of its functions to be delivered and decisions about NHS funding to be made in the region's nine Places – Cheshire East, Cheshire West, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington, Wirral.

While NHS Cheshire and Merseyside will retain overall accountability for NHS resources deployed at Place-level, Place-based partnerships – led by Place Directors – will have freedom to design and deliver services according to local need.

The infographic below - courtesy of the King's Fund - sets out the key functions of Place-based partnerships:

Figure 1 Key functions of place-based partnerships



C&M ICB - Key Priorities - Recap

NHS
Cheshire and Merseyside

1 Improve population health and healthcare

- Reduce deaths from cardiovascular disease, suicide and domestic abuse
- Reduce levels of obesity
- Reduce harm from alcohol
- Provide high quality, safe services
- Provide support to all those experiencing 'long Covid'
- Provide integrated, high quality, mental health and wellbeing services for all people requiring support from low levels of intervention to crisis management and inpatient care
- Underpin improvements in health and healthcare with Research and Innovation by supporting collaboration between Cheshire and Merseyside academic partners and making them a key part of Cheshire and Merseyside Health and Care Partnership

2 Tackle unequal outcomes and access

- Reduce the life expectancy gap in the most deprived communities, in children and those with mental health conditions and help people live extra years in good health
- Improve early diagnosis, treatment and outcome rates for cancer
- Improve waiting times for children and adult mental health services
- Target those with chronic diseases so they access services especially those in our most deprived areas
- Reduce the impact of poor health and deprivation on educational achievement

3 Enhance productivity and value for money

- Prioritise making greater resources available to prevention and well-being services
- Plan, design and deliver services at scale (where appropriate) to drive better quality, improved effectiveness and efficiency
- Maximise opportunities to reduce costs by procuring and collaborating on corporate functions at scale
- Develop whole-system plans to address workforce shortages and maximise collaborative workforce opportunities
- Secure value for money
- Develop a whole system Estates Strategy

4 Support broader social and economic development

- Embed a commitment to social value in all our partner organisations
- Establish an 'Anchor Institution' in Cheshire and Merseyside, offering significant employment opportunities for local people
- Integrated Care System will be involved in regional initiatives to develop economy and support communities in Cheshire and Merseyside
- Develop a programme in schools to support mental wellbeing of young people and inspire a career in health and social care
- Work with Local Economic Partnerships to connect partners with business and enterprise.

[No Title]

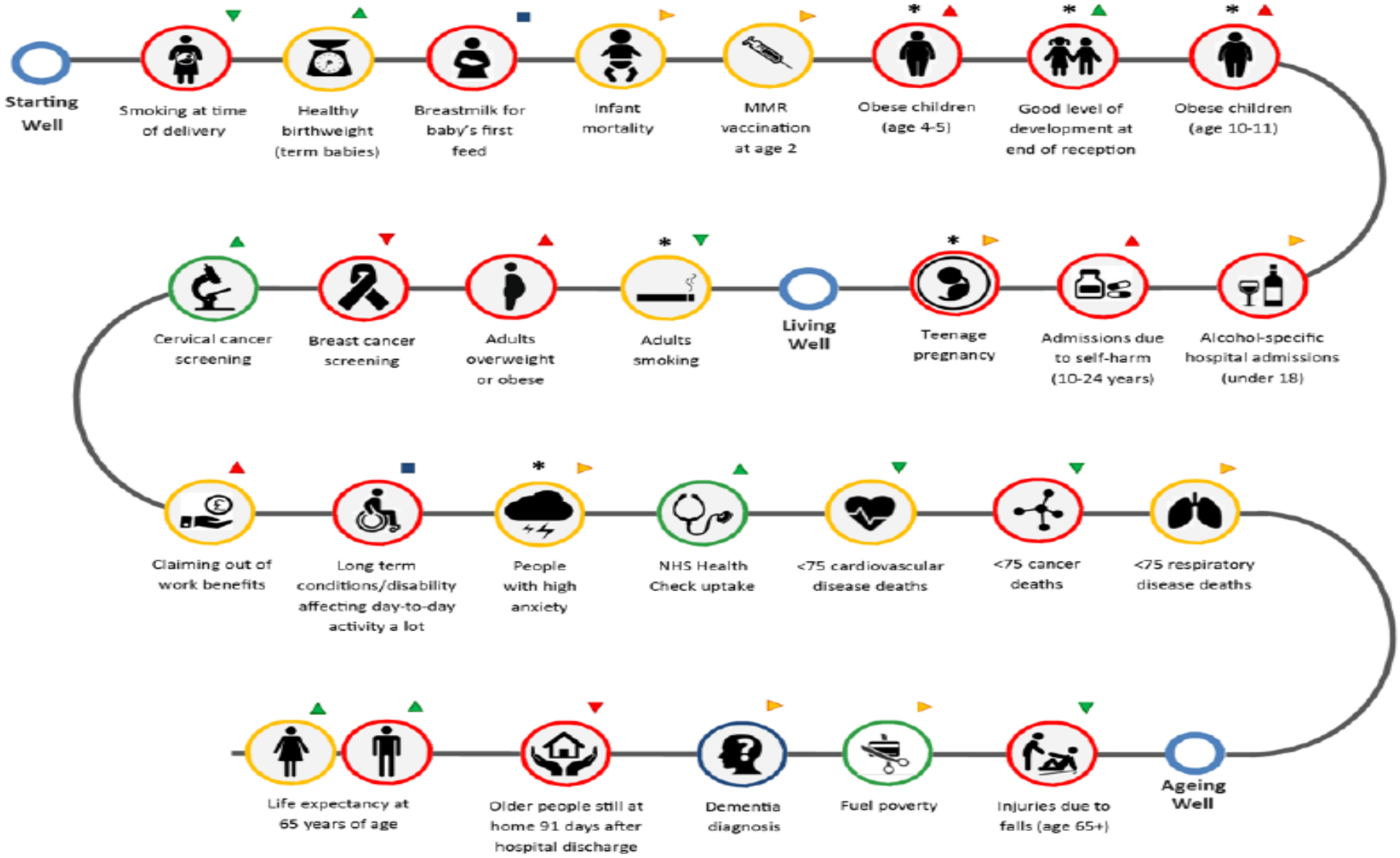
C&M ICB – Aligned to Halton Place Priorities

NHS
Cheshire and Merseyside

Halton's life course statistics 2021

A comparison to the North West

* INDICATES NATIONAL DATA COLLECTION HAS BEEN AFFECTED BY COVID-19



HALTON FACTS

Population

About **129,400** people live in Halton.

By 2041, this is projected to change:

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

Deprivation

48.7% of Halton's population live in the top **20%** most deprived areas in England.

Child Poverty

19.6% of children aged 0-15 live in relative low income households

KEY

Direction of travel

- ▲ Improved since last period
- ► Similar to last period
- ▼ Worse than last period
- ■ No Comparator

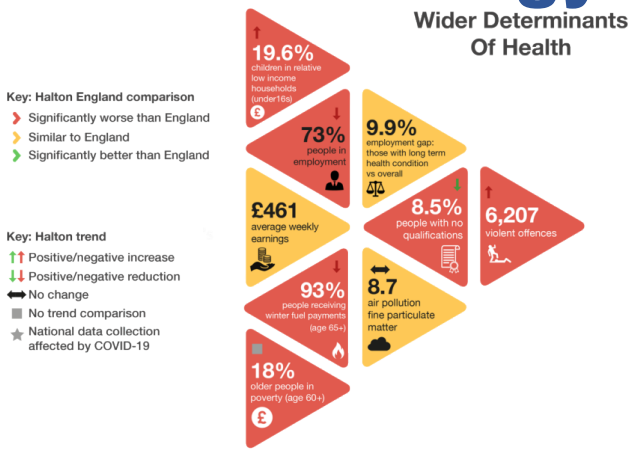
Statistical significance to North West

- Better
- No different
- Worse
- Lower

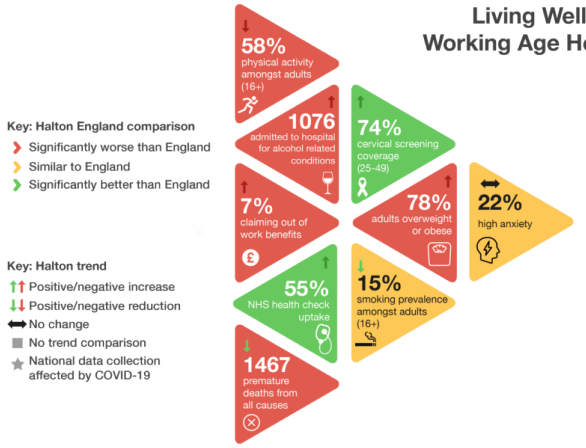
For more information, please contact Halton Borough Council's Public Health Intelligence Team: health.intelligence@halton.gov.uk

Icons made by Flaticon and available here: www.flaticon.com
Concept developed from Gateshead PHAR 2013/14 and leicestershire PHAR 2015

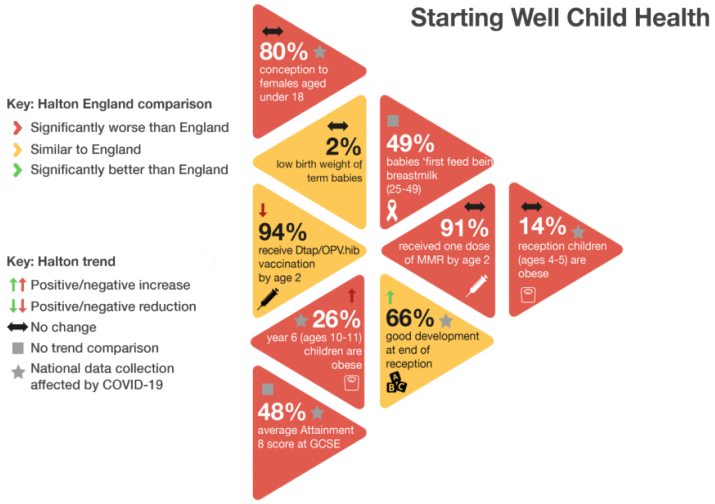
Halton Joint Health and Wellbeing Strategy



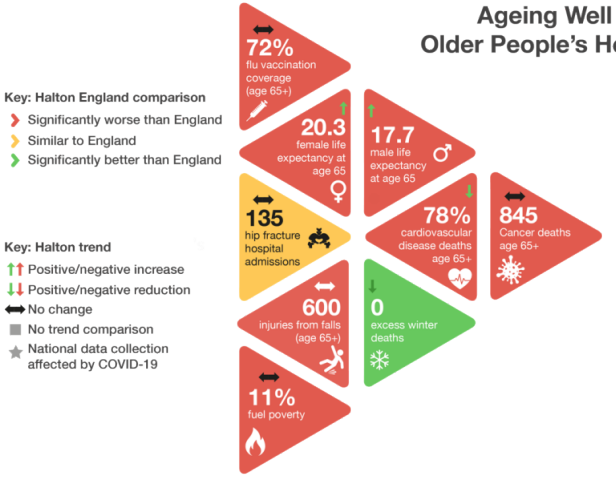
The Wider Determinants of Health: Improve the employment opportunities for the people of Halton in particular where it affects children and families.



Living Well: Provide a supportive environment where systems work efficiently and support everyone to live their best life



Starting well: Enabling children and families to live healthy independent lives



Ageing Well: Enabling older adults to live full independent healthy lives

Vulnerable Groups

Marmot and All Together Fairer

Inequalities/PHM/Core20+5

One Halton

One Halton's Ambition

To improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and independence, arranging local, community based support and ensuring high quality services for those who need them

Leadership, Oversight and Delivery Arrangements:

Achievement of our ambition and delivery of our strategic priorities is led and overseen by the One Halton Place Based Partnership Board.

Our vision for neighbourhood working is greater than just health and social care and moves beyond treating symptoms to addressing the underlying causes of poor health and wellbeing and supporting people to have a good life.

Strategic Priorities and Goals:

Wider Determinant of Health: Improve the employment opportunities for the people of Halton in particular where it affects children and families.	**Starting Well:** Enabling Children and Families to live Healthy Independent Lives.	**Living Well:** Provide a supportive environment where systems work efficiently and support everyone to live their best life.	**Ageing Well:** Enabling Older Adults to live Full Independent Healthy Lives.
Goal: A more financially active and enabled community who are employed in good jobs that provide greater financial stability, improves quality of life and provide better health outcomes	**Goal: More financially stable,** informed and supported families with children who have better health outcomes	**Goal**: A more supported and enabled community who are able to understand where to go to get the support and care they need in time.	**Goal:** A more active and independent older population who are able to live at home or are supported to get the care they need.

Integrated Neighbourhood Working:

One Halton partners have also agreed that the development of an integrated neighbourhood way of working as fundamental to our success.

Building on the good work completed to date including learning from the pandemic

Delivering both the NHS Operational Plan and the Long Term plan

Addressing the Challenges in Halton

Cheshire and Merseyside

We want to:

Create a better understanding the impact of poverty and health inequalities within local communities

Focus on wider determinants using Marmot priorities

Focus on delivery of CORE20PLUS5

Focus on prevention to tackle the drivers of the life expectancy gap locally

Social Prescribing

Some One Halton Partnership priorities. Further work being undertaken.

STARTING WELL

Family Hubs
(infant feeding; perinatal MH; Parenting; Parent and Carer Panels; Start for Life)

LIVING WELL

Prevention
(screening, healthy weight, CVD)
Mental health and Wellbeing
(self-harm, talking therapies)
EMI Health Checks

AGEING WELL

End of Life

Social Isolation

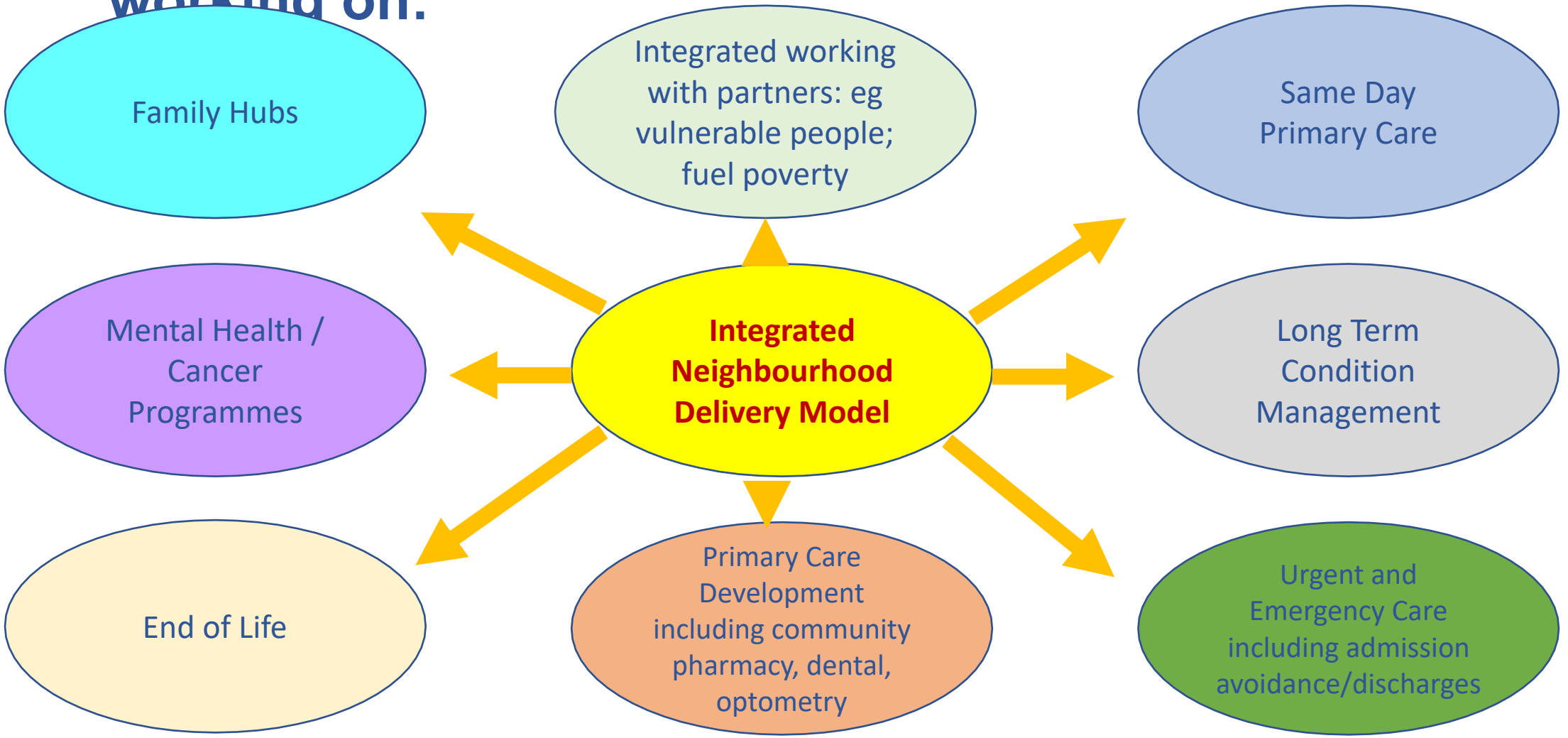
Integrated Neighbourhood Delivery Model

Same Day Primary Care

Long Term Conditions

Addressing Health Inequalities

Some examples of things we are working on:



Financial Maturity Framework Digital Strategy Estates and Assets Strategy

Summary: working together in Halton to:

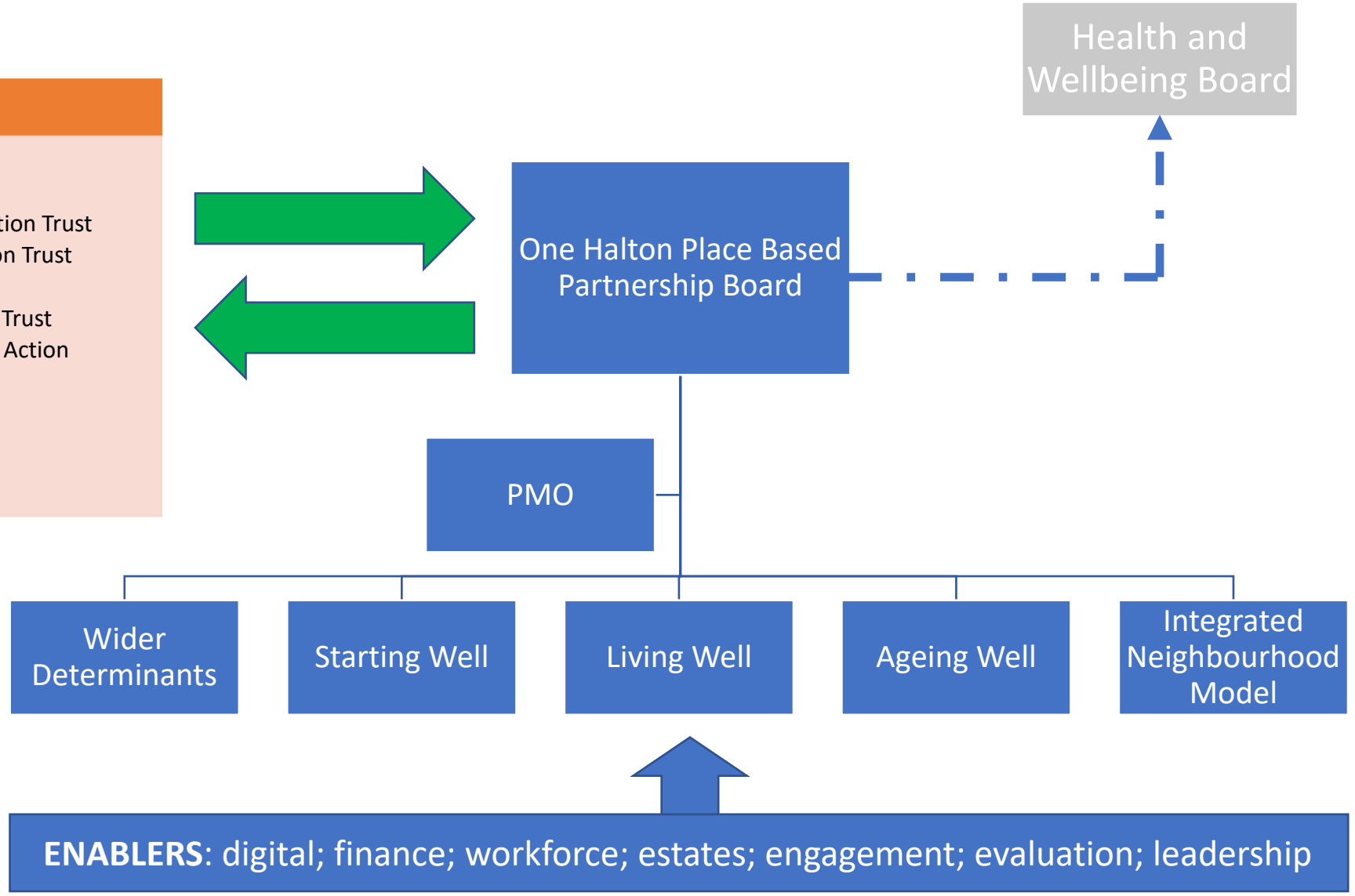
1. Deliver **NHS Operational Planning Priorities 2022/23** and local **Place priorities** and **Halton Joint Health and Wellbeing Strategy**.
2. Improve the **employment opportunities** for the people of Halton in particular where it affects children and families.
3. Enable **Children and Families** to live Healthy Independent Lives.
4. Provide a **supportive environment** where systems work efficiently and support everyone to **live their best life**.
5. Enable **Older Adults to live Full Independent Healthy Lives**.
6. Ensure that **primary care** is fully integrated into delivery mechanisms in Halton.
7. Mitigate the impact of **cost-of-living** increases on our population and **support the most vulnerable**.
8. Maximise the use of **public sector estate** and ensure that this is linked to Halton Council's local plans and regeneration work.

One Halton – Delivery Structure

NHS
Cheshire and Merseyside

Partner Organisations

- NHS Cheshire and Merseyside
- Halton Borough Council
- Bridgwater Community Healthcare NHS Foundation Trust
- Warrington and Halton Hospitals NHS Foundation Trust
- Healthwatch Halton
- St Helens and Knowsley Teaching Hospitals NHS Trust
- Halton and St Helens Voluntary and Community Action
- Widnes Primary Care Network
- Runcorn Primary Care Network
- Mersey Care NHS Foundation Trust
- Halton Housing



Some examples of work stream progress

Cancer Update

Halton Cancer Improvement Group was established to ensure a shared understanding of existing prevention and diagnosis services. It is a partnership across Halton which works with the C&M Cancer Alliance Group to seek opportunities for improving the focus on cancer prevention services including:

1. **Improved utilisation of existing resources**
2. **Understanding and removing barriers to uptake**
3. **Collaboration of partners to improve uptake**
4. **Consistent messages to patients**
5. **Consider service improvements / changes required to improve access**
6. **Reduce unwarranted variation and health inequalities**

Cancer Update

Cancer screening campaign launched in Halton borough

25TH JUNE HEALTH

The campaign, 'Two Minutes of Chat and An Early Screening', is backed by actors Will Mellor and Ralf Little *(Image: Supplied)*

Runcorn and Widnes World

25 June 2025

The CMCA has worked with Runcorn-born writer and creator of Two Pints of Lager and A Packet of Crisps, Susan Nickson, to create the **campaign for Halton to raise awareness of cancer screening**.

The videos were filmed with local **Runcorn and Widnes residents**, rather than actors, at some well-known venues across the area. Also making an appearance in the campaign are the famous faces of Will and Ralf, who are widely recognised to Halton residents as they help show how important it is to start those conversations about **breast, bowel and cervical cancer screenings.**

Mobile Cervical Screening Pilot

1. 12-week programme commenced in January until March
2. 1 location per week in Halton
3. Delivered by Living Well Service, utilising the Living Well Bus
4. Drop in
5. Focusing on non-responders
6. Reached 116 people from Halton over 10 weeks
7. In addition, between November 2024 – April 2025 Halton sexual health service piloting Saturday cervical screening clinics targeting first timers and advertising sexual health as a site for cervical screening

Developing Integrated Approaches

Same Day Access

In response to Fuller (2022) to:

- Enable PCNs to evolve into integrated neighbourhood teams
- Develop a single system-wide approach to managing integrated urgent care and improve access to care

Encompasses 14 Practices and 2 UTCs, building upon the MGPAM. Community Pharmacy, Community Services, Social Prescribing & Health Improvement are included.

Results: *Improved relationships, respect & understanding of roles, change in patient and workforce behaviours, new and updated pathways (e.g. Pharmacy First from UTCs), improvement culture and cross organisational booking (UTCs/Practices) ensuring co-morbidities are triaged by a GP.*

Long Term Condition Management – Respiratory

Driven by local and system-wide needs, this is a multi-Place programme comprising:

- Respiratory Review – designing an integrated model for prevention and management (COPD and asthma.)
- Proactive Care Management – scoping a future model for early intervention, MDT approach & risk stratification tools (implementation from 2026/27.)

Reporting into the C&M Respiratory Network, baseline data gathered, pathway development started, and digital tools explored to support self-management. Service changes are enabling an MDT approach. A quarterly bulletin supports collaboration and visibility.

Developing Integrated Approaches

Halton Intermediate Care and Frailty Service – an integrated health and care rapid response team supporting rehabilitation and preventing admissions. Multi-disciplinary SPA includes clinicians, nurses, therapists, administrative and social care staff.

Runcorn PCN Pharmacy team & Northwest Kidney Network (NWKN) are:

- Reviewing best practice & delivering education workshops for Pharmacists & GPs, pro-active identification & targeting of patients.
- Holding peer review meetings with practices & targets set to embed best practice.
- Neighbourhood proactive CKD model - including Nephrology consultants, psychologists, PCN pharmacists etc to discuss high risk CKD patients, identified by risk stratification, at MDT.

An integrated health and care approach to **care home quality improvement.**

Developing Integrated Approaches

Runcorn PCN ARRS funded Health Engagement Officers:

- Offer support to families of children with behavioural difficulties, mental health problems and neurodiversity.
- Liaise with schools, CAMHS and VCSE for children and young people.
- Provide education to practice teams (referrals and signposting.)
- Support families with children awaiting neurodiversity assessments.

Widnes PCN Cardio Renal Metabolic Conditions - partners and patients designed and implemented a Wellness Hub where Consultants, community nurses & GPs hold “one stop” clinics for diagnosis and management of heart failure. (HSJ award winning.)

Family Hubs & co-location of Building Attachment and Bonds Service - bring together council, health, and community services to support families to access the right support at the right time. An innovative digital offer underpins this service. A parent infant mental health service supports vulnerable parents and babies, preventing babies from entering care and delivering life-changing outcomes.

Mental Health Care Navigators, hosted by VCSE, embedded in secondary care community teams/in-patient units to address social needs by facilitating connection with local VCSE organisations for patients with SMI & complex needs, reducing anxiety and social isolation.

Primary Care Research Function: PCN, GP Federation and acute trust partnership, adding to research evidence for deprived populations.

Delivery & Challenges

REPORT TO: Health and Social Care Policy & Performance Board

DATE: 23 September 2025

REPORTING OFFICER: NHS Director – Halton

PORTFOLIO: NHS

SUBJECT: Model ICB Update

WARD(S): Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Board with an update on the Model ICB Blueprint.

2.0 **RECOMMENDATION: That the Board:**

i) **That this report is received and noted.**

3.0 **SUPPORTING INFORMATION**

3.1 On 01 April 2025, Sir Jim Mackey, Chief Executive of NHS England, wrote to all ICBs and NHS trusts to provide further detail on the Government's reform agenda for the NHS. https://www.england.nhs.uk/long-read/working-together-in-2025-26-to-lay-the-foundations-for-reform/

The letter highlighted the significant progress made in planning for 2025/26 and emphasised a move to a medium-term approach to planning, to be shaped by the Ten-Year Health Plan and the outcome of the Spending Review. The letter stated that ICBs will be central to future plans as strategic commissioners, playing a critical role in realising the ambitions of the Ten-Year Health Plan; however, all ICBs would be required to reduce their management (running and programme) costs by an average of 50%.

3.2 The letter outlined that in delivering the cost reductions, it will be essential to maintain some core staff, and to maintain or invest in strategic commissioning functions, building skills and capabilities in analytics, strategy, market management, and contracting. The need for ICBs to commission and develop neighbourhood health models was also set out. Additionally, NHS providers were also instructed to reduce their corporate cost growth by 50% by quarter three of 2025/26, with savings reinvested locally to enhance frontline services. The reform programme will also bring together NHS England and the Department of Health and Social Care to create a single aligned centre.

3.3 On 02 May 2025 the Draft Model ICB Blueprint version 1.0 document was shared with all ICBs (Appendix). The Blueprint outlines the future role and functions of

ICBs as strategic commissioners within the NHS. Developed collaboratively by ICB leaders and NHS England, the blueprint provides a clear direction for the evolution of ICBs, ensuring they are well-equipped to improve population health, ensure access to high-quality services, and manage health budgets effectively. It recognises the need to build strong strategic commissioning skills to improve population health and reduce inequalities and focus on the delivery of the three strategic shifts – sickness to prevention, hospital to community, analogue to digital.

3.4 Alongside the publication of the blueprint NHS England informed ICBs that the indicative management cost per head of the population is £18.76, and ICBs are expected to use the Model ICB Blueprint to create bottom-up plans for a new operating model for the ICB that are affordable within the reduced running cost envelope. These plans were submitted to NHS England on 30 May 2025 and are to be implemented during quarter three 2025/26 (and by December 2025), although it is possible that this timetable may slip. For NHS Cheshire and Merseyside ICB to meet this cost per head target this equates to a 31% reduction in management costs. ICBs are encouraged to expedite these changes as any in-year savings can be used on a non-recurrent basis to address in-year transition pressures or risks to delivery in wider system operational plans.

3.5 The ask of NHS Cheshire and Merseyside ICB this year is significant. We are required to maintain effective oversight of the delivery of the 2025/26 plans, build the foundation for neighbourhood health and manage the local changes with ICB redesign, including supporting staff through engagement and consultation. Over the coming months the ICB will be going through an organisational redesign process, which involves an organisation review throughout quarter one, implementation in quarter two and transitioning into the new ICB form in quarter three of this financial year.

3.6 To respond effectively to the ICB Blueprint, NHS Cheshire and Merseyside has mobilised a programme of work that will provide the necessary support structure to meet the requirements set within the document. It is a function-led approach to make sure the new form of our organisation is appropriate for delivering the future purpose of the ICB, and it is clear that a fundamental change of this nature will result in a very different structure for the organisation than what is currently in place.

3.7 One of the key requirements of the blueprint was to establish a Transition Committee or equivalent to have oversight of the organisational change and duties transfer. We have established the NHS Cheshire and Merseyside Reconfiguration and Transition Task and Finish Group to undertake this responsibility, and which now meets on a weekly basis.

3.8 A high-level programme plan has been developed based on the guidance published by NHS England, namely the key milestones that we are required to deliver on through quarters one to three of the financial year 2025/26.

3.9 In the coming months, NHS Cheshire and Merseyside will work to implement the new organisational structure and will keep all partners regularly updated as to progress.

4.0 POLICY IMPLICATIONS

4.1 As the national reforms and the new operating model are implemented during the coming period, NHS Cheshire and Merseyside will need to evolve and further develop and there will be a need to understand any potential impact on policies of all of the partner organisations within the system, including the Council.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 NHS Cheshire and Merseyside works collaboratively with both statutory and non-statutory organisations serving residents and patients within Halton. As the ICB further develops partners will need to understand more fully the resourcing and financial impacts on a collective basis at Place.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

NHS Cheshire and Merseyside ICB through One Halton Partnership arrangements supports the Council's and the Health and Wellbeing Board priorities for a Healthy Halton.

6.1 Children & Young People in Halton

NHS Cheshire and Merseyside ICB through One Halton Partnership arrangements supports the Council's Health & Wellbeing Board's priority of improving levels of early child development. One of the system thematic priorities is Start Well.

6.2 Employment, Learning & Skills in Halton

NHS Cheshire and Merseyside ICB through One Halton Partnership arrangements shares the Council's priorities for employment, learning and skills in Halton. One of the system thematic priorities is Wider Determinants which encompasses employment, education and opportunities as priorities.

6.3 A Healthy Halton

NHS Cheshire and Merseyside ICB through One Halton Partnership arrangements is a key stakeholder locally supporting the Council & Health and Wellbeing Board's priorities for supporting improved health outcomes and reducing health inequalities for Halton's population.

6.4 A Safer Halton

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

safer Halton.

6.5 **Halton's Urban Renewal**

The NHS reforms to deliver integrated ways of working and Place Based Partnerships seek to engender a whole place collaborative approach.

There is a One Halton work stream relating to assets to understand the public estate that supports delivery (in the widest sense) in Halton and work towards collaborative planning of the public estate.

It is also important to plan appropriately for healthy communities evidence-led approaches to meeting the future needs of Halton's population. One Halton will link into future regeneration schemes and developments in the Borough to ensure appropriate planning and system partner involvement. There are recent examples of joint working with the delivery of a Hospital Hub in Shopping City and the development of the Town Deal for Runcorn Old Town.

7.0 RISK ANALYSIS

7.1 This will require further work to be undertaken when the new target operating model arrangements are in place and NHS Cheshire and Merseyside understands the range of services and activity that will be delivered at scale (Cheshire & Merseyside footprint), those delivered at devolution footprint, and those delegated to place (eg: One Halton) provided by the different partners.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Irrespective of the model ICB blueprint changes, all services will continue to require equality impact assessments for any fundamental changes to service delivery to ensure equality and access to services is considered.

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

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 This report is for information only, therefore there are no environmental or climate implications as a result of this report.

Model Integrated Care Board – Blueprint v1.0

Introduction

On 1 April, we wrote to Integrated Care Board (ICB) and provider leaders outlining how we will work together in 2025/26 to deliver our core priorities and lay the foundations for reform. The letter set out the critical role ICBs will play in the future as strategic commissioners, and in realising the ambitions that will be set out in the 10 Year Health Plan. As ICBs need to develop plans to reduce their costs by the end of May, we committed to clarifying the role of ICBs by co-producing a Model ICB Blueprint and sharing the functional output of this work.

This Model ICB Blueprint has been developed by a group of ICB leaders from across the country, representing all regions and from systems of varying size, demographics, maturity and performance. It is a joint leadership product, developed and written by ICBs in partnership with NHS England. The group has worked together at pace to develop a shared vision of the future with a view to providing clarity on the direction of travel and a consistent understanding of the future role and functions of ICBs.

The delivery of the 10 Year Health Plan will require a leaner and simpler way of working, where every part of the NHS is clear on its purpose, what it is accountable for, and to whom. We expect the 10 Year Health Plan to set out more detail on the wider system architecture and clarify the role and accountabilities of trusts, systems, and the centre of the NHS.

We are sharing this blueprint with you today without the corresponding picture of what the future of neighbourhood health will look like or the role of the centre or regional teams.

We are also sharing this now without the benefit of the wide engagement with staff and stakeholders that will be required to get the detail and implementation right. Given the pace at which this work has been developed over recent weeks, our initial focus has been system-led design. We are now sharing it more widely for discussion and refinement and will be setting up engagement discussions over the coming weeks.

This blueprint document marks the first step in a joint programme of work to reshape the focus, role and functions of ICBs, with a view to laying the foundations for delivery of the 10 Year Health Plan. It is clear that moving forwards, ICBs have a critical role to play as strategic commissioners working to improve population health, reduce inequalities and improve access to more consistently high-quality care and we look forward to shaping the next steps on this together.

1. Context

In July 2022, Integrated Care Boards (ICB) were established with the statutory functions of planning and arranging health services for their population, holding responsibility for the performance and oversight of NHS services within their footprint. Alongside these system leadership and commissioning roles, they were also set up with a range of delivery functions, including emergency planning, safeguarding and NHS Continuing Healthcare assessment and provision.

As the Darzi review noted[1], since 2022, there have been differing interpretations of the role of ICBs, with some leaning towards tackling the social determinants of health, some focused on working at a local level to encourage services to work more effectively together, and some focused on supporting their providers to improve (in particular) financial and operational performance. The wider context, including performance measures focused on hospitals and the requirement for ICBs to ensure their Integrated Care System (ICS) delivers financial balance, mean that ICBs have found it hard to use their powers to commission services in line with the four ICS objectives. This has largely resulted in the status quo with increasing resources directed to acute providers, when the four objectives should have instead led to the opposite outcome.

As the Darzi review concludes, the roles and responsibilities of ICBs need to be clarified to provide more consistency and better enable the strategic objectives of redistributing resource out of hospital and integrating care. Crucial to this is a rebuilding of strategic commissioning capabilities, requiring "*as strong a focus on strategy as much as performance*" and a parallel investment in the skills required to "*commission care wisely as much as to provide it well*".

The 10 Year Health Plan will reinforce the criticality of this role and the Secretary of State is clear about his desire – and the need – to deliver the three shifts. The NHS needs to deliver better value for its customers – the population of England. This means increasingly focusing on prevention and reducing inequalities, delivering more services in a community/ neighbourhood based setting – and ensuring all services are delivered as efficiently and effectively as possible, in particular through the use of technology.

Across the NHS, these three strategic shifts form the foundation of the Model ICB's approach to transformation and redesign:

- **treatment to prevention:** A stronger emphasis on preventative health and wellbeing, addressing the causes of ill health before they require costly medical intervention and

[1] https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

reducing inequalities in health. This involves proactive community and public health initiatives, working closely with local authorities, to keep people healthy.

- **hospital to community:** Moving care closer to home by building more joined-up, person-centred care in local neighbourhoods, reducing reliance on acute care.
- **analogue to digital:** Harnessing technology and data to transform care delivery and decision-making. From digital health services for patients, to advanced analytics (population health management, predictive modelling) for planners, the focus is on smarter, more efficient, and more personalised care.

These shifts set the direction for how ICBs need to operate going forward. The NHS needs strong commissioners who can better understand the health and care needs of their local populations, who can work with users and wider communities to develop strategies to improve health and tackle inequalities and who can contract with providers to ensure consistently high-quality and efficient care, in line with best practice.

This document, developed by a working group consisting of ICB leaders from across the country, sets out a blueprint for how ICBs can operate within a changing NHS landscape. It covers the following areas:

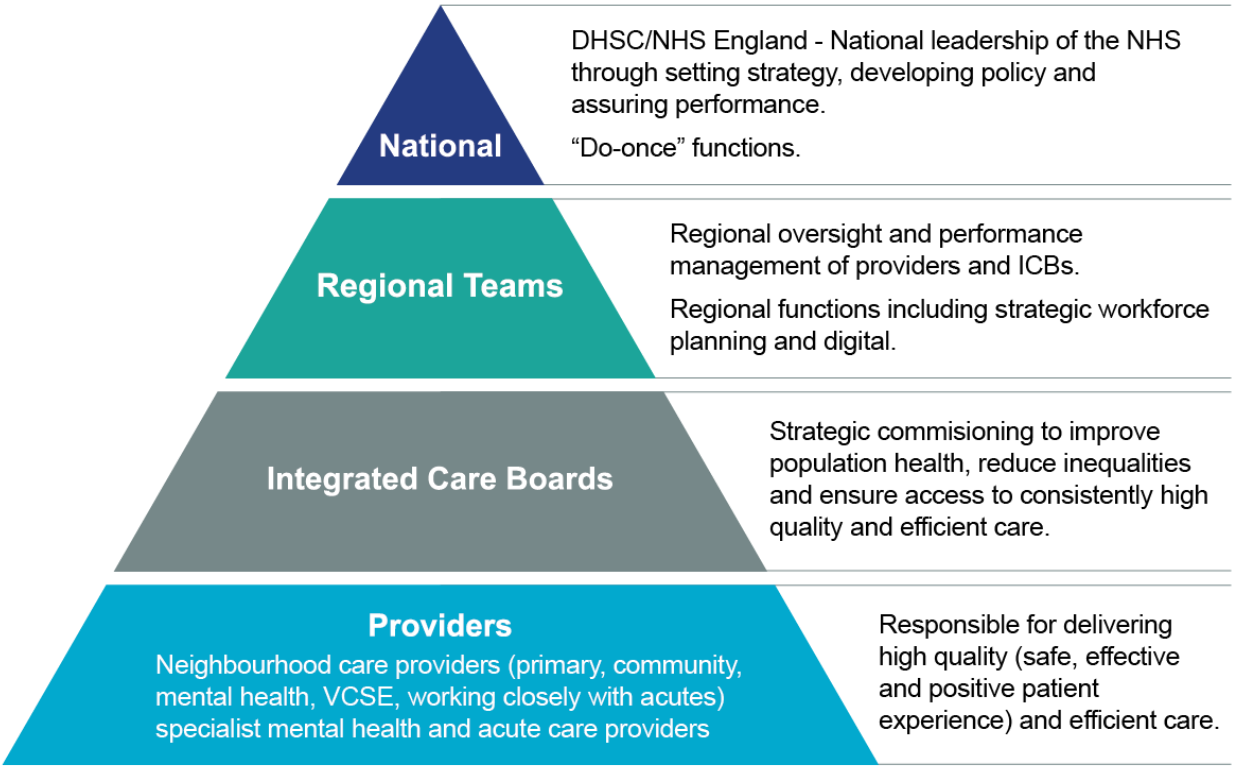
- **purpose** – why ICBs exist
- **core functions** – what they do
- **enablers and capabilities** – what needs to be in place to ensure success
- **managing transition** – supporting ICBs to manage this transition locally and the support and guidance that will be available.

2. Purpose and role: why ICBs exist

ICBs exist to improve their population's health and ensure access to consistently high-quality services. They hold the accountability for ensuring the best use of their population's health budget to improve health and healthcare, both now and in the future.

ICBs provide system leadership for population health, setting evidence based and long-term population health strategy and working as healthcare payers to deliver this, maximising the value that can be created from the available resources. This involves investing in, purchasing and evaluating the range of services and pathways required to ensure access to high quality care, and in order to improve outcomes and reduce inequalities within their footprint. ICBs not only commission services but also align funding and resources strategically with long-term population health outcomes and manage clinical and financial risks.

The refreshed role of ICBs has been developed through a set of assumptions about a refreshed system landscape, along the lines set out below:



3. Core functions: What ICBs do

To deliver their purpose, ICBs focus on the following core functions:

The following table summarises the activities that make up these core functions.

Model ICB core functions and activities	
Activity	**Detail**
1. Understanding local context: assessing population needs now and in the future, identifying underserved communities and assessing quality, performance and productivity of existing provision	
Population data and intelligence	• Using data and intelligence (including user feedback, partner insight, outcomes data, public health insight) to develop a deep and dynamic understanding of their local population and their needs and how these are likely to change over time • Leveraging real-time data and predictive modelling to identify risk, understand variation, and direct resources where they will have the greatest impact (allocative efficiency) • Segmenting their population and stratifying health risks • Dis-aggregating population health data to surface inequalities, generate actionable insights, inform service design and deployment and scrutinise progress towards equity
Forecasting and modelling	• Developing long-term population health plans using epidemiological, actuarial, and economic analysis • Forecasting and scenario modelling demand and service pressures • Understanding current and future costs to ensure clinical and financial sustainability • Convening people, communities and partners to challenge, critique and inform population health plans, demand modelling and cost forecasts
Reviewing provision	• Reviewing current provision using data and input from stakeholders, people and communities • Building a deep understanding of operational performance, quality of care (safety, effectiveness, user experience) and productivity/unit cost across all providers
2. Developing long term population health strategy: Long-term population health planning and strategy and care pathway redesign to maximise value based on evidence	
Developing strategy with options for testing and engagement	• Drawing on a variety of inputs (analysis of population health needs, evidence base on what works, national and international examples, user priorities, innovation and horizon scanning, bottom-up costing, principles of healthcare value, impact/feasibility analysis) to develop strategic options for testing and engagement with partners, people and communities • Developing and agreeing best practice care pathways with partners, people and communities, using national guidance and working closely with local clinical leaders to inform this

	• Aligning funding with need and impact using locally adapted actuarial models and bottom-up costing (“should cost” principles) • Ensuring efficiency and equity using value-based approaches to prioritisation, underpinned by public health principles
Setting strategy	• Setting overall system strategy to inform allocation of resources to maximise improved health and access to high quality care (safety, effectiveness, user experience), shifting focus from institutions to population outcomes, and targeting health inequalities by improving equity of access, experience and outcomes • Determining where change is required, the priority outcomes for improvement and population metrics to track • Co-producing strategy with communities, reflecting unmet needs and targeting inequalities • Designing new care models and investment programmes and co-ordinating major transformation programmes • Collaborating with local authorities, place-based partnerships, provider collaboratives, academia, think tanks, and analytics partners to develop and refine strategy
3. Delivering the strategy through payer functions and resource allocation: oversight and assurance of what is purchased and whether it delivers outcomes required	
Strategic purchasing	• Aligning funding to needs using data-driven models • Defining outcome-linked service specifications • Setting strategic priorities for quality assurance and oversight, developing policies and frameworks for quality improvement • Prioritising interventions to address health inequalities
Market shaping and management	• Understanding the different costs and outcomes of a range of providers • Building robust “should cost” and “should deliver” models to test against • Introducing and encouraging new providers where gaps exist in the market, for example, frailty models • Working with providers to understand factors necessary for sustainability, for example, the link between elective orthopaedics and trauma • Exploring a range of payment mechanisms
Contracting	• Negotiating and managing outcome-based contracts • Monitoring provider performance and benchmarking services with continuous review of impact, access and quality • Using performance frameworks, invoice validation • Establishing procurement governance, value-for-money checks

Payment mechanisms	• Designing incentives (blended payments, gainshare, shared savings) to improve equity, efficiency and productivity • Implementing risk mitigation strategies (for example, collaborative risk-pools) • Using financial stewardship tools (cost-effectiveness thresholds, return on investment) • Deploying payment models to improve equity (for example, blended payments linked to reducing inequalities)
4. Evaluating impact: day-to-day oversight of healthcare utilisation, user feedback and evaluation to ensure optimal, value-based resource use and improved outcomes	
Utilisation management	• Day-to-day oversight of service usage using real-time dashboards (admissions, urgent and emergency care attendances, prescribing, coding etc.) • Identifying unwarranted care variations utilising benchmarking tools and clinical audits and unwarranted over treatment, for example cataracts • Convening clinical reviews and managing complex cases • Optimising care pathways with providers
Evaluating outcomes	• Evaluating the outcomes from commissioned services • Rigorous monitoring of priority metrics, identifying unwarranted variation and clear feedback loops to inform commissioning adjustments and understand the return on investment • Establishing feedback loops for adaptive planning • Embedding feedback from people and communities, staff and partners into evaluation approaches
User feedback, co-design and engagement	• Evaluation, co-design and deliberative dialogue with people and communities, using design thinking methodologies • Ensuring user feedback mechanisms are embedded in how resource is allocated and evaluated
Governance and Core Statutory Functions: Ensures the ICB is compliant, accountable, and safe	
Ensuring the ICB is compliant, accountable and safe	• Establishing robust governance structures and processes to ensure legal compliance, transparency and public accountability • Fulfilling statutory duties (for example, equality, public involvement) and monitoring of equity outcomes alongside access, quality, and efficiency • Implementing strong clinical and information governance and effective financial and risk management systems • Maintaining business continuity and emergency planning • Overseeing delegated functions with proportionate assurance

ICB functional changes

To support the development of the future state, ICBs should consider the following assumptions about some of the functional changes that could happen. We are sharing this to provide an indication of the future state, however the detail and implementation will depend on multiple factors, including engagement and refinement with partners, the parallel development of provider and regional models, readiness to transfer and receive across different parts of the system and, in some cases, legislative change.

ICBs will need to work closely with their staff to ensure they are supported, to retain talent and to safely manage delivery across the wider system and public sector, including when functions move to different parts of the landscape.

Given the implications of these functional changes on different parts of the system, next steps will need to be developed by working closely with partners nationally and within local systems over the coming months. In light of this, no specific timeframes are provided at this stage.

ICB functional changes		
Change to manage	**Functions in scope**	**Guiding notes**
Grow: functions for ICBs to grow / invest in over time to deliver against the purpose and objectives	Population health management – data and analytics, predictive modelling, risk stratification, understanding inequalities	• Essential for core role and activities • Can be delivered within existing legislation • Will require investment in new capabilities over time
	Epidemiological capability to understand the causes, management and prevention of illness	
	Strategy and strategic planning including care pathway redesign	
	Health inequalities and inclusion expertise – capacity and capability to routinely dis-aggregate population and performance data to surface health inequalities, generate actionable insights, drive	

	evidence informed interventions and build intelligence to guide future commissioning and resource allocation decisions	
	Commissioning neighbourhood health	
	Commissioning of clinical risk management and intervention programmes (working with neighbourhood health teams to ensure proactive case finding)	
	Commissioning end-to-end pathways (including those delegated by NHS E: specialised services; primary medical, pharmacy, ophthalmic and dental services (POD); general practice, and further services that will be delegated by NHS England to ICBs over time) *Vaccinations and screening will be delegated by NHS England to ICBs in April 2026* *All remaining NHS England direct commissioning functions will be reviewed during 2025/26*	
	Core payer functions – strategic purchasing, contracting, payment mechanisms, resource allocation, market shaping and management, utilisation management	
	Evaluation methodologies and evidence synthesis using qualitative and quantitative data, feedback and insights	

	User involvement, user led design, deliberative dialogue methodologies	
	Strategic partnerships to improve population health (public health, local partners, VCSE, academia, innovation)	
Selectively retain and adapt: functions for ICBs to retain and adapt including by delivering at scale	Quality management – understanding drivers of improved health, range of health outcome measures, elements of high-quality care (safety, effectiveness, user experience); child death reviews	• Embed in commissioning cycle, monitoring of contracts • Avoid duplication with providers, regions and CQC • Use automated data sources and single version of the truth
	Board governance	• Look to streamline Boards to deliver core role as set out • Headcount should be reduced at Board level with the right roles and profiles to deliver core Model ICB functions
	Clinical governance	• Strengthen focus on embedding management of population clinical risk, best practice care pathways in commissioning approach
	Corporate governance (including data protection, information governance, legal services)	• Maintain good governance practice; look to deliver some functions at scale across ICBs
	Core organisational operations (HR, communications, internal finance, internal audit, procurement, complaints, PALs)	• Look to streamline and deliver some functions at scale
	Existing commissioning functions, including clinical policy and effectiveness – local funding decisions (individual funding	• Will be built into new commissioning/payer functions operating at ICB and pan-ICB level

	requests; clinical policy implementation)	
Review for transfer: functions and activities for ICBs to transfer over time, enabled by flexibilities under the 2022 Act for ICBs to transfer their statutory duties	Oversight of provider performance under the NHS performance assessment framework (finance, quality, operational performance)	• Performance management, regulatory oversight and management of failure to transfer to regions through the NHS Performance and Assessment Framework • Market management and contract management functions to be retained and grown in ICBs
	Emergency Preparedness, Resilience and Response (EPRR) and system coordination centre	• Transfer to regions over time
	High level strategic workforce planning, development, education and training	• Transfer to regions or national over time, retain limited strategic commissioning overview as part of strategy function
	Local workforce development and training including recruitment and retention	• Transfer to providers over time
	Research development and innovation	• Transfer to regions over time, with ICBs retaining and building strategic partnerships to support population health strategy
	Green plan and sustainability	• Transfer to providers over time
	Digital and technology leadership and transformation	• Transfer digital leadership to providers over time enabled by a national data and digital infrastructure
	Data collection, management and processing	• Transfer to national over time
	Infection prevention and control	• Test and explore options to streamline and transfer some activities out of ICBs

	Safeguarding	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	SEND	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	Development of neighbourhood and place-based partnerships	• Transfer to neighbourhood health providers over time
	Primary care operations and transformation (including primary care, medicines management, estates and workforce support)	• Transfer to neighbourhood health providers over time
	Medicines optimisation	• Transfer delivery to providers over time, retain strategic commissioning overview as part of strategy function
	Pathway and service development programmes	• Transfer to providers, retain strategic commissioning overview as part of strategy function
	NHS Continuing Healthcare	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	Estates and infrastructure strategy	• Transfer to providers over time, retain limited strategic commissioning overview as part of strategy function
	General Practice IT	• Explore options to transfer out of ICBs ensuring consistent offer

4. Enablers and capabilities: what ICBs need to ensure success

For an ICB to effectively perform the core functions set out in section 3, several key enablers need to be in place. A high-level summary of these is set out below:

- **Healthcare data and analytics –** to enable ICB decisions to be guided by population health data and insights, ICBs will need to develop strong population health management approaches underpinned by robust data capability. This will need to include developing the capabilities to segment the population and stratify risk and build a person-level, longitudinal, linked dataset integrating local and national data sources alongside public and patient feedback. There will need to be appropriate data-sharing and governance agreements to track individuals' journeys across health and care (to understand needs and outcomes holistically); and deploy predictive modelling to foresee future demand, cost and impact of interventions. ICBs will need to cultivate teams with the ability to analyse and interpret complex data (health economists and data-scientists) and deploy data-driven techniques (such as modelling the return on investment for preventative interventions). Data can be integrated reliably between services to provide real-time, accurate data enabling better decision-making and interoperability – the NHS Federated Data Platform (FDP) will be crucial to enable this work, and should be used as the default tool by ICBs.

- **Strategy –** ICBs will need to develop effective strategy capability, comprised of individuals with good problem solving and analytical skills. They will need to foster a greater understanding of value-based healthcare alongside the ability to synthesise a range of information (qualitative and quantitative) and develop actionable insights to support prioritisation. ICBs will need strategic leaders who can diplomatically and collaboratively work with a range of partners including by facilitating multi-agency forums and collaborative decision-making. They will also need the ability to navigate and synthesise complexity so that people and communities, staff and partners can understand the full picture, and be able to draw people together around the shared goal of improving population health.

- **Intelligent healthcare payer –** for ICBs to develop into sophisticated and intelligent healthcare payers, they will need to invest in their understanding of costs ('should cost' analysis) and wider finance functions, developing capabilities in strategic purchasing, contracting, design and oversight of payment mechanisms, utilisation management and resource allocation. This will need to include commercial skills for innovative contracting and managing new provider relationships. ICB staff will need to learn how to proactively manage and develop the provider market, using procurement and contracting levers to incentivise quality improvement and innovation. This should involve techniques that ensure effective use of public resources so that investment decisions are guided by

relative value, not just demand or precedent. This calls for deliberate use of tools such as programme budgeting and decommissioning frameworks to support allocative efficiency.

- **User involvement and co-design –** for services to truly meet communities' needs, people must be involved from the very start of planning through to implementation and review. Each ICB should have a systematic approach to co-production – meaningfully involving patients, service users, carers, and community groups in designing solutions. This goes beyond formal consultation and means working with people as partners. ICBs will need to ensure that focused effort and resources are deployed to reach seldom heard and underserved people and communities, working with trusted community partners to achieve this. Ultimately, this enabler is about shifting the relationship with the public from passive recipient to active shaper of health and care, with a particular focus on underserved communities.

- **Clinical leadership and governance –** ICBs will need effective clinical leadership embedded in how they work, ensuring they have a solid understanding of population clinical risk and of the best practice care pathways required to meet population needs and improve outcomes. Clinical governance and oversight will be crucial in ensuring that the decisions that ICBs make are robust, particularly regarding the prioritisation of resources. Contract management of commissioned services will need to include effective quality assurance processes.

- **System leadership for population health –** effective system leadership will be essential to driving improvements in population health. ICB leaders and staff need to be adept at system thinking, analytics, and collaboration. They will need to work diplomatically and be comfortable driving change and influencing without direct authority. ICBs should develop and foster strategic partnerships across their footprints with a range of partners (including academia, VCSE, innovation), alongside working together with providers and local government as they develop and implement their strategies.

- **Partnership working with local government –** recognising the critical and statutory role of local authorities in ICSs and as partner members of ICBs, engagement and co-design with local government will be critical to the next phase of this work. Linked to this, is the need for ICBs to continue to foster strong relationships with the places within their footprint, building a shared understanding of their population and working together to support improved outcomes, tackle inequalities and develop neighbourhood health. We will be working jointly with the Local Government Association to take this development work forwards.

- **Supporting ICB competency and capability development – national support offer and maturity assessment –** it is proposed that a national programme of work, including

a new commissioning framework, is developed to ensure ICBs have the necessary capabilities and competencies to discharge their functions effectively. This should be developed by learning from successful international models and World Class Commissioning and form the basis of future assessments of ICB maturity.

5. Managing the transition

The ask on ICBs is significant this year as they work to maintain effective oversight of the delivery of 2025/26 plans, build the foundation for neighbourhood health and manage the local changes involved with ICB redesign, including supporting their staff through engagement and consultation.

To support with this, the following sections set out some high-level principles around:

- delivering ICB cost reductions plans and realising the savings
- managing the impact on staff
- designing leadership structures of ICBs
- managing risk during transition through safe governance
- expectations for safe transition of transferred functions

Delivering ICB cost reductions plans and realising the savings

ICBs will need to use this guidance to create bottom-up plans which are affordable within the revised running cost envelope of £18.76 per head of population. More details on this are set out below:

- the calculations to derive the £18.76 operating cost envelope include all ICB running costs and programme pay (only excluding POD and specialised commissioning delegation)
- the reduction in ICB costs to meet this target must be delivered by the end of Q3 2025/26 and recurrently into 2026/27
- ICBs are encouraged to expedite these changes as any in-year savings can be used on a non-recurrent basis to address in-year transition pressures or risks to delivery in wider system operational plans and potentially sooner to mitigate and de-risk financial plans
- there will be flexibility at an ICB-level, as some inter-ICB variation may be warranted and will need to be managed within a region to account for hosted services, however we expect delivery of the target at an aggregate regional level
- generating savings cannot be a cost shift to a provider unless overall there is the saving, for example, a provider takes on an ICB operated service and therefore requires circa 50% less cost in line with the £18.76 running cost envelope

We recognise that not all functional changes to reach the Model ICB can be done this year as some changes will require legislation and any transfer arrangements will need to be

carefully managed to ensure safe transition. Recognising this, we anticipate that most savings will come from streamlining approaches, identifying efficiency opportunities – through benchmarking, AI and other technological opportunities and from at scale opportunities afforded through greater collaboration, clustering and where appropriate, eventual merger of ICBs. Principles to apply to footprints, clustering and mergers will be communicated and coordinated by regional teams.

NHS England is providing a planning template to facilitate the May 2025 plan returns. This will be issued in the week commencing 6 May 2025. Plans should be submitted to your regional lead by 5pm on **30 May 2025**. Plans will set out how each ICB intends to achieve the £18.76 operating cost envelope and will then go through a national moderation process (involving a confirm and challenge process) to support consistency of approach and sharing of opportunities. These plans should be informed at a high level by the vision set out in this blueprint.

Support for managing the impact on staff

A national support offer will be available to ensure fair and supportive treatment of staff affected by the transition. This includes advice on voluntary redundancy and Mutually Agreed Resignation Schemes (MARS), along with guidance on redeployment and retention where appropriate. Funding mechanisms to support these options will be clarified centrally ensuring local systems can manage workforce changes consistently. Emphasis will be placed on transparent, compassionate communication and engagement to retain talent and maintain morale through the change process. We will work in partnership with trade union colleagues to implement the change for staff.

Advice on leadership structures of ICBs

ICBs are expected to maintain clear, accountable leadership with effective governance during the transition and beyond. ICBs should look to streamline Boards and reduce headcount at Board level to deliver core purpose and role as described. Leadership structures and executive portfolios should also reflect the functions as set out above, including skills in population health data and insights, strategic commissioning (including strategy, partnerships and user involvement), finance and contracting and clinical leadership and governance. At Board level, a strong non-executive presence is encouraged to support both oversight and the delivery of transition priorities.

Managing risk during transition through safe governance

To ensure a safe and coherent transition, each ICB should establish a dedicated Transition Committee, including both executive and non-executive members. These committees will take responsibility for managing local risks, tracking progress, and overseeing the development of organisational design and implementation of change processes.

To support this work, a central NHS England programme team — under the leadership of an Executive SRO — will be set up to provide coordination, support and a check and challenge process on ICB plans. This will seek to ensure appropriate support guidance is developed to facilitate the transition, share best practices, and facilitate consistency across systems to deliver the vision set out here. This central support will also help ICBs navigate legal, operational, and workforce challenges while ensuring focus remains on delivery of statutory duties throughout the transition.

Expectations for safe transition of transferred functions

Safe transition of functions is critical to the success of the new Model ICB design and the future system landscape. To manage this transition effectively, an assessment of readiness is necessary for both the sender and the receiver. Implementing a gateway process will help verify readiness before transferring staff and functions underpinned by clear governance frameworks, outcome metrics, financial risk arrangements, and escalation protocols to ensure safe and effective delivery.

NHS England is currently developing the operating model for the Model Region. We will continue to work with ICBs as we develop the regional approach to ensure alignment with the Model ICB design and implementation. We have been clear that performance management of providers against the NHS Performance and Assessment Framework (NPAF) will transfer to Regions under the new design. It will be important to be clear on responsibilities as these functions transfer. Once transferred ICBs will oversee providers through their contracting arrangements but will not be responsible for leading the regulatory oversight of providers against the NPAF.

Frequently asked questions

FAQs covering all aspects of transition is being developed to support ICBs as they manage these elements locally.

Please direct any questions to england.Model-ICB@nhs.net and we will use these to inform future sets of FAQs.

REPORT TO: Health & Social Care Policy and Performance Board

DATE: 23rd September 2025

REPORTING OFFICER: Debbie O'Connor, Head of Care Management

PORTFOLIO: Adult Social Care

SUBJECT: Introducing the Social Care Workforce Race Equality Standard (SC-WRES) Individual Data Report and Action Plan

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To introduce the SC-WRES and to provide Health PPB with the SC-WRES 2024 Individual Data Report and Action Plan.

2.0 **RECOMMENDATION: That**

(1) The report be noted.

3.0 **SUPPORTING INFORMATION**

3.1 **SC-WRES**

3.1.1 The Social Care Workforce Race Equality Standard (SC-WRES) Improvement Programme is driving real change by empowering organisations to actively address and dismantle racism and discrimination within the social care sector workforce.

3.1.2 The SC-WRES supports organisations to address evidence and make progress towards race equality. It requires local authorities to collect and submit data on an annual basis based on nine indicators which highlight differences in experiences of Black, Asian and minoritised ethnic staff. It holds up a mirror to reveal inequalities, supports change, and strengthens the accountability of organisations.

3.1.3 Organisations can then use their findings to develop action plans to support organisational change. The SC-WRES Improvement Programme is a long-term process, as new practices are embedded into everyday behaviour with change monitored year on year.

3.1.4 The SC-WRES was successfully run as a test in 2021 with 18 local authorities and rolled out further with 23 Local Authorities in Phase 1 (2023-24). Skills for Care launched the national SC-WRES annual report in March 2024. Please see appendix 3.

3.1.5 Skills for Care have now extended its support for the SC-WRES Improvement Programme into phase two. This initiative aims to address race inequality in the social care workforce by gathering insights into the experiences of Black, Asian, and minoritised ethnic staff. Over 50 local authorities will participate in the upcoming phase.

3.1.6 The SC-WRES is a new annual data return made to Skills for Care and represents details of the Council's adult social care workforce.

3.2 **The 12-month cycle**

3.2.1 Please see appendix 1 for the 12-month improvement programme.

3.3 **SC-WRES Individual Data Report**

3.3.1 We received back from Skills for Care that all data quality checks passed. No actions to take.

3.3.2 When starting to produce the SC-WRES Individual Data Report from the graphs within the data, there was a discrepancy with the data that we had submitted and the checked data.

3.3.3 Indicator 4 – Fitness to Practice had the discrepancy. On the spreadsheet that we submitted the Fitness to Practice was 100% for white, but on the checked spreadsheet it was 17% white and 83% Black, Asian or minority ethnic background. For the regulated professional staff who entered fitness to practice process column has changed to 12, but on the original spreadsheet it was 2. It is now split to 2 white and 10 Black, Asian or minority ethnic background and it should just be 2 white. This has now been rectified.

3.3.4 We also, queried Indicator 6 & 7, this was blank on our original spreadsheet, and there was now information on the checked one. Going forwards for next year so that we can complete Indicator 6 & 7, Skills for Care have said that they would like LAs to find a suitable way to gain the information for Indicators 6 & 7. Most commonly, LAs have added questions to do this within their existing staff surveys.
Examples of questions are below:

- ***In the last 12 months, have you experienced harassment, bullying, or abuse from people who use social care, their relatives, or the public?***
- ***In the last 12 months, have you experienced harassment, bullying, or abuse from colleagues / managers?***

3.3.5 Skills for Care have suggested that the report should be shared widely. The SC-WRES now sits on the ASC EDI Group and the report has been shared with the EDI Strategic Group. Please see appendix 2.

3.4 **National Report**

3.4.1 Skills for Care have published their latest findings from the Social Care Workforce Race Equality Standard (SC-WRES). In 2024, 76 local authorities participated in the SC-WRES improvement programme, with 73 providing data about their adult social care workforce and 43 (of the 73) also providing data about the children's social care workforce for the SC-WRES 2024 report.

3.4.2 The report reveals challenging data: staff from minoritised ethnic backgrounds are 48% less likely to be appointed from shortlist, 37% more likely to face formal disciplinary action, and are underrepresented in senior management (12% vs. 20% overall workforce). Please see appendix 3.

3.4.3 The adult social care workforce employed by local authority and independent sector employers had more ethnic diversity than the population of England.

- The diversity of the adult social care sector varied by region, with the most diversity within the London region and the least within the Northern regions.
- The diversity of adult social care varied by job role, with registered nurses and care workers having the most diversity, while senior management and personal assistants had the least.
- The diversity of adults social care has been increasing over the last four years. 2023/24 saw the largest increase in diversity since records began. Which is, in part, due to international recruitment.
- Within adult social care employers, there were differences in diversity, with local authorities having a less diverse workforce than the independent sector. Local authorities had slightly more diversity than the population of England.

3.5 **Comparisons**

3.5.1 Indicator 1: Pay bands, it is difficult to compare our report to the national report because for our report Skills for Care has broken it down to less than £40,000, £40,000 - £79,000 and £80,000 and over but the national report is broken down to less than £30,000, £30,000 - £69,000 and £70,000 and over.

3.5.2 Indicator 2: Appointed from shortlist, for the national report applicants from a Black, Asian or minority ethnic background were half as likely to be appointed from shortlist, across all employers, compared to applicants with a white ethnicity (a relative likelihood of 0.54) for adult social care. For Halton, the relative likelihood of applicants from a Black, Asian or minority ethnic background being appointed from shortlisting, across all posts, compared to applicants with a white ethnicity is 0.44. Therefore, staff with a Black, Asian or minority ethnic

background were relatively less likely to be appointed from shortlist.

3.5.3 Indicator 3: Disciplinary process from the national report staff with a Black, Asian or minority ethnic background from adult social care were 19% more likely (a relative likelihood of 1.19.) For Halton, our relative likelihood was 0.00 and we had no staff with a Black, Asian or minority ethnic background entering the disciplinary process.

3.5.4 Indicator 4: Fitness to practise, for the national report at responding adult local authorities, staff in a regulated profession, from a Black, Asian or minority ethnic background were 8% more likely to enter the fitness to practise process compared to staff from a white ethnic background. For Halton, the relative likelihood of regulated profession staff from a Black, Asian or minority ethnic background entering the fitness to practice process compared to white regulated profession staff was 0.00. Therefore, regulated professional staff from a Black, Asian or minority ethnic background were less likely to enter the fitness to practice process than white regulated profession staff.

3.5.5 Indicator 5: Funded non-mandatory continuous professional development (CPD), for the national report staff from a Black, Asian or minority ethnic background were 3% more likely to access funded non-mandatory CPD in the last 12 months, compared to staff from a white ethnic background in adult social care services. For Halton, the relative likelihood of regulated profession staff from a Black, Asian or minority ethnic background accessing funded non-mandatory, across all posts, compared to white staff was the same (a ratio of one to one).

3.5.6

Indicator 8: Turnover of directly employed staff, for the national report at responding local authorities, the likelihood of staff from a Black, Asian or minority ethnic background employed by adult social care local authority employers leaving during the last 12 months was around the same as staff with a white ethnic background (a relative likelihood of 1.03). For Halton, the relative likelihood of employees from a Black, Asian or minority ethnic background leaving in the past 12 months compared to white employees was 0.35. Therefore, staff with a Black, Asian or minority ethnic background were relatively less likely to leave than white staff.

3.5.7

Indicator 9: Senior manager membership, for the national report, staff from a Black, Asian or minority ethnic background were 48% less likely be in senior manager roles compared to staff with a white ethnic background (a relative likelihood of 0.52). For Halton, we have no noted Black, Asian or minority ethnic background to be in senior manager roles.

3.6

SC-WRES Action Plan

3.6.1

Throughout the improvement programme, local authorities will

develop and submit their action plan for tangible change and improvement, using findings from the data analysis.

3.6.2 There is deeper reflection on the preliminary decisions about solutions and how the organisation knows that what it plans to do will work and what success looks like. There should be interrogation by stakeholders to make this robust and sustainable. Use your 'Data Report' to inform and create your 'Action plan'.

3.6.3 Discussion would consider what interventions have worked in the past, what the evidence base is and issues of cost vs impact. Specific interventions, e.g. leadership programmes and training, should be explored. A final priority list should be signed off, which forms a comprehensive plan.

3.6.4 Please see appendix 4 for our SC-WRES Action Plan which has been put together with the support of the ASC EDI Group. This has been shared with Emran Ali, the staff voice lead.

3.7 **Next Steps**

3.7.1 Following the report being shared widely, we then need to look at the Action Plan. This sits with the ASC EDI Group. Originally, this was due to be completed at the end of April and this has now been extended. The submission period of the LA Action Plan opened on 1st May and the deadline was Friday 27th June. Our action plan was submitted on 18th June 2025.

3.7.2 Registration was open for the SC-WRES improvement programme phase 3 and the closing date to register was 30 June 2025. As we have experienced the SC-WRES Improvement Programme is built on a continuous improvement approach, ensuring that progress is ongoing, is structured and responsive to feedback. It is designed to contribute, and lead to transformational change. Not all actions are achievable within the first year of the plan and should be reviewed in subsequent phases of the SC-WRES continuous improvement programme. Skills for Care is committed to support organisations to implement this meaningful change by offering registration on the SC-WRES Programme for three years instead of registering each year. We have registered for the three years.

4.0 POLICY IMPLICATIONS

4.1 As a representation of the workforce and the structure it sits within the data allows us to reveal inequalities, support change and strengthen the accountability of organisations.

5.0 FINANCIAL IMPLICATIONS

5.1 None identified.

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

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**
Good quality information about the Adult Social Care workforce is vital to help improve the planning and quality of Social Care services, which will improve outcomes for people who use these services, both now and in the future. It will help to achieve an anti-racist workplace.

6.2 **Building a Strong, Sustainable Local Economy**
The SC-WRES is a powerful tool in achieving meaningful and sustainable organisational change towards race equality and telling the story nationally through the SC-WRES annual report.

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

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**
The SC-WRES supports us to address evidence and make progress towards race equality.

6.5 **Working Towards a Greener Future**
None

6.6 **Valuing and Appreciating Halton and Our Community**
The SC-WRES is a scheme to highlight, and thereby tackle, racial inequalities in social care workforce.

7.0 **RISK ANALYSIS**

7.1 For the data collected the tool automatically produces charts from our data which we can then use to create our own report, allowing us to reflect our findings and use this evidence to create an action plan.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An Equality Impact Assessment (EIA) is not required for this report.

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: SC-WRES timeline Jan 2025

Appendix 2: SC-WRES Individual Data Report
Appendix 3: SC-WRES 2024 National Report
Appendix 4: SC-WRES Action Plan

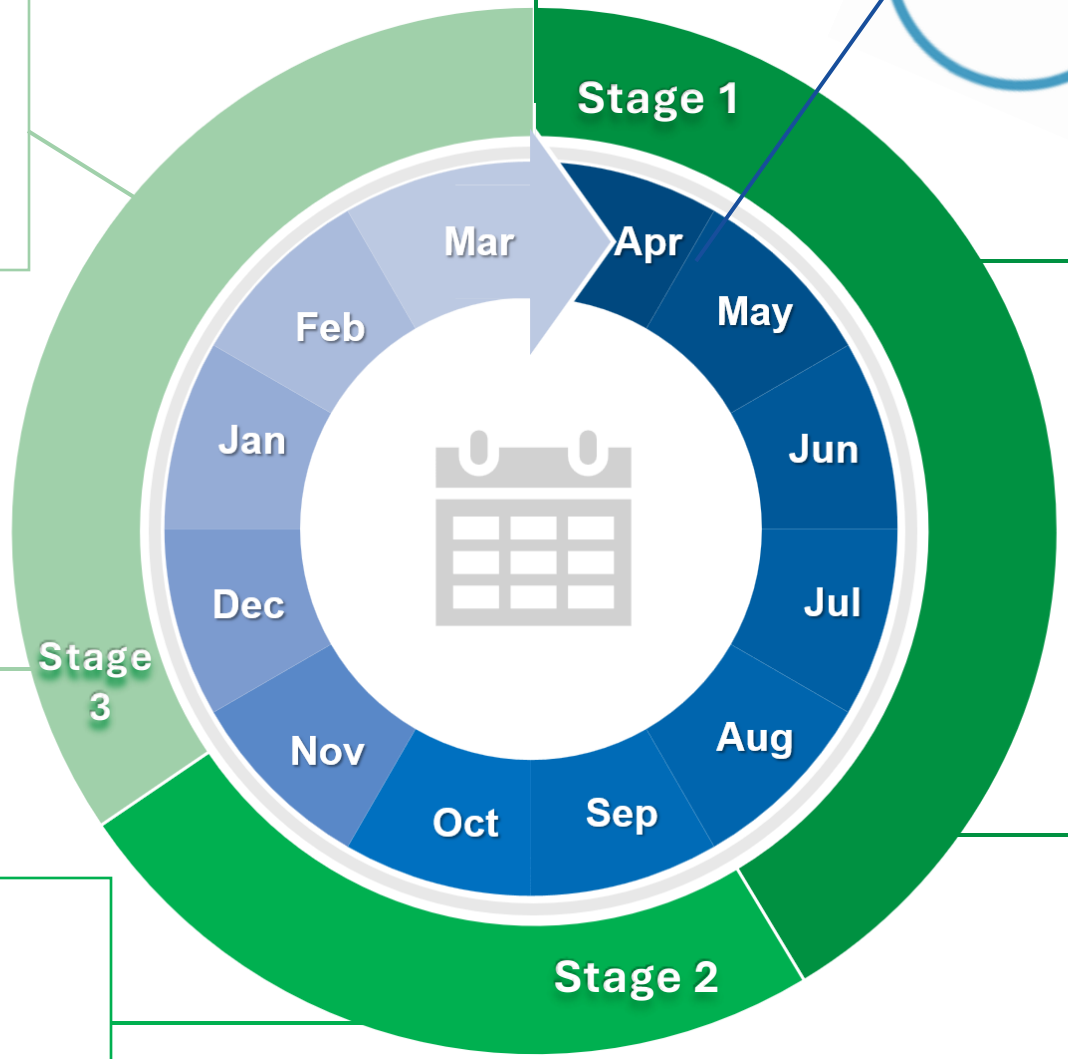
Attached separately.

SC-WRES 12-month timeline...

Summit your action plan
May 1st– to 27th June 2025 is the Action plan submission window .

The SC-WRES Improvement Programme cycle begins late Spring

Action plan development
Your data report will show which areas need addressing within your organisation. This is a key component of your SC-WRES Improvement journey.



Registration – all sites
All sites must register; continued and new to participate in the SC-WRES Improvement Programme.

Your local authority induction session
Skills for Care will run Information sessions where the SC-WRES team will explain what participating in SC-WRES involves.

Data analysis
We will provide you with a template on how you can share your findings and share within your organisation.

Data report
Developing your own report from the data. What will you do with this information? Which internal teams are involved?

Prepare for SC-WRES implementation
Skills for Care will support you throughout your SC-WRES journey. We will do this by inviting you and your internal team to monthly Community of Practice sessions. Throughout July to August, we'll support you to understand how to collect your data.

Creating your internal SC-WRES team
Once you have registered, establish your internal team/support to partake successfully & implement SC-WRES.

Collect your data
Sep – Nov is the data collection window. How and who will do this in your team

Submit your data
Submit your data by November.

SC-WRES individual local authority data report

Halton Borough Council

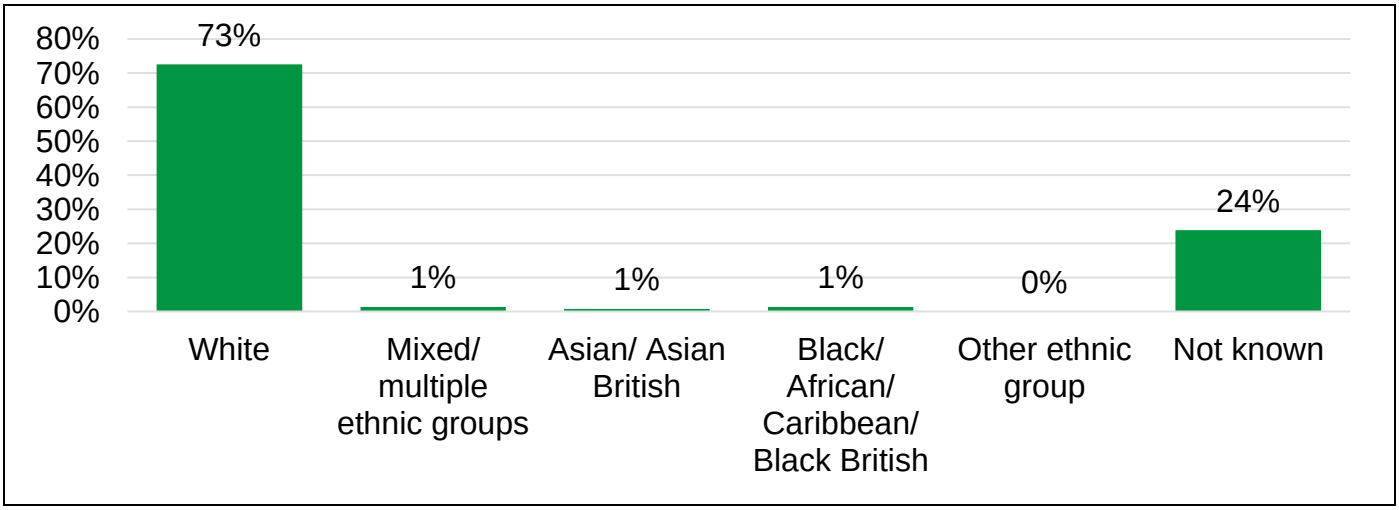
2024/25

Overview

This staff overview collects the headcount of directly employed staff of each ethnic group. These numbers include any staff employed by the LA that works in or contributes to adult social care or children's social care, including care providing and non-care providing staff e.g. HR, commissioning, finance.

All Social Care Workforce Race Equality Standard indicators collect staff numbers by a list of 19 ethnicities. The definitions of ethnicity we are using are based on the Office for National Statistics – Census 2021. The list also includes 'not known'. These ethnicities were then grouped into five categories. Chart 1 shows staff by these five ethnicity groups and not known in this local authority.

Chart 1. Directly employed staff of each ethnic group

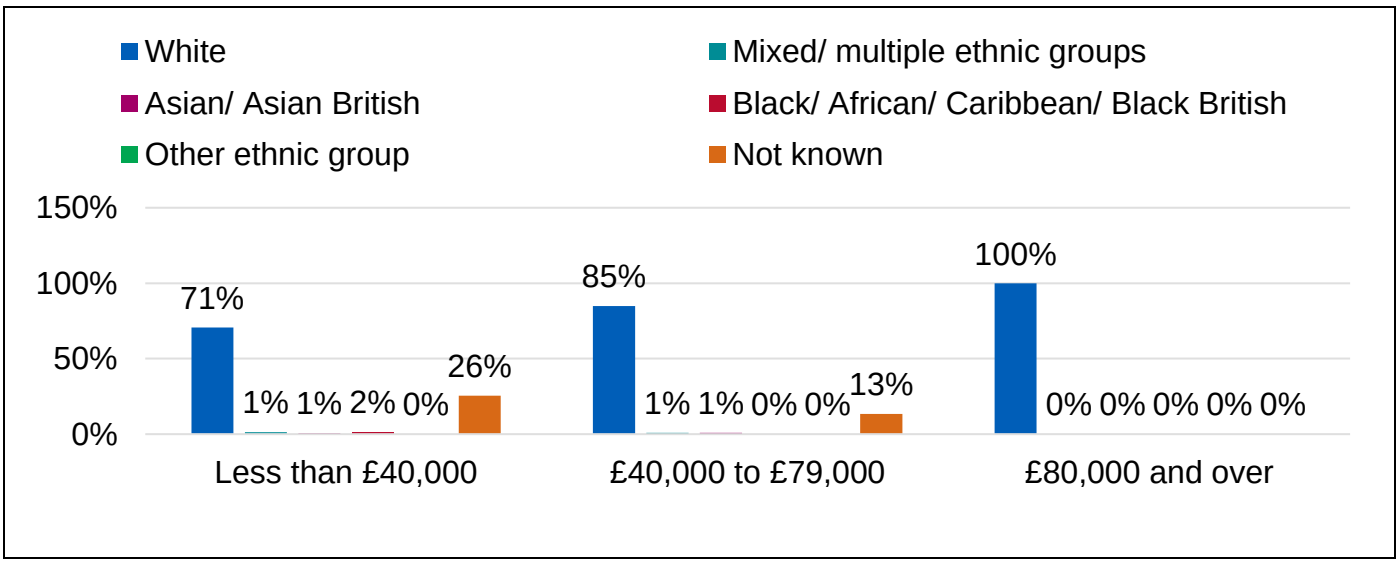


SC-WRES Indicator 1: Pay bands

Indicator 1 collects information about the workforce ethnicity breakdown across 12 pay bands[1]. The chart below shows pay bands grouped into three categories, 'less than £40,000', '£40,000 to £79,000', and '£80,000 and over'. The chart below shows staff by five ethnicity groups and not known in this local authority.

Chart 2. Pay bands by ethnic group

[1] Pay bands collected were Under £25,000, £25,000 to £29,999, £30,000 to £34,999, £35,000 to £39,999, £40,000 to £44,999, £45,000 to £49,999, £50,000 to £59,999, £60,000 to £69,999, £70,000 to £79,999, £80,000 to £89,999, £90,000 to £99,99, £100,000 and over.



SC-WRES Indicator 2: Appointed from shortlist

This indicator asks for the headcount of directly employed staff shortlisted and appointed in the last 12 months.

Chart 4 shows the proportion of applicants that were shortlisted by ethnicity **and** the proportion of people who were appointed, by ethnicity in this local authority. The chart shows one bar for people shortlisted and one for people appointed, by five ethnicity groups and not known.

Chart 4. Proportion of staff shortlisted and appointed by ethnicity

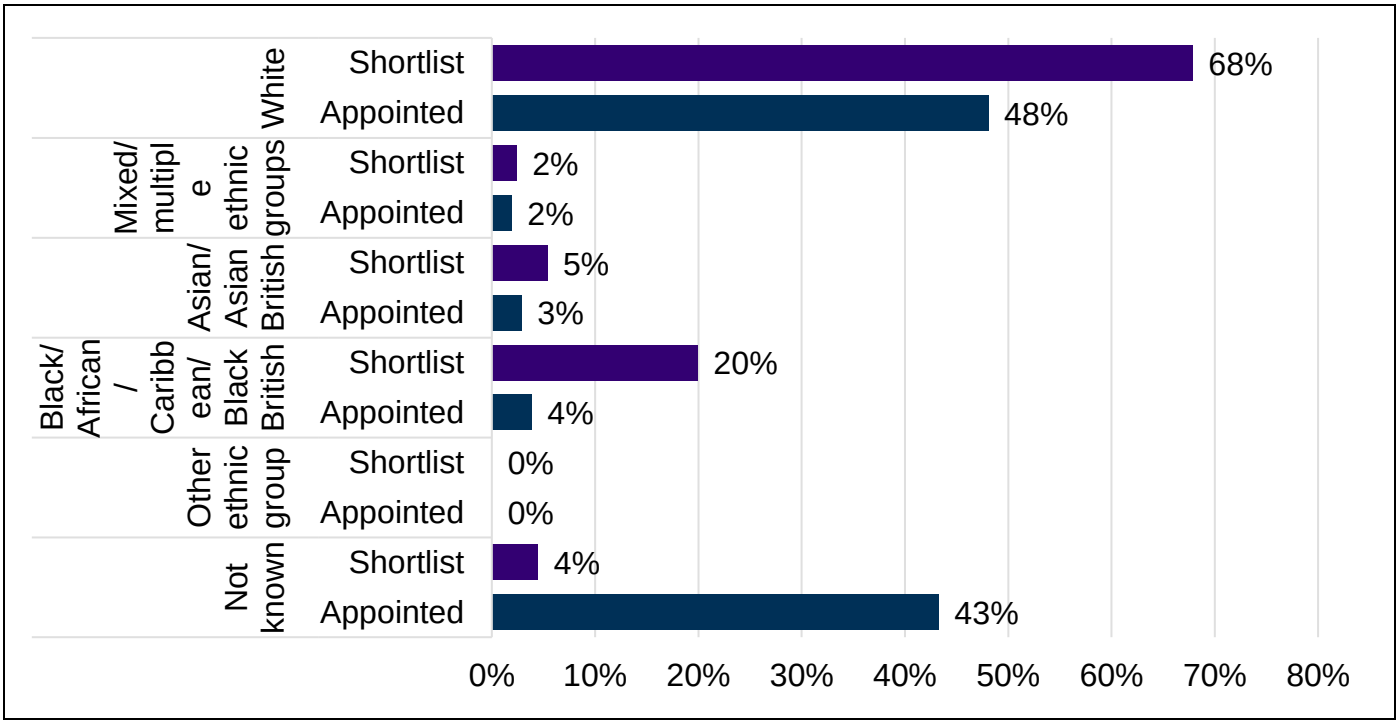
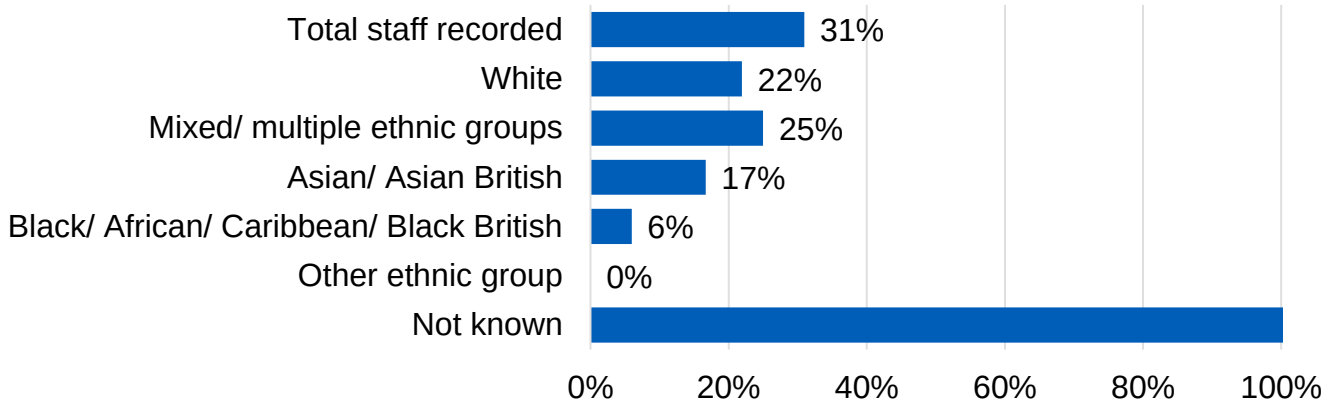


Chart 5 shows the percentage of staff **appointed** from shortlist by ethnicity. The chart shows one bar for each of the five ethnicity groups and one for not known in this local authority.

Chart 5. Percentage of staff appointed from shortlist by ethnicity



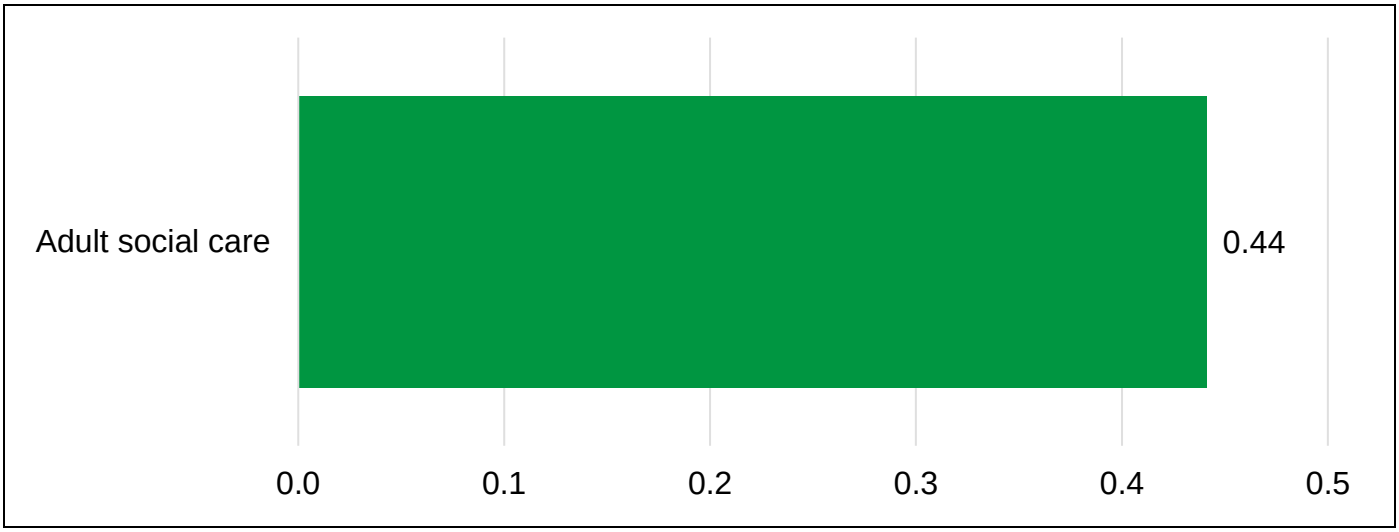
Relative likelihood definition

The relative likelihood is the percentage (or proportion) of one group experiencing an outcome, divided by the percentage (or proportion) of another group experiencing an outcome. The closer a relative likelihood is to one, the greater equality there is between the two groups. If a likelihood is less than one then one group is less likely to experience an outcome than the other group, and vice versa. If relative rate is less than 0.80 or more than 1.25 then it is suggested that ongoing monitoring from analysts and priority for policy action could be considered.[2]

The relative likelihood of applicants from a Black, Asian or minority ethnic background being appointed from shortlisting, across all posts, compared to applicants with a white ethnicity is 0.44. Therefore, staff with a Black, Asian or minority ethnic background were relatively less likely to be appointed from shortlist.

Chart 6. Relative likelihood of applicants from a Black, Asian or minority ethnic background being appointed from shortlisting, across all posts, compared to white applicants

[2] https://www.gov.uk/government/publications/using-relative-likelihoods-to-compare-ethnic-disparities

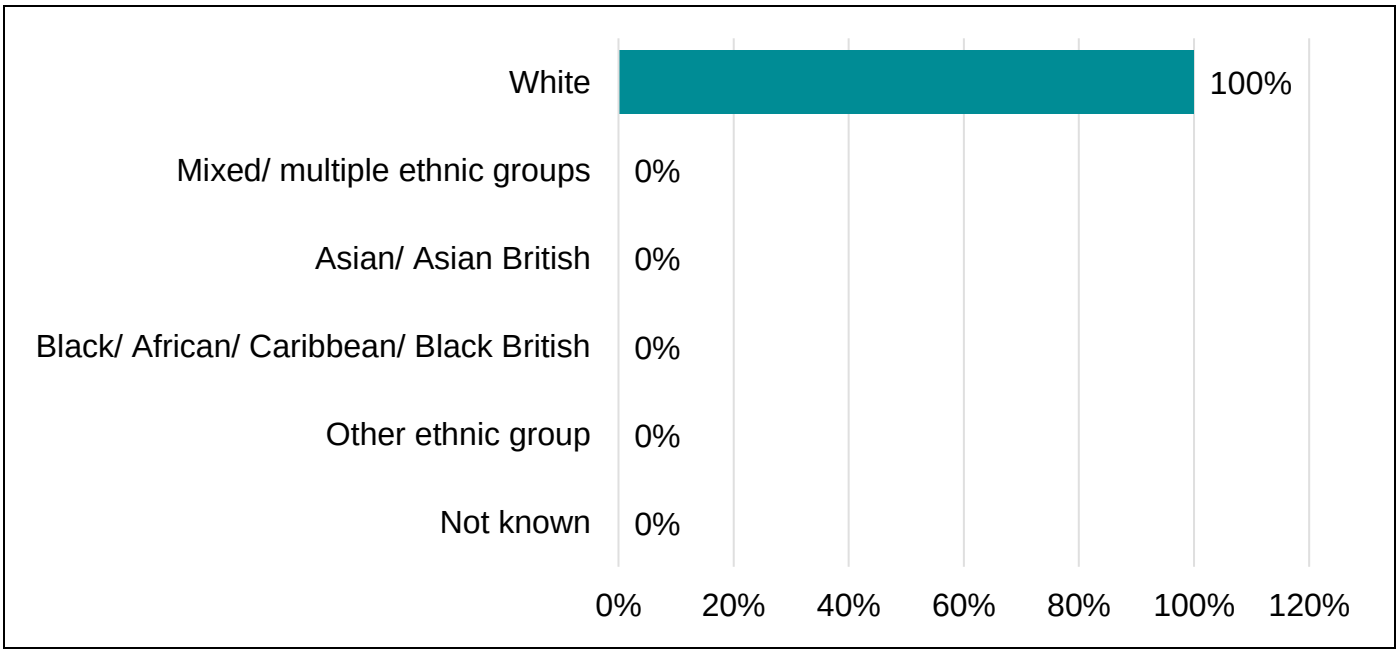


SC-WRES Indicator 3: Disciplinary Process

Indicator 3 asks for the number of directly employed staff who have entered the formal disciplinary process in the last 12 months. This count includes all directly employed staff who have entered the formal disciplinary process in the last 12 months. This refers to the formal disciplinary process only, not including probation, performance management or other forms of action.

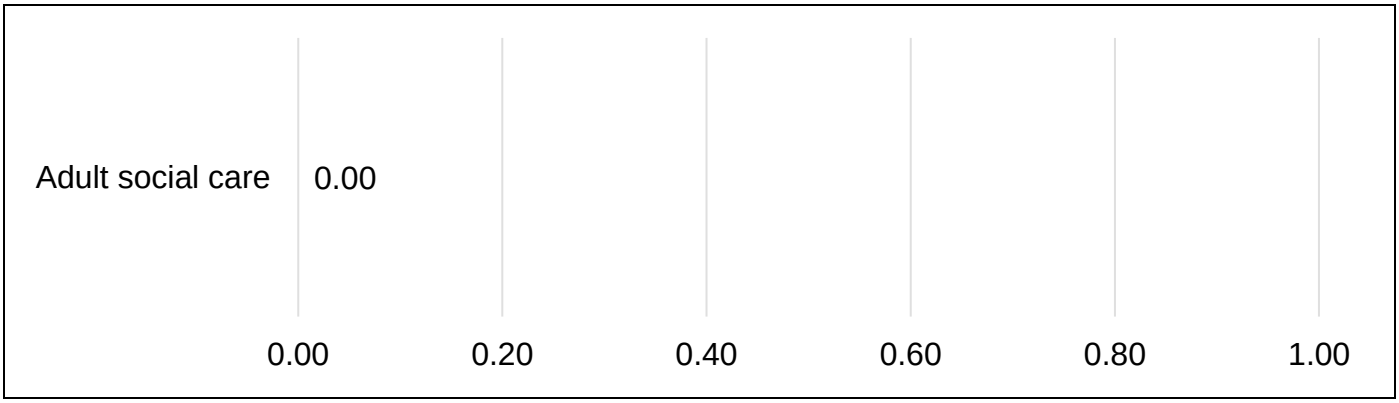
The chart below shows the proportion of staff who entered the formal disciplinary process in the last 12 months. The chart shows one bar for each of the five ethnicity groups and one for 'ethnicity not known' in this local authority.

Chart 7. Proportion of staff who entered the formal disciplinary process in the last 12 months, by ethnicity



The relative likelihood of staff from a Black, Asian or minority ethnic background entering the formal disciplinary process, across all posts, compared to white staff was 0.00. Therefore, staff with a Black, Asian or minority ethnic background were relatively less likely to enter the formal disciplinary process than white staff.

Chart 8. Relative likelihood of staff from a Black, Asian and minority ethnic background entering the formal disciplinary process compared to white staff.

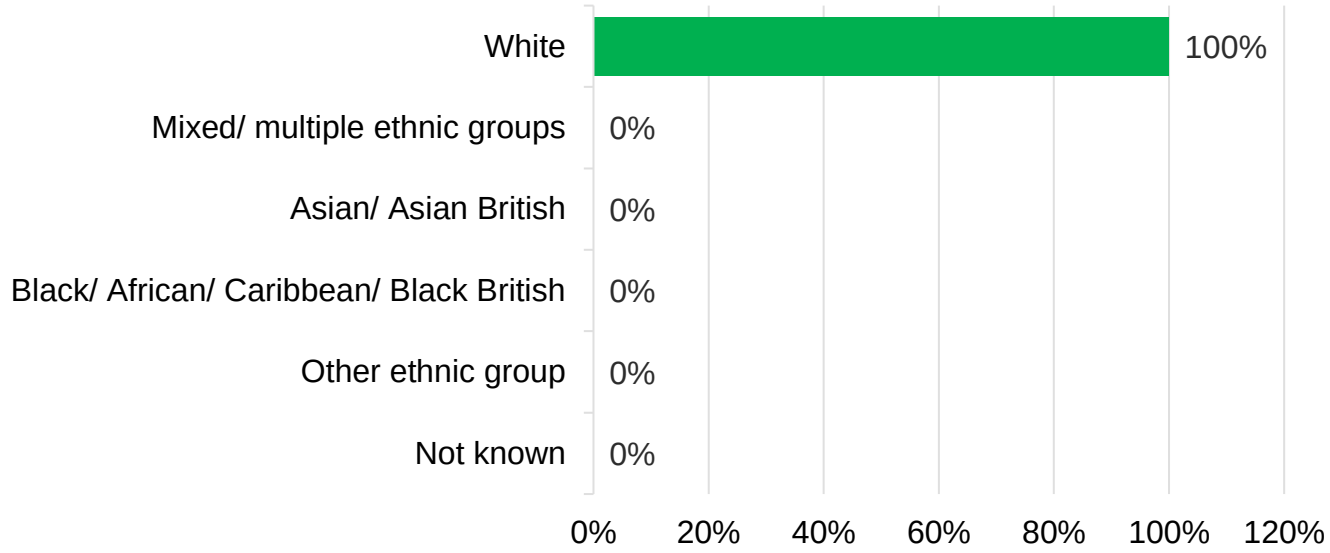


SC-WRES Indicator 4: Fitness to practice

This indicator is based on the headcount of directly employed regulated profession roles and those who have entered the fitness to practice process in the last 12 months. This includes ‘staff that are professionally regulated and directly employed by social service departments’ – this usually would encompass nurses, occupational therapists, psychologists, and social workers.

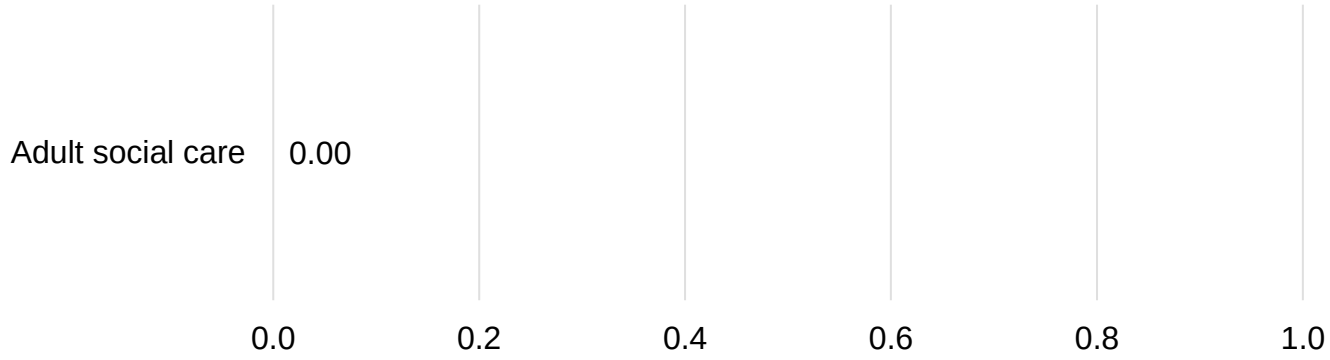
The chart below shows the proportion of regulated profession staff who entered the fitness to practice process. The chart shows one bar for each of the five ethnicity groups and one for ‘ethnicity not known’ for this local authority.

Chart 9. Regulated professionals who entered the fitness to practice process, by ethnicity



Relative likelihood of regulated profession staff from a Black, Asian or minority ethnic background entering the fitness to practice process compared to white regulated profession staff was 0.00. Therefore, regulated professional staff from a Black, Asian or minority ethnic background were less likely to enter the fitness to practice process than white regulated profession staff.

Chart 10. Relative likelihood of directly employed regulated profession staff from a Black, Asian or minority ethnic background entering the fitness-to-practice process in the last 12 months compared to white staff.



SC-WRES Indicator 5: Funded non-mandatory continuous professional development

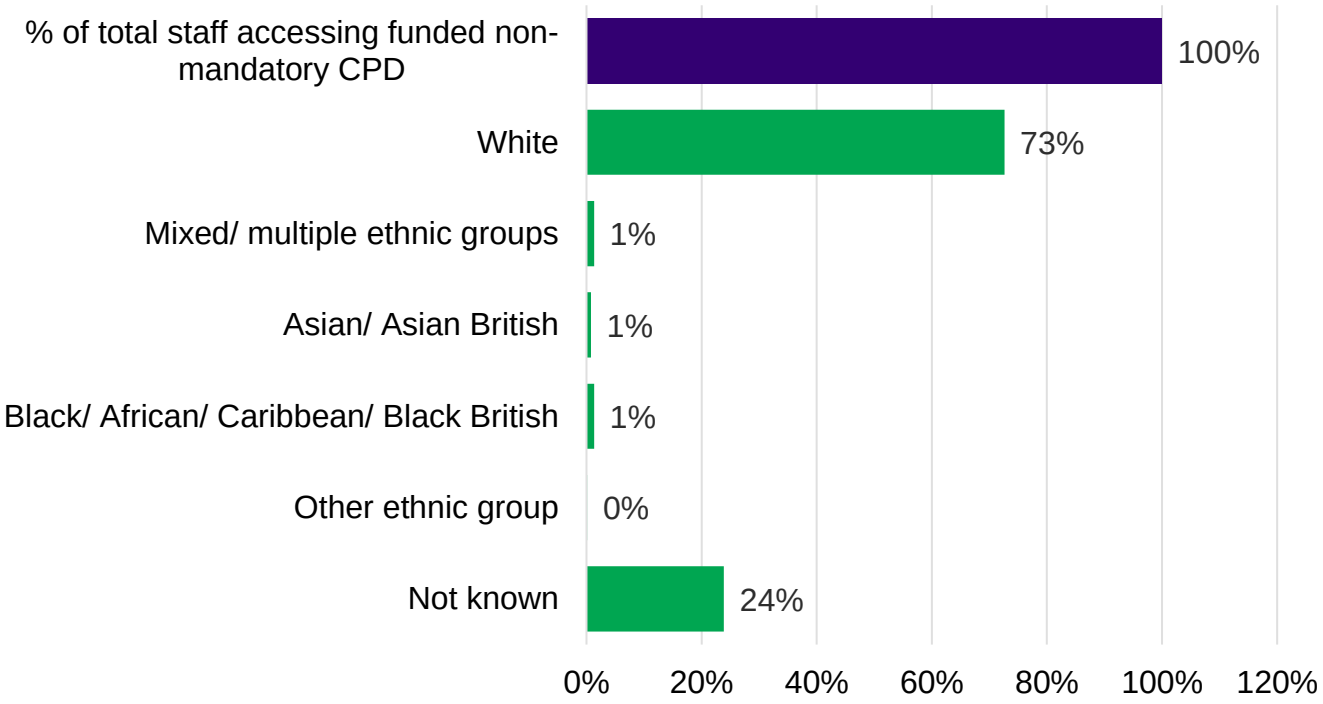
This indicator is based on the headcount of directly employed staff accessing funded non-mandatory continuous professional development (CPD) in the last 12 months. This is a count of directly employed staff accessing any funded non-mandatory CPD (as yes=1 or no=0) and not a count of the incidents of training (which could be greater than one per employee).

Non-mandatory training refers to any learning, education, training, or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement (e.g., fire

safety training) or mandated by the organisation. Accessing non-mandatory training and CPD in this context refers to courses and developmental opportunities for which places were offered and accepted.

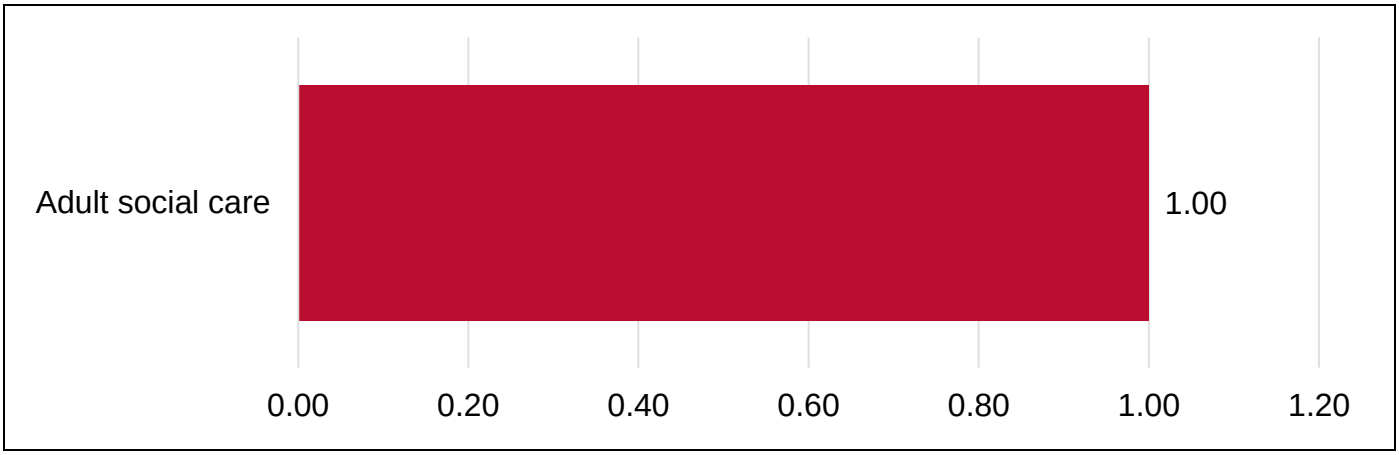
The chart below shows the proportion of staff accessing funded non-mandatory CPD. The chart shows one bar for each of the five ethnicity groups and one for 'ethnicity not known' for this local authority.

Chart 11. Staff accessing funded non-mandatory CPD, by ethnic group



Relative likelihood of regulated profession staff from a Black, Asian or minority ethnic background accessing funded non-mandatory , across all posts, compared to white staff was the same (a ratio of one to one).

Chart 12. Relative likelihood of directly employed staff from a Black, Asian or minority ethnic background accessing funded non-mandatory continuous professional development in the last 12 months as compared to white staff



SC-WRES Indicator 6 and 7: Harassment, bullying or abuse

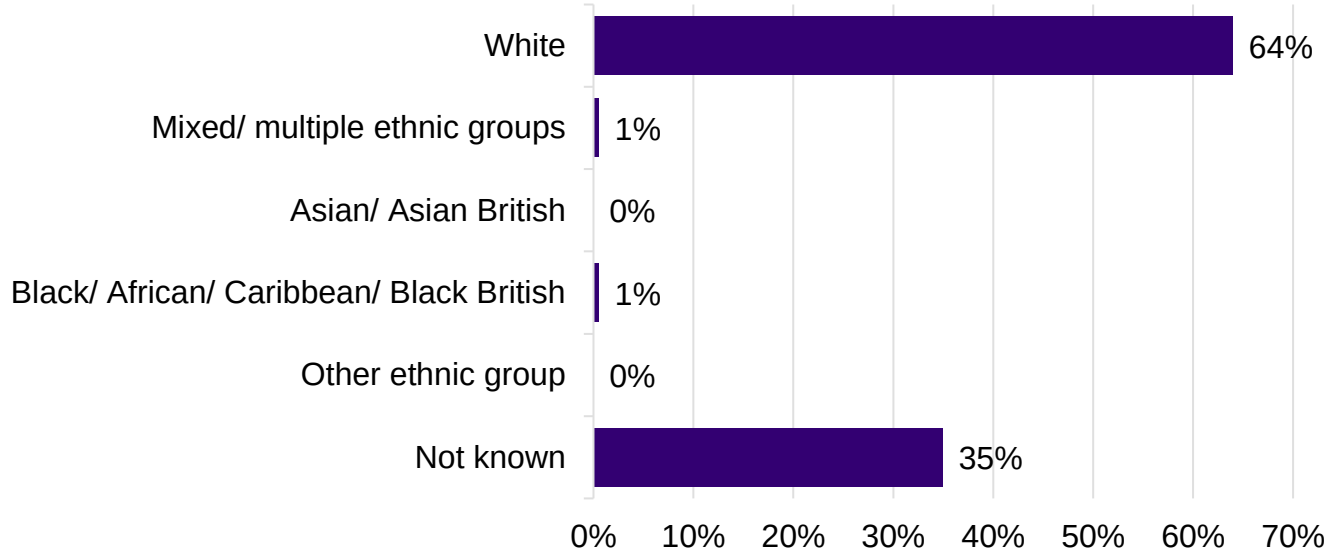
These two indicators collect information on the headcount of employees experiencing harassment, bullying or abuse from ‘service users, relatives or the public’, and from colleagues and/or from managers in last 12 months. This information is collected via a staff survey and the base for this indicator is the number of staff who completed the staff survey and not the number of people reported in the staff overview.

Please note that we could not get the information for Indicator 6 and 7: Harrassment, bullying or abuse as there was no information on the spreadsheet.

SC-WRES Indicator 8: Turnover of directly employed staff in the last 12 months

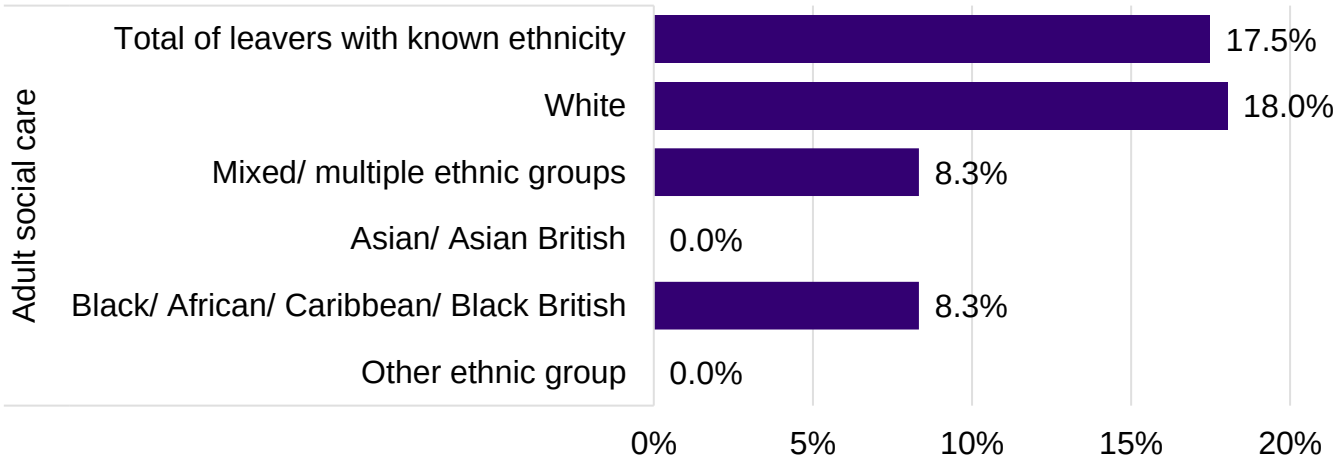
This indicator collects information on the headcount of directly employed staff leaving the organisation in the last 12 months. This number includes those who have left employment and not people leaving for other roles in the same local authority. Leaving the organisation is defined to cover all leavers, voluntary and involuntary, including those who resign, retire, or are made redundant.

Chart 15. Proportion of leavers in the past 12 months, by ethnicity.



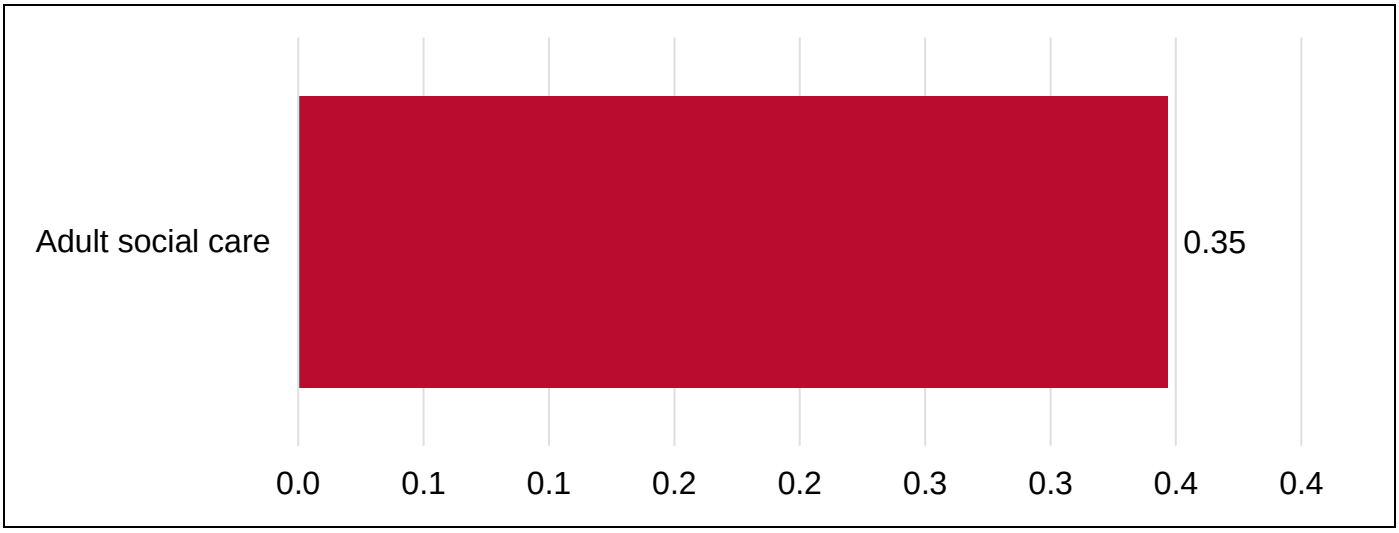
The following chart shows the turnover rate of staff by ethnicity. Turnover is calculated as (leavers/staff)*100.

Chart 16. Turnover rate by ethnicity.



The relative likelihood of employees from a Black, Asian or minority ethnic background leaving in the past 12 months compared to white employees was 0.35. Therefore, staff with a Black, Asian or minority ethnic background were relatively less likely to leave than white staff.

Chart 17. Relative likelihood of directly employed staff from a Black, Asian, or minority ethnic background leaving the organisation during the last 12 months compared to white staff

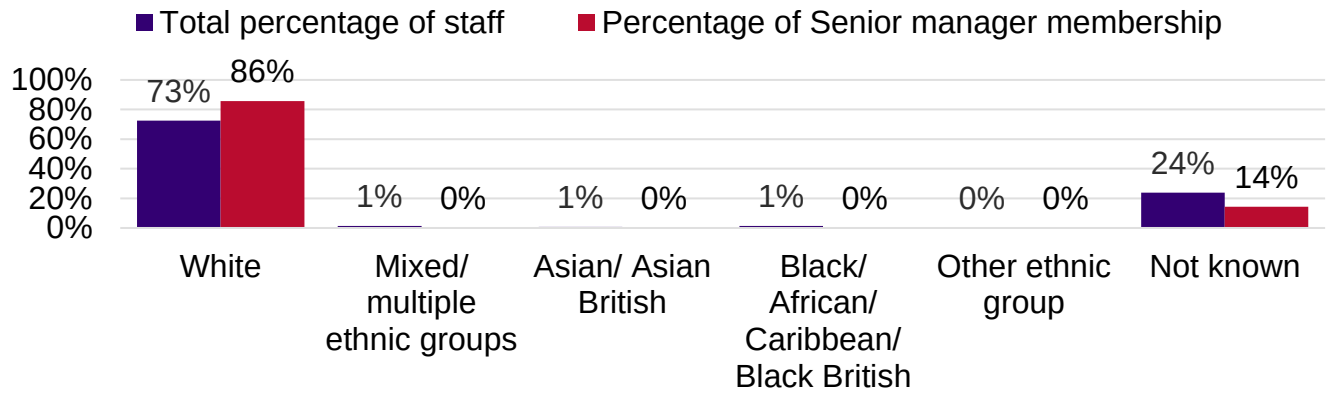


SC-WRES Indicator 9: Senior manager roles

This indicator shows the headcount of directly employed staff in senior manager roles. Senior management roles include Directors of Adult Social Care, Directors of Children's Services, Assistant Directors, and those directly line managed by Assistant Directors and equivalents. This number does include 'acting up' and secondments.

The chart below shows the percentage difference between organisations' senior management and its overall workforce.

Chart 18. Organisations' senior management membership and its overall workforce by ethnicity group.



Social Care Workforce Race Equality Standard (SC-WRES) 2024 report

Supporting race equity in the workforce

May 2025

Contents

Acknowledgements

Thank you to the many contributors to this report and particularly all the employers who have completed the Social Care Workforce Race Equality Standard (SC-WRES) data return and programme. Without their contributions this report would not be possible.

This report was researched and compiled by Sarah Davison, Workforce Intelligence Analyst and we specially thank her for her ongoing commitment to SC-WRES and data education; and the SC-WRES Team: Fiona Murphy, Jessica Chalk, and Seerah Ghory at Skills for Care. And with thanks to Karen Linde (consultant) for her valued contribution.

We would like to thank the hard work and support of the Race Equity Reference Group and the Independent Advisory Group on SC-WRES. The Independent Advisory Group (IAG) for the SC-WRES is an advisory group composed entirely of global majority social care professionals, leaders, academics and authors including people drawing on care and support. The IAG represents both adult social care and children's social care. They provide expert advice and collaborate with other social care organisations on SC-WRES. Tricia Periera and Godfred Boahen are co-chairs, Clenton Farquharson and Meera Spillett are co-vice chairs. Skills for Care are pleased to be supported by the Independent Advisory Group on SC-WRES and for their on-wavering commitment to SC-WRES.

Feedback on any aspect of the report is welcomed and will improve future editions. Please contact our Equality and Rights team: equalityandrights@skillsforcare.org.uk

Terminology used in this report

Throughout this report we will be using the terms *people from minority ethnic backgrounds*, *people from a Black, Asian or minority ethnic background* and *global majority colleagues.* However, we acknowledge concerns that some ways of categorising ethnicity have not reflected how people recognise themselves and their self-identity.

The definitions of ethnicity we are using are based on the Office for National Statistics – Census 2021.

The EDI related terminology in this report is advised on by the Skills for Care Race Equity Reference Group (RERG).

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Foreword from our CEO

I’m proud to say that Skills for Care has continued our support for the Social Care Workforce Race Equality Standard (SC-WRES) for another year of data collection, peer-to-peer support and action planning in 2024/25. We’ve always seen ourselves as custodians of SC-WRES on behalf of the children’s and adult social care sectors, and we want to thank everyone who is involved in its development, including the Race Equity Reference Group and Independent Advisory Group, for their advice.

Our sector is diverse but not always inclusive, as the data shows. Skills for Care is on this journey too, with much work ahead as we seek to increase our diversity and keep supporting social care to become anti-racist and inclusive. This programme provides the data needed for conversations that drive change, but we all must lead this change ourselves and we all need to have those conversations and not shy away from them.

As a white leader, I deeply value the support of the Race Equity Reference Group, the Independent Advisory Group on SC-WRES, and colleagues who share their personal, lived experiences. I strive to be aware of systemic racism, recognise my own privilege, and lead change within my sphere. However, I know that I inevitably miss things and need the support of others for my own development.

We've made significant progress with 76 local authorities now participating in SC-WRES, using nine indicators to improve experiences for minority ethnic staff, addressing issues like bullying, harassment, and access to development opportunities.

These local authorities represent 97,900 workers, and we've shared detailed analysis of their data. We are grateful to everyone in those local authorities from across England who are working so hard to embed SC-WRES in the way they operate.

The report reveals challenging data: staff from minority ethnic backgrounds are 48% less likely to be appointed from shortlist, 37% more likely to face formal disciplinary action, and underrepresented in senior management (12% vs. 20% overall workforce). The report also highlights positive case studies from local authorities showing how SC-WRES can improve workplace experiences for minority ethnic staff.

There's much more to do, but this report's rich data and analysis demonstrate SC-WRES's potential to drive meaningful change in social care.

Professor Oonagh Smyth
Chief Executive, Skills for Care

Reflections from the IAG on the Social Care Workforce Race Equality Standard

Reflecting on the 2023/2024 Social Care Workforce Race Equality Standard (SC-WRES) report, and the positive increase in the numbers of local authorities adopting the SC WRES, it is clear that progress has been made. The report highlights continuing disparities in the workforce. The journey towards true race equity in the social care sector remains ongoing and urgent.

The Independent Advisory Group (IAG) for the SC-WRES welcomes several proactive developments highlighted in this year's report. We have seen encouraging examples of local authorities actively embedding anti-racist practice and leadership, prioritising inclusion as a core value. Progress in areas such as workforce representation varies with some local authorities promoting the creation of equitable opportunities and demonstrating that when commitment translates into action, meaningful change is possible.

Yet, as we noted in our input last year, systemic change requires sustained focus and courage. This year's report also reminds us of the persistent inequities and barriers faced by people from global majority backgrounds across all levels of the social care workforce. These challenges are a stark reminder of how far we must go in achieving a truly inclusive sector that reflects and values the diversity of the communities we serve.

The rising tensions and summer riots in 2024, were a painful reminder of how much work remains and further highlighted the critical importance of our collective efforts to dismantle racism and inequity. Now more than ever, we must stand resolute in our commitment to fairness. This means embracing the language of anti-racism, promoting safe and inclusive spaces for dialogue, recognising and addressing unwitting prejudice, and holding ourselves accountable to the principles of equity and justice.

As we look ahead, the SC WRES is about assuming responsibility. It requires recognising that systems produce their design, and if we seek different results, system redesign is necessary. SC-WRES facilitates this process by providing both a map and a mirror—the data to monitor progress and the accountability to ensure change occurs. SC-WRES remains an essential framework for addressing inequalities, driving systemic improvement, and empowering leaders to demonstrate compassionate and inclusive leadership.

Our collaborative efforts aim to create a social care sector where every individual feels truly valued, respected, motivated, and supported to succeed. We recognise and appreciate the commitment of local authorities who have joined the SC-WRES and encourage others to join too, together we can identify and eradicate systemic racism.

As an Independent Advisory Group made up of people with lived and professional experience in social care, we are clear: equity is not optional. It is a moral and professional imperative. And we are proud to be shaping a future in which social care truly reflects the diversity, dignity, and aspirations of the communities it serves. We are committed to the mission around improving race equity, recognising that the progress we make today will shape the future of social care for generations to come.

Executive summary

The Social Care Workforce Race Equality Standard (SC-WRES) Improvement Programme is built on a continuous improvement approach, ensuring that progress is ongoing, structured and responsive to feedback. It is designed to contribute, and lead to, transformational change.

The SC-WRES collects data on nine indicators using the SC-WRES metric and supports an organisation to benchmark, reflect on and improve outcomes in race equity for their workforce. It has three main components which cannot be separated.

1. Data collection and a national annual report
2. Peer-to-peer support and monthly community of practice sessions
3. Individual data reports and action plans

The three components are designed to ensure that data findings are acted on, by employers, within a continuous improvement framework, reflecting on and implementing the evidence gained.

Community of Practice sessions

The monthly Community of Practice sessions are a key element of the improvement programme and provide a non-judgemental space, where confidentiality is encouraged, exclusively for local authorities to come together with their peers, subject-matter experts and the SC-WRES team to share learning, problem-solve and gain knowledge and expertise.

Action plans

Action plans are a vital output of the SC-WRES programme which show how local authorities have translated their data report into improvement. Once local authorities have their data findings the next step is to share these internally with senior leaders and staff networks, reflect and consult to agree on achievable actions, and develop and implement the action plan.

This executive summary predominately focuses on the key findings from the SC-WRES data collection, relating to workers employed in local authority social services departments.

Diversity within adult social care

- Estimates of the **adult** social care local authority workforce, as described in Skills for Care's annual 'The workforce employed by adult social services departments in England' report showed that this part of the sector had more ethnic diversity than the population of England, with 79% of all employees having a white ethnic background compared to 81% of the population of England.
- Employees working within the adult social care independent sector, as described in 'The state of the adult social care sector and workforce in England' report showed that there was more diversity in the independent sector workforce than the local authority workforce, with 65% of employees having a white ethnic background.
- 31% of social workers employed by adult social care local authorities were from a Black, Asian or minority ethnic background compared to 26% of social workers employed by children's social care local authorities.

Response rates and representativeness of the data

76
local authorities in the SC-WRES programme.

73
local authorities provided to the SC-WRES.

43%
of the adult local authority workforce was represented in the SC-WRES.

- In 2024, 73 local authority employers provided data about their adult social care workforce and 43 (of the 73) also provided data about the children's social care workforce.
- The responding local authorities employed 97,900 staff between them. This was 58,600 in adult social care and 39,300 staff working in children's social care.

Indicator 1: Pay bands

- A total of 95% (69 of 73) of adult local authority employers and 91% (39 of 43) of children's social care employers provided data for indicator 1.
- There is pay band information, where ethnicity is known, for a total of 81,000 staff; this is 49,100 adult social care staff and 31,900 children social care staff.
- It should be noted that there are lots of factors that could be affecting pay rates for someone working in social care, and their ethnicity is only one of those factors, for example job role, geographic location or experience, qualifications and training.
- **Of responding local authority employers, there was a smaller proportion of staff from a Black, Asian or minority ethnic background (14%) in the higher pay band of '£70,000 and over' compared to the 'less than £30,000' lower and '£30,000 to £69,000' middle pay bands (18% and 22% respectively). Therefore, staff from a Black, Asian or minority ethnic background were less represented in the highest pay band.**

A relative likelihood is a number that shows how much two groups differ in their chances of experiencing something. For SC-WRES, it compares the chances of people from Black, Asian, or minority ethnic backgrounds experiencing certain outcomes to the chances of staff from white backgrounds. If the number is close to 1, it means both groups have similar experiences.

Indicator 2: Appointed from shortlist

- A total of 59% (43 of 73) of adult local authority employers and 65% (28 of 43) of children's social care employers provided data for indicator 2.
- Responses are based on 48,900 people, where ethnicity was known, who were shortlisted, comprising 29,600 shortlisted for adult social care roles and 19,400 shortlisted for children's social care roles. Reponses are also based on 11,600 people, where ethnicity was known who were appointed, comprising 7,300 people appointed to adult social care and 4,350 people appointed to children's social care roles.
- **At responding local authorities, staff with a Black, Asian, or minority ethnic background were 48% less likely to be appointed from shortlist than staff with a white ethnic background. The likelihood was the same, half as likely, for adult social care and children's social care employers.**

Indicator 3: Disciplinary process

- A total of 88% (64 of 73) of adult social care local authorities and 93% (40 of 43) of children's social care local authorities provided data for indicator 3.
- Responses are based on 775 people, across all employers, who have entered the formal disciplinary process, comprising 450 people from adult social care local authority employers and 325 people from children's social care. This equates to 1.0% of the total workforce of the responding local authorities who entered the process.
- **At responding local authorities, staff with a Black, Asian or minority ethnic background were 37% more likely to enter the formal disciplinary process, compared to staff with a white ethnic background (a relative likelihood of 1.37). Staff from adult social care were 19% more likely (a relative likelihood of 1.19) and staff from children's social care were 67% more likely (a relative likelihood of 1.67).**

Indicator 4: Fitness to practise

- A total of 37% (27 of 73) of adult social care local authorities and 40% (17 of 43) of children's social care local authorities provided data for indicator 4. Data availability for this indicator was low, with nearly three fifths (62%) of responding local authority employers not having the required data to report.
- Information, where ethnicity was known, was from 3,500 staff with a regulated profession working in adult social care, where less than 25 had entered the process (0.6%), and 3,500 regulated profession staff working in children's social care where 50 had entered the process (1.4%).
- **At responding adult local authorities, staff in a regulated profession, from a Black, Asian or minority ethnic background were 8% more likely to enter the fitness to practise process compared to staff from a white ethnic background. This outcome was different in the children's social care sector, where staff in a regulated profession, from a Black, Asian or minority ethnic background were 114% more likely to enter the fitness to practise process compared to staff from a white ethnic background.**
- We do know that the results shown here are an accurate reflection of the responding local authorities however our conclusion is that we need to collect more data about this indicator to understand to what extent ethnicity has an effect on the likelihood of staff in a regulated profession entering the fitness to practise process. We have plans to support local authorities participating in the 2025 SC-WRES programme to better collect this information.

Indicator 5: Funded non-mandatory continuous professional development (CPD)

- 56% (41 of 73) of adult social care local authorities and 53% (23 of 43) of children's social care local authorities provided data for indicator 5. Some local authorities did not have any data available for this indicator, and some were excluded based on data quality or deviations from the definition of the indicator.
- Information is based on 25,700 employees, where their ethnicity was known, who had accessed funded non-mandatory CPD in the 12 months prior to this data collection period. This was comprised of 16,500 adult social care employees and 9,250 children's social care employees.

- **At responding local authorities, staff with a Black, Asian or minority ethnic background were 5% more likely to access funded non-mandatory CPD in the last 12 months, compared to staff from a white ethnic background (a relative likelihood of 1.05). Staff from a Black, Asian or minority ethnic background were 3% more likely in adult social care services and 9% more likely in children's social care services.**

Indicator 6: Harassment, bullying or abuse from service users, relatives or the public

- 18% (13 of 73) of adult social care local authorities and 16% (7 of 43) of children's social care local authorities provided data for indicator 6. The information for this indicator was collected via a staff survey but not all local authorities carried out a survey, so the response rate was lower than other indicators.
- Analysis is based on staff where their ethnicity is known. Information is based on 4,050 adult social care employees who completed the staff survey, of which 525 (13.6%) reported experiencing harassment, bullying or abuse from 'service users, relatives or the public'. Information is also based on 2,900 children's social care employees completing the staff survey, of which 325 (11.0%) of those reported experiencing harassment, bullying or abuse.
- **Within responding local authorities, staff from a Black, Asian or minority ethnic background were 35% less likely to experience harassment, bullying or abuse from people who use social care, relatives, or the public in the 12 months prior to data collection, compared to staff from a white ethnic background (a relative likelihood of 0.65). This experience was similar for adult social care employees at 34% less likely and children's social care employees at 40% less likely.**
- We do know that the results shown here are an accurate reflection of the responding local authorities however our conclusion is that, next year, we need to collect more data about this indicator to understand to what extent ethnicity has an effect on the likelihood of staff experiencing harassment, bullying or abuse from people who use social care, relatives or the public. We have plans to support local authorities participating in the 2025 SC-WRES programme to better collect this information.

Indicator 7: Harassment, bullying or abuse from colleagues and managers

- A total 14% (10 out of 73) of adult social care local authorities and 16% (7 out of 43) of children's social care local authorities provided data for indicator 7. The information from this indicator was collected via a staff survey but not all local authorities carried out a survey, so the response rate was lower than other indicators.
- Analysis is based on staff where their ethnicity is known. This was a total of 5,800 staff who completed the staff survey (3,600 adult social care employees and 2,200 children's social care employees); 300 of whom reported experiencing harassment, bullying or abuse from a colleague (175 from adult social care and 100 from children's social care) and 250 of whom reported experiencing harassment, bullying or abuse from a manager (150 from adult social care and 100 from children's social care).
- **At responding local authorities, staff from a Black, Asian or minority ethnic background were 28% less likely to experience harassment, bullying or abuse from colleagues in the last 12 months compared to staff from a white ethnic background (a relative likelihood of 0.72).**

- **At responding local authorities, staff from a Black, Asian or minority ethnic background were 12% less likely to experience harassment, bullying or abuse from managers in the last 12 months compared to staff from a white ethnic background (a relative likelihood of 0.88).**
- We do know that the results shown here are an accurate reflection of the responding local authorities; however, our conclusion is that next year, we need to collect more data about this indicator to understand to what extent ethnicity has an effect on the likelihood of staff experiencing harassment, bullying or abuse from colleagues and from managers. We have plans to support those participating in the 2025 SC-WRES to better collect this information.

Indicator 8: Turnover of directly employed staff

- This indicator looks at the number of leavers in the past 12 months, prior to this data collection period, by ethnicity. It should be noted that there are lots of factors that can affect an employee's choice to leave, and their ethnicity is only one of those factors. Examples include job satisfaction, pay and benefits, workload and stress, training and development and opportunities, workplace culture and environment and personal circumstances.
- 99% (72 of 73) of adult local authority employers and all children's social care employers (43 of 43) provided the number of leavers by ethnicity information for this indicator.
- Information was based on 85,000 workers and 9,950 leavers in the past 12 months. This constituted of 50,900 employees and 5,550 leavers from adult social care, and 34,100 employees and 4,500 leavers from children's social care.
- **At responding local authorities, the likelihood of staff from a Black, Asian or minority ethnic background employed by adult social care local authority employers leaving during the last 12 months was around the same as staff with a white ethnic background (a relative likelihood of 1.03).**
- **Staff from a Black, Asian or minority ethnic background employed by children's social care local authority employers were 21% more likely to leave during the last 12 months compared to staff with a white ethnic background (a relative likelihood of 1.21).**

Indicator 9: Senior manager membership

- 97% (71 of 73) of adult social care local authorities and 95% (41 of 43) of children's social care local authorities provided data for indicator 9. Analysis is based on 2,250 staff, with ethnicity known, in senior management roles, comprised of 1,300 staff from adult social care and 950 staff from children's social care.
- 2% of all staff recorded by local authority employers were in senior manager roles (2% for adult social care and 3% for children's social care).
- **At responding local authorities, there was a smaller proportion of staff with a Black, Asian or minority ethnic background in senior management positions (12%) compared to the overall workforce (20%).**
- **Staff from a Black, Asian or minority ethnic background were 45% less likely be in senior manager roles compared to staff with a white ethnic background (a relative likelihood of 0.55). Staff were around half as likely (48%) in adult social care (a relative likelihood of 0.52) and 39% less likely in children's social care (a relative likelihood of 0.61).**

Introduction to SC-WRES

1 Introduction to SC-WRES

1.1 Who are Skills for Care?

Skills for Care is the strategic workforce development body for adult social care in England. Everything we do is about making sure the sector has enough people with the right skills and values to provide the best possible care and support.

We work across the health and social care system to understand the key drivers of change in social care - and the capacity, characteristics and skills that are needed in our workforce to meet people's future needs.

We've led the development of a much-needed Workforce Strategy for adult social care – working with a wide range of organisations and people who have a stake in the future of the sector. In that strategy we recommended that the SC-WRES was mandated for all local authorities to increase its scale and impact.

One of our four strategic priorities[1] is supporting culture and diversity because it is essential if we are to achieve our vision of a fair and just society where people can access the advice, care and support they need to live life to the fullest. We can't deliver this priority without collaboration – one of our core values. By working with our partners, we're able to bring together a vast array of expertise, support, and influence – which in turn increases the impact and reach of our work.

There are so many benefits to individuals and organisations of having a more equal, diverse and inclusive workforce. Our review of the benefits of recruiting and retaining a diverse workforce for organisations found evidence of a positive link between diversity and business performance, reduced costs and improved quality of care.

This report looks at two sources of data that Skills for Care holds. The first is our Adult Social Care Workforce Dataset and the second is the SC-WRES data itself. For further information on our approach and to understand more about the analysis that we employed, go to Appendix 1.

1.2 Equity, Equality, diversity and inclusion at Skills for Care

Skills for Care promotes diverse and compassionate leadership across the social care sector and has resources available for managers supporting the workforce, such as guidance on creating an inclusive organisation and a positive culture toolkit. Much of our EDI focus in recent years has concentrated on race equity because we know it is essential to workplace culture and the well-being of the social care workforce., Improving race equity, as a systemic

[1] https://www.skillsforcare.org.uk/About-us/Our-strategy/Our-strategy.aspx

issue, is known to lead to positive changes in organisational culture which supports progress with other protected characteristics. Skills for Care has developed the Moving Up programme which has been designed to support Black and Asian minoritised managers and aspiring managers in social care, who are seeking to progress in their careers. Through a combination of self-learning and online sessions, the programme provides tools and guidance to help participants understand and influence their career progression.

As part of our efforts to promote diverse leadership across the sector, Skills for Care has partnered with the Stephen Lawrence Research Centre (SLRC) on a collaborative Storytelling Project: 'Telling the Story of Black, Asian and Minoritised Ethnic Staff in and to Leadership in Social Care'. This research explores the experiences of Black, Asian, and minoritised ethnic staff on their journey to and through leadership in social care, helping to identify the systemic barriers and racism they face both when entering and once in leadership roles. Using evidence from SC-WRES data, equality, diversity and inclusion research, and broader social and human rights contexts, the project aims to drive attitudinal change, inform policy, and reshape workforce programmes to foster greater diversity in leadership and create long-term industry-wide change.

Other EDI focus has included our LGBTQ+ Learning Framework and values based recruitment.

1.3 What is the SC-WRES?

The SC-WRES Improvement Programme collects data on nine indicators using the SC-WRES metric and supports organisation to benchmark, reflect on and improve outcomes in race equity for their workforce. It has three main components which cannot be separated.

1. Data collection and a national annual report
2. Peer-to-peer support and monthly community of practice sessions
3. Individual data reports and action plans

The three components are designed to ensure that data findings are acted on by local authority employers within a continuous improvement framework (more information about this part of the programme please see section 4).

The Workforce Race Equality Standard (WRES) was developed for the NHS in 2014 by the NHS Equality and Diversity Council. Skills for Care commissioned a scoping review in 2019 (Linde,K.Kline,R.2018) to look at the relevance of the WRES in social care. This led to the Chief Social Worker for Adults, Skills for Care and the Department of Health and Social Care and Department for Education testing the Social Care WRES with 18 local authorities in 2022. From 2023, this important work has been funded directly by Skills for Care. Due to the absence of government funding, Skills for Care, who are committed to supporting this important area of work, have directly funded SC-WRES in 2023 and 2024, while continuing to

explore its ongoing sustainability. 23 local authorities and 76 local authorities took part respectively. This report analyses the data submitted by the 73 of the 76 local authorities, participating in phase two, in 2024/25.

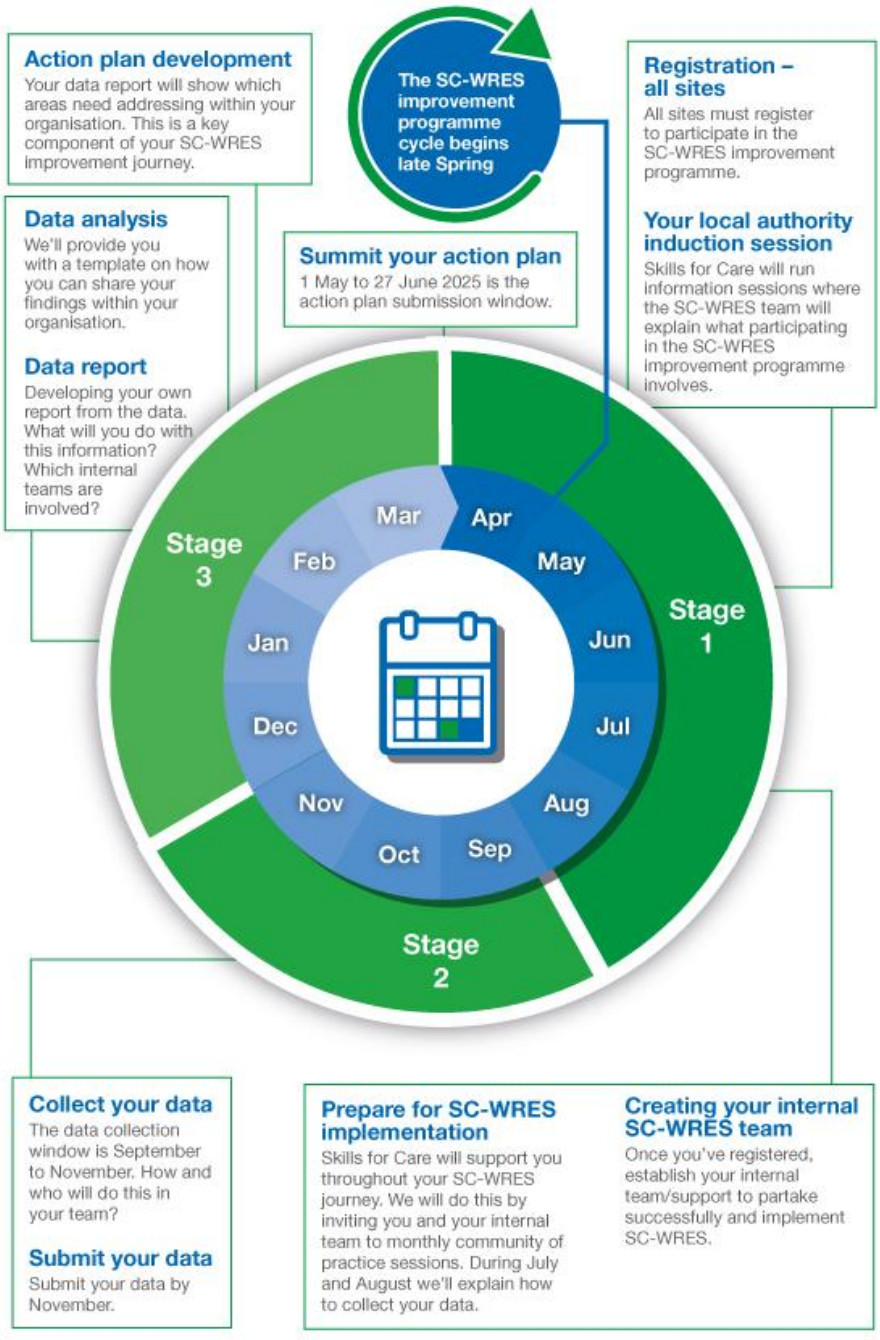
The SC-WRES Improvement Programme aligns with the NHS Workforce Race Equality Standard - 7 out of 9 are the same indicators. Each indicator in the metric helps us to understand race disparities.

Diagram 1. The SC-WRES Indicators

Participating local authorities begin by bringing together a project group representing different expertise (for example, HR, equalities, workforce, staff representatives, principle social workers, senior leaders) to agree governance, support, engagement and communication. The group analyses their data, check the findings and develop actions with involvement across their organisation. They agree an approach to ongoing monitoring and gathering feedback on the impact of action plans, ensuring that this involves consultation with staff.

The diagram below shows the SC-WRES improvement cycle which enables us to support local authorities in a more efficient and step by step way. This is to ensure local authorities reflect on best practice for their workplace culture and progress through the improvement programme successfully.

Diagram 2. The SC-WRES participants timeline Phase 2 2024/2025



1.4 Growth in SC-WRES

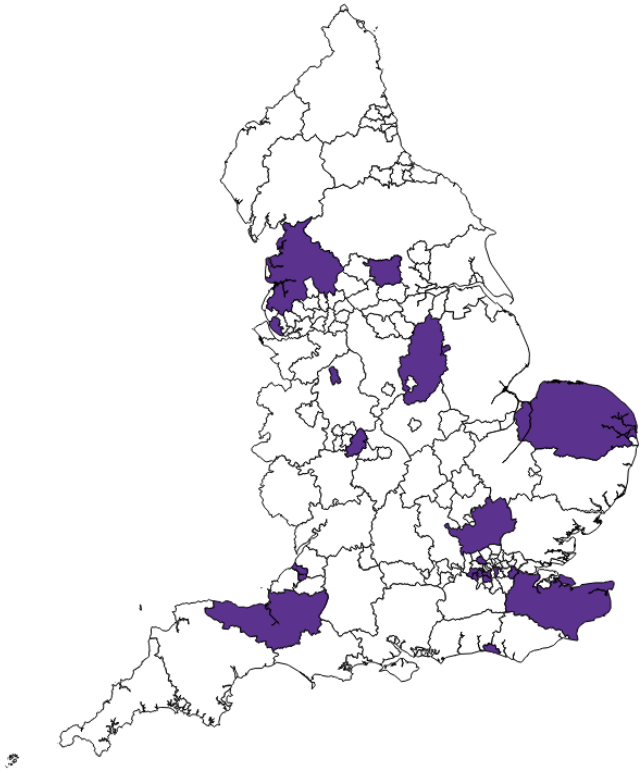
Considerable foundational work has been undertaken to enable the scaling up of SC-WRES in a supported, careful, measured way, within 3 years. This includes working more closely with partners, sharing stories from participants about impact and providing a wealth of resources and support guidance about what is involved and how to practically action the various steps and stages.

There have been three phases to the SC-WRES, which began in 2021:

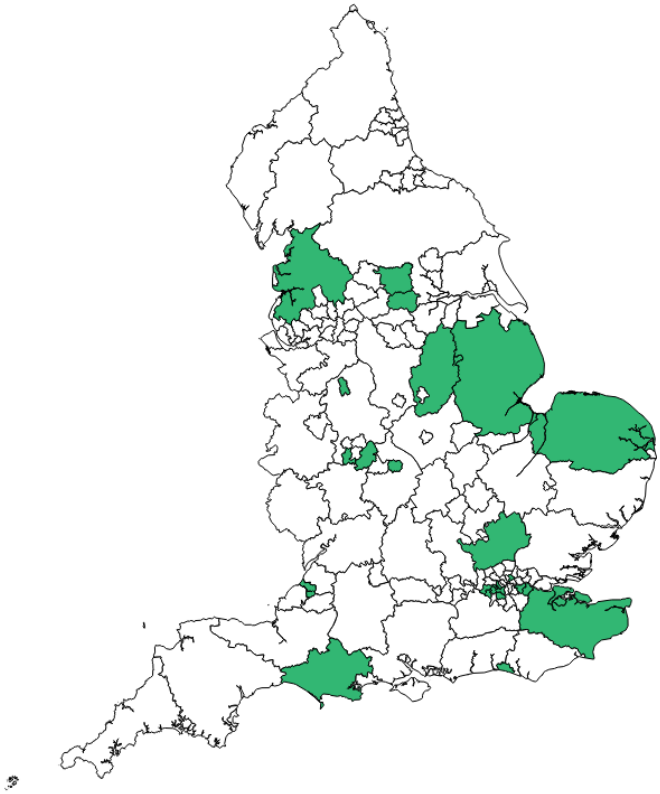
- The Test Phase, with 18 local authorities, involved testing the indicators and data tool.
- Phase 1, with 23 local authorities, established the improvement framework, methodology and community of practice.
- Phase 2, with 76 local authorities, strengthened our guidance and action plan support and scaled up all aspects of the programme support.

The maps below show which social care local authority employers have signed up to the SC-WRES programme in 2021, 2023 and 2024.

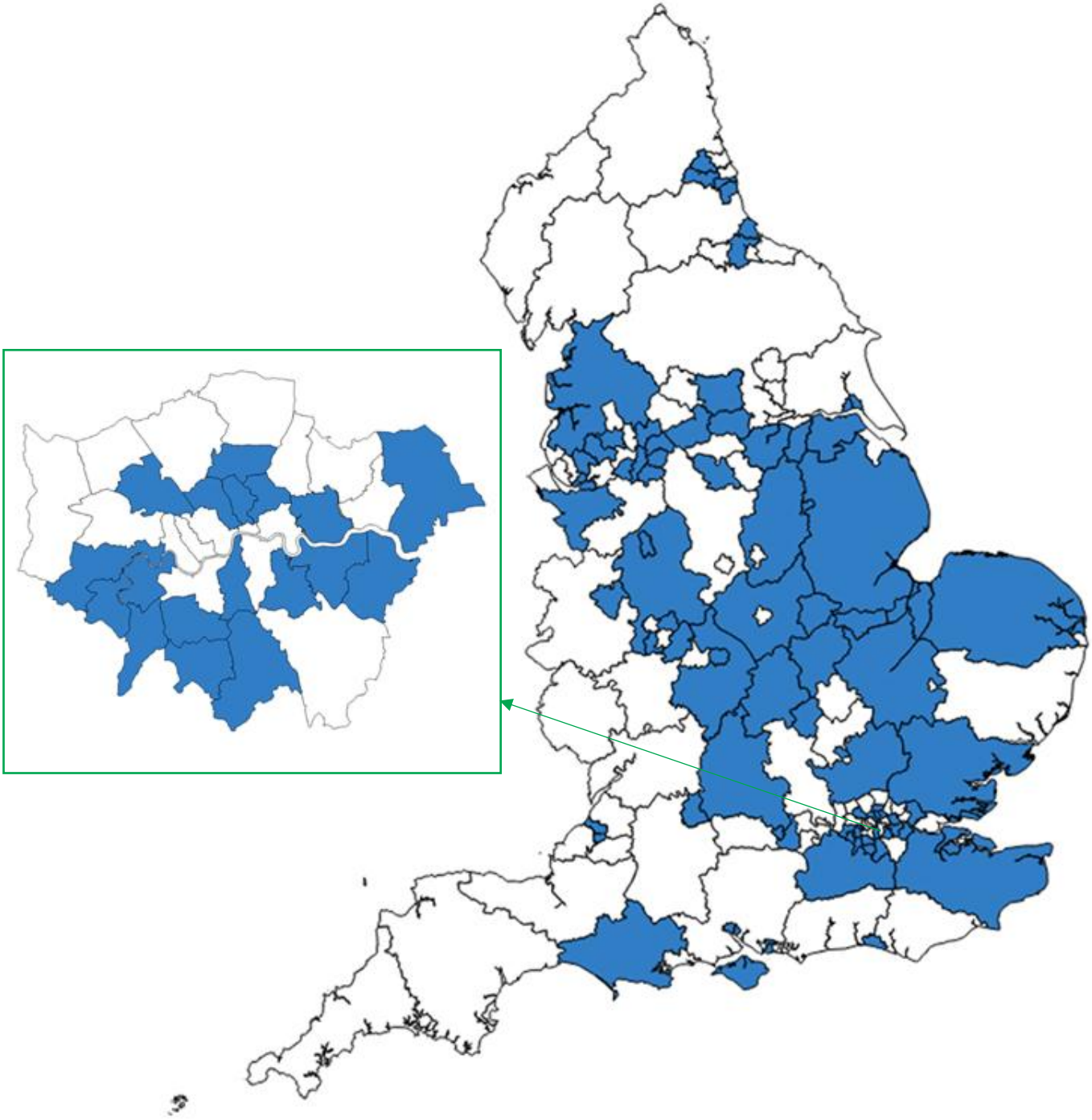
Map 1. All 18 local authorities in the SC-WRES programme 2021



Map 2. All 23 local authorities in the SC-WRES programme 2023



Map 3. All 76 local authorities in the SC-WRES programme 2024



There has been significant growth in participation in London, the North West and North East in 2024/2025.

Sarah McClinton, Chief Social Worker for Adults, said:

"The 2024 SC-WRES report highlights both progress and pressing challenges across the adult social care workforce. Encouragingly, the report shows that adult social care is one of the most ethnically diverse sectors in public service. In 2023/24, the adult social care workforce was more diverse than the general population of England. **Notably, 18% of adult social care staff identified as Black, African, Caribbean or Black British – compared to just 4% of the national population.** We've also seen the largest increase in workforce diversity since records began, partially driven by international recruitment.

But whilst representation is improving, the data reveals that equity is yet to be achieved and representation alone does not equate to equity. Disparities remain stark across roles. While care workers and registered nurses reflect the highest levels of diversity, senior management roles remain disproportionately white. **Staff from Black, Asian and minority ethnic backgrounds are half as likely to hold senior positions or be appointed from shortlist compared to their white counterparts in adult social care**. We must ask ourselves why – despite a diverse workforce overall – minority ethnic staff remain underrepresented in positions of influence and leadership.

It is essential that we create environments where our workforce feels valued, respected, and supported to thrive. **Yet, staff from Black, Asian and minority ethnic backgrounds are 19% more likely to enter formal disciplinary processes and 8% more likely to be subject to fitness to practise procedures compared to their white colleagues across adult social care.** These disparities point to underlying systemic inequalities that can undermine confidence, wellbeing and progression. Addressing this is not just about improving workforce dynamics – it's about better outcomes for the communities we serve, and an inclusive workforce is key to building trust with diverse communities.

The SC-WRES continues to be a vital programme in helping us understand where these inequities exist and where focused attention is needed, and we will remain committed to working with Skills for Care to turn these insights in to action. The support that the programme offers to local authorities provides us with an opportunity to work towards meaningful change."

Jess McGregor ADASS President, Executive Director, Adults and Health, said:

For far too long we have suspected that systemic oppression and racial injustice are impacting our Adult Social Care workforce. The Social Care WRES provides us with evidence that allows us to understand how and where this is showing up and enables us to take action to tackle it. Knowing that Black, Asian and minority ethnic colleagues are more likely to go through disciplinary processes and fitness to practise procedures than their white counterparts is an important step. But it is only a first step. It is now incumbent on us all to change that.

Care Quality Commission, said:

“The CQC are supportive of the Workforce Race Equality Standard as a tool to depict the reality of race equity. We undertake the WRES ourselves as an organisation. The Social Care Workforce Race Equality Standard (SC-WRES), while still at an early stage, illustrates that by using the 9 indicators we can clearly see there are many areas where improvement needs to happen. We know that some local authorities are using their SC-WRES action plans to inform their CQC assessment process and we hope this mechanism will continue to grow in the years ahead.”

Richard Christian, Workforce Lead at Dorset Council, said:

“We are really pleased at Dorset Council to be participating in, and benefitting from, the SC-WRES for a second year. In addition to helping us to identify areas for improvement it has also enabled us to celebrate some things that we were already doing well and can build upon. As one of the biggest employers within what is a rural county with less ethnic diversity within our population than some other council areas, it is important that we show leadership and challenge ourselves to engage in a continuous cycle of improvement.”

Nyoka Fothergill, Head of Service Delivery (Community Social Work) at Leeds City Council, said:

"I’m really proud to be in this space to be able to help shape that, not just for my own personal self, but for all the other staff and all the other social workers that will join our organisation and look up and think that they can get there too."

Read the full case study here: SC-WRES case study - Leeds City Council

Jonathan White, Diversity and Inclusion Manager at Hertfordshire County Council, said:

“Hertfordshire’s engagement with SC-WRES has continued to strengthen partnerships between colleagues in Adult Care and Children’s Services who are committed to learning from each other’s experiences to improve the experience of global majority colleagues in and beyond social care. SC-WRES has enabled us to be smarter at using our data to drill down to what the real issues are and to determine where best to focus our attentions. It has also supported us to have difficult yet needed dialogue with colleagues at all levels of the organisation, and bring to light some of the real feelings and experiences which has helped to shape our action plan. In a broader sense, our work has led to conversations across the council modelling best practice in anti-racist and anti-discriminatory practice and working towards a ‘one council’ approach to key priorities.”

Stuart Lennie, Adult Social Care Practice Lead at Stockton-on-Tees Borough Council, a new council to the SC-WRES programme for 2024/2025 Phase 2, said:

"Participating in SC–WRES has been an illuminating experience for us, helping us to better understand race equality within Stockton-on-Tees Borough Council. In our organisation, it has been a positive example of interdepartmental collaboration between Adult Social Care, Children's Services and Human Resources (HR.) From the outset, we worked together in jointly making the decision to register which ensured a shared a commitment. We worked collaboratively to plan our data submission, which meant we were all clear from the outset in terms of what was required of us and ensured we were successfully able to submit data on time. Our interdepartmental working group has continued to work together in developing our SC–WRES action plan which there is a shared dedication and commitment to. In our view, collaboration between departments has made the process easier, more efficient and more effective in achieving outcomes."

Diversity within adult social care

2 Diversity within adult social care

The strength of social care is in celebrating, valuing, and recognising what makes people unique and supporting them to live the life they choose. To do this, it is vital that the social care workforce reflects the society we live in, and that people feel included and treated equally.

Supporting culture and diversity is a key focus for us, as one of Skills for Care's strategic priority areas is to ensure the workforce is treated equally, feels included and valued, and is supported to stay well and pursue their careers in social care. Skills for Care is committed to using our data and insight to identify and tackle areas and issues where there is more work to do, to ensure that diversity is valued and that organisational cultures are positive.

Skills for Care provides intelligence and robust data to help empower the sector to make plans for change based on hard facts. The Adult Social Care Workforce Data Set (ASC-WDS) is an online data collection service and the leading source of workforce information for the **adult** social care sector in England. It holds information on over 21,000 care providing locations and 700,000 workers. The information in this chapter is based on information collected in the ASC-WDS.

It should be noted that there is no directly equivalent data collection for the children's social care sector. Therefore, the detailed information available in this chapter is not available for the children's workforce. However, please see chart 3 at the end of this chapter for an analysis of the ethnicity of social workers working in the children's sector.

2.1.1 Key findings

- The adult social care workforce employed by local authority and independent sector employers had more ethnic diversity than the population of England.
- The diversity of the adult social care sector varied by region, with the most diversity within the London region and the least within the Northern regions.
- The diversity of adult social care varied by job role, with registered nurses and care workers having the most diversity, while senior management and personal assistants had the least.
- The diversity of adults social care has been increasing over the last four years. 2023/24 saw the largest increase in diversity since records began. Which is, in part, due to international recruitment.
- Within adult social care employers, there were differences in diversity, with local authorities having a less diverse workforce than the independent sector. Local authorities had slightly more diversity than the population of England.

2.1.2 The state of the adult social care sector and workforce report

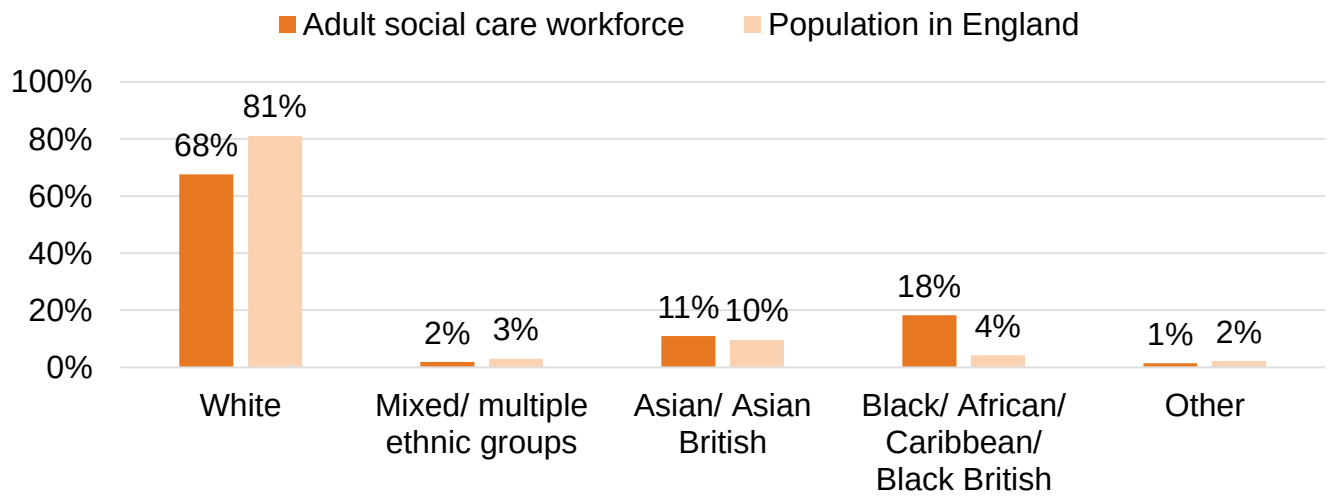
Skills for Care researches and compiles the annual 'State of the adult social care sector and workforce report'. It is based on data collected in Skills for Care's Adult Social Care Workforce Data Set (ASC-WDS), which provides a comprehensive analysis of the adult social care workforce in England and the characteristics of the 1.84 million total posts (1.59 million people or 1.705 million filled posts) working in it in 2023/24. Topics covered include recent trends in workforce supply and demand, employment overview, recruitment and retention, demographics, pay, qualification rates, and future workforce projections.

This information is taken from the State of the adult social care sector and workforce report and provides information about the ethnicity of people working in the adult social care sector. It provides context for chapter three.

2.1.3 Ethnicity

The adult social care sector was more diverse in 2023/24 than the population of England as shown in the chart below. In particular, there was a much higher proportion of people with a Black, African, Caribbean or Black British ethnicity within adult social care (18%) compared to the wider population (4%). The proportion of adult social care workers with a white ethnicity was 68% compared to 81% of the population in England.

Chart 1. Proportion of the adult social care workforce and population in England by ethnicity, 2023/24
Source: Skills for Care estimates, Census 2021



The ethnic profile of the adult social care sector in England varied by region in the local authority and independent sectors. This variation is partly influenced by the local population, which forms the recruitment pool for all employers in the area.

Table 1. Proportion of the adult social care workforce by ethnicity and region (local authority and independent sectors only), 2023/24

Source: Skills for Care estimates

	White	Mixed/ multiple ethnic groups	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Other
England	**66%**	**2%**	**11%**	**19%**	**1%**
Eastern	69%	2%	10%	18%	1%
East Midlands	69%	2%	11%	18%	1%
London	25%	3%	21%	49%	3%
North East	88%	1%	3%	8%	1%
North West	79%	2%	8%	10%	1%
South East	66%	2%	13%	17%	2%
South West	80%	1%	8%	10%	1%
West Midlands	62%	2%	13%	21%	1%
Yorkshire and the Humber	78%	2%	8%	12%	1%

In 2023/24 the ethnic profile of the adult social care workforce also varied across different job roles.

Table 2. Proportion of the adult social care workforce by ethnicity and selected job roles, 2023/24

Source: Skills for Care estimates

	White	Mixed/ multiple ethnic groups	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Other
All job roles	**68%**	**2%**	**11%**	**18%**	**1%**
Senior management	81%	2%	7%	10%	0%
Registered manager	78%	1%	7%	13%	1%
Social worker	70%	3%	7%	19%	1%
Occupational therapist	80%	2%	5%	12%	1%
Registered nurse	52%	2%	22%	22%	2%
Senior care worker	68%	1%	15%	14%	1%
Care worker	60%	2%	13%	24%	1%
Support and outreach	69%	2%	6%	21%	1%
Personal assistant	84%	2%	7%	6%	2%

The ethnic profile of the adult social care workforce in the local authority and independent sector has remained relatively stable between 2017/18 and 2021/22, as shown in the table below. Since 2022/23 the diversity of the adult social care workforce has increased.

Table 3. Proportion of the adult social care workforce by ethnicity (local authority and independent sectors only), 2017/18 to 2023/24

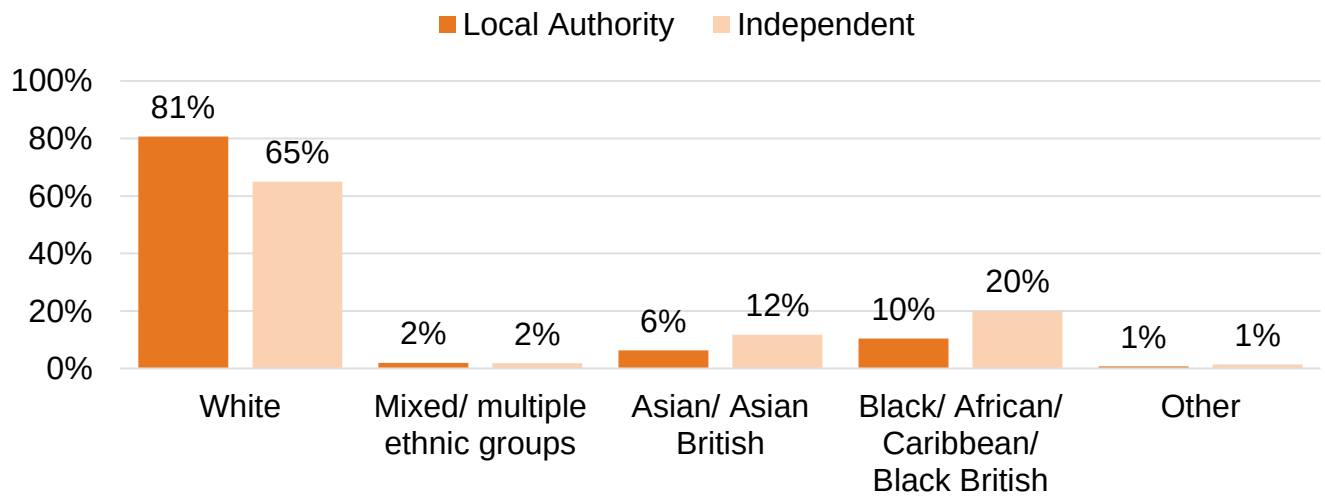
Source: Skills for Care estimates

	White	Mixed/ multiple ethnic groups	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Other
2017/18	79%	2%	7%	11%	1%
2018/19	79%	2%	7%	11%	1%
2019/20	79%	2%	7%	12%	0%
2020/21	78%	2%	7%	12%	1%
2021/22	77%	2%	7%	13%	1%
2022/23	73%	2%	9%	14%	1%
2023/24	66%	2%	11%	19%	1%

The table below shows the proportion of the adult social care workforce by ethnicity with then local authority compared to the independent sectors. The chart shows that the workforce employed by local authorities is less diverse than the independent sector, with 81% of the local authority workforce having a white ethnicity. The SC-WRES collects information from local authority employers only.

Chart 2. Proportion of the adult social care workforce employed by local authority and independent sector employers, by ethnicity, 2023/24

Source: Skills for Care estimates



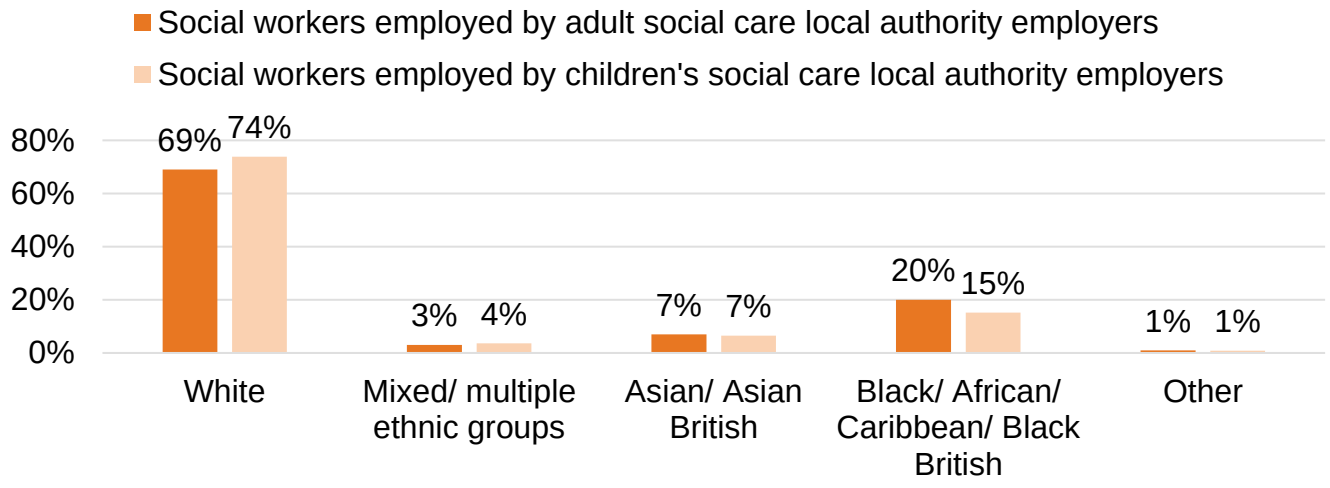
The State of the adult social care sector and workforce report has information about other protected characteristics including age, gender, disability and nationality. There is also information about international recruitment. This information is available in our written report or our data visualisation, both on our workforce intelligence website.

The Department for Education collects information about social workers working in the children's local authority sector, the chart below shows the headcount percentage by ethnicity group, for children and family social workers in post at 30 September 2024 with known ethnicity.

The chart also shows the ethnicity of social workers employed by adult social care local authority employers.

Chart 3. Ethnicity of social workers employed by adult social care and children's social care local authority employers

Source: Skills for Care estimates 2023/24 and Children's Social Care - Outcomes and Enablers



Chief Social Worker for Children and Families, Isabelle Trowler, said:

"The findings from the this SC-WRES report are really quite shocking. In children's social care, significant disparities remain evident. Staff from Black, Asian, or minority ethnic backgrounds were found to be half as likely to be appointed from a shortlist as their white counterparts. They were also 67% more likely to enter formal disciplinary processes and 114% more likely to enter fitness to practise procedures than their white colleagues. Furthermore, only 12% of senior management positions in children's social care were held by minority ethnic staff, despite these groups representing 19% of the overall workforce. Employees from a minority ethnic background in children's social care were also 39% less likely to hold senior management roles than their white colleagues. Finally, staff from minority ethnic backgrounds in children's social care were 21% more likely to leave their roles within the last 12 months compared to white staff.

Looking more widely across the children's and families social care sector (Children's social work workforce, Reporting year 2023 - Explore education statistics - GOV.UK), the diversity of the workforce has been steadily increasing. Particularly among Black social workers we can see a changing workforce profile. Around a quarter of children and family social workers now come from minority ethnic backgrounds, a notable rise since 2017. While this is higher than in some other public sector professions, such as teaching, it still does not reflect the diversity of the children and families being supported—where the proportion of children in need from ethnic minority backgrounds is significantly higher.

This SC-WRES report raises significant questions about race equity in the children's workforce, particularly around potential barriers to progression and contribution at senior levels. It is vital that we take these findings seriously and work collectively to ensure that opportunity,

recognition, and career progression are truly equitable for all those working in children's social care. We will continue to meet with Skills for Care to ensure progress is made to dovetail the work of SC-WRES in local authorities with the work that we are doing in the Department for Education with the sector, and the development of the Children's Social Care Dashboard which we published for the first time in 2021, alongside the new statutory Children's Social Care National Framework."

Dudley Sawyerr, chair of the Race Equity Reference Group, said:

"Leading with purpose: sustaining momentum for race equity with the SC-WRES

The Race Equity Reference Group (RERG) remains committed to supporting Skills for Care in their EDI work, and with the SC-WRES Improvement Programme, to ensure race equity is not just an aspiration but a lived reality for the social care workforce. The SC-WRES continues to serve as a critical tool for measuring and addressing racial inequities within social care. We know that data alone does not drive change – leadership and culture is hugely important. Now in its third year, it is great to see SC-WRES growing, from the 18 trailblazing local authorities who tested the indicators in 2021, to 23 local authorities in 2023-24 and the now 76 local authorities voluntarily participating in 2024-25.

The social care workforce is becoming more ethnically diverse with higher proportions of Black, Asian and minoritised ethnic workers in social care, yet the evidence from this report indicate that structural barriers remain firmly in place, particularly when it comes to representation across leadership roles. We know that diversity in numbers alone is not enough – equity in experience, progression and decision-making is essential. It is important to raise awareness on EDI throughout the sector and while we support the work by various authorities, employee networks, people boards, and local government councillors, EDI should be a standard for all care providers, managers, and workforce networks. Importantly, we mustn't forget about, and must recognise, the impact on the frontline workforce.

SC-WRES offers a pathway forward. It is a reporting mechanism and a call to action and while its impact is growing, its success depends on engagement and practice. The challenge now is not just in recognising inequities, but in actively dismantling them. Race equity must be an ongoing priority, and the RERG remain committed to support Skills for Care in their EDI work, and with the SC-WRES Improvement Programme, to ensure race equity is not just an aspiration but a lived reality for the social care workforce.

The RERG has been established to support Skills for Care's commitment on championing equity, equality, and diversity and supports Skills for Care to develop a positive and practical narrative on race equality. The RERG is made up of representatives from across the sector and includes people who work in and across social care and people with lived experience. The importance of the RERG has grown with the continuous increase of both home grown and international staff from underrepresented communities."

SC-WRES indicator analysis and results

3 SC-WRES indicator analysis and results

3.1 Introduction

This chapter is an overview of the data collected during the 2024 SC-WRES programme. It shows the total of all 73 local authority employers who responded. Data is split into adult and children's social care and also by ethnicity group. The report shows the results of each of the indicators as either percentages or relative likelihoods.

For a methodology of the 2024 SC-WRES data collection please see appendix 1. This appendix includes information about small numbers and data sharing, the data collection process, what relative likelihoods are and how to interpret them, data quality and how this data was checked.

3.2 Response rates and data representation

76
local authorities in the SC-WRES programme.

73
local authorities provided data to the SC-WRES.

43%
of the **adult** local authority workforce was represented in the SC-WRES.

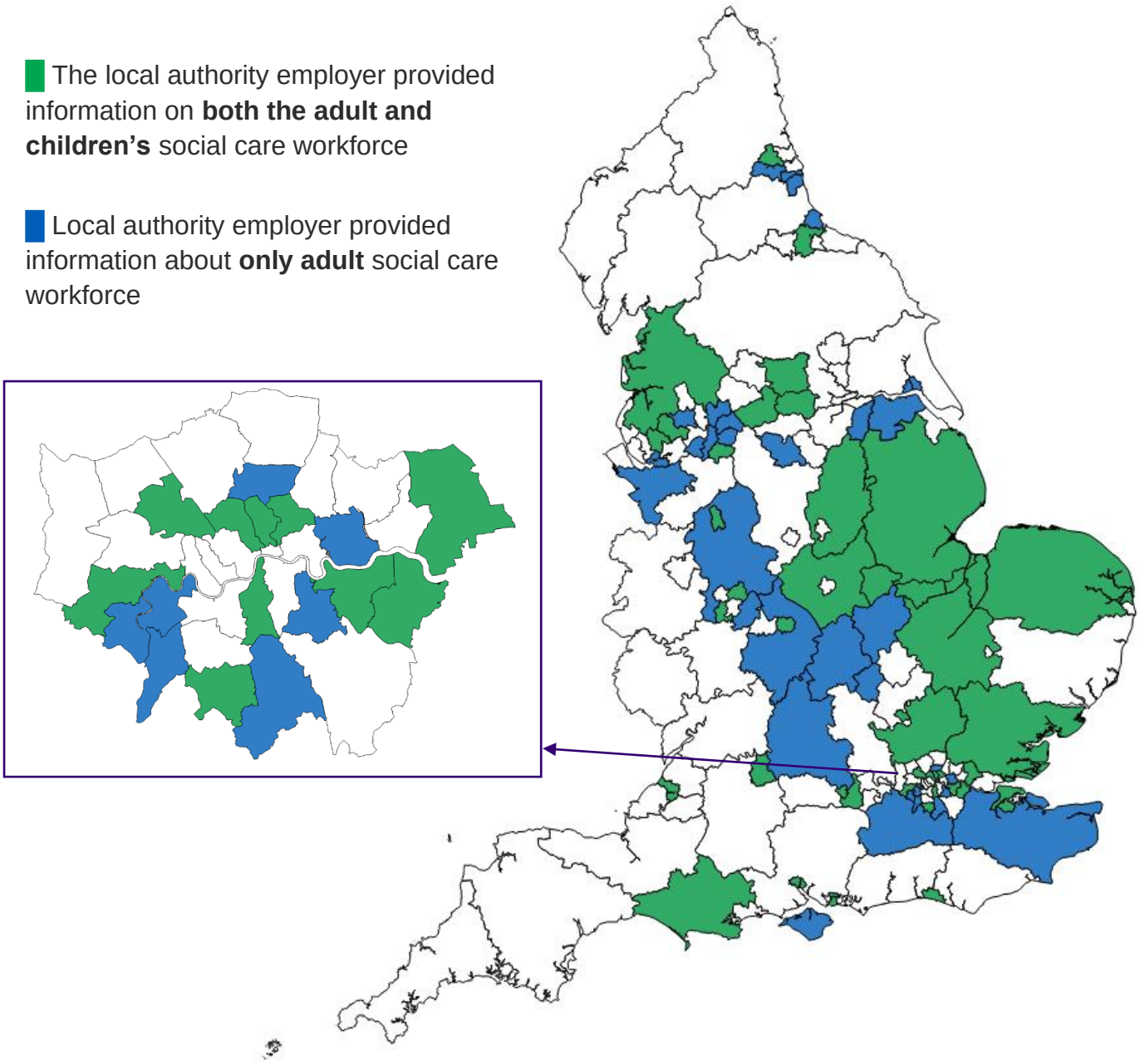
In 2024, 76 local authority employers were included in the SC-WRES programme, of which 73 local authority employers were included in the analysis for this report. Three local authorities were unable to provide a data return by the date required to be included in this analysis. These three local authorities have since provided their data and have continued with the SC-WRES programme.

All 73 local authority employers provided data about their adult social care workforce and 43 (of the 73) also provided data about the children's social care workforce. The table below shows the number of local authorities who provided data by region.

Table 4. Number of local authorities who responded, by region
Base. 73 adult social care local authorities and 43 children's social care local authorities
Source. SC-WRES, 2024

	Adult social care	Children's social care
Eastern	7	7
East Midlands	6	4
London	16	10
North East	5	2
North West	12	4
South East	11	6
South West	3	3
West Midlands	7	4
Yorkshire and the Humber	6	3

Map 4. Responding local authority employers
Base. 73 adult social care local authorities and 43 children's social care local authorities
Source. SC-WRES, 2024



The responding local authorities employed 97,900 staff between them, this was 58,600 in adult social care and 39,300 staff working in children's social care.

Just under half (43%) of the adult social care workforce employed by local authorities were represented in the SC-WRES in 2024. The table below shows the number of staff employed in adult social care compared to those in the SC-WRES by region.

Chart 4. Percent coverage of the adult social care workforce employed by local authorities that submitted data to the SC-WRES programme

SC-WRES Base. 73 adult social care local authorities, 43 children's social care local authorities
Source. SC-WRES, 2024 and ASC-WDS, 2024

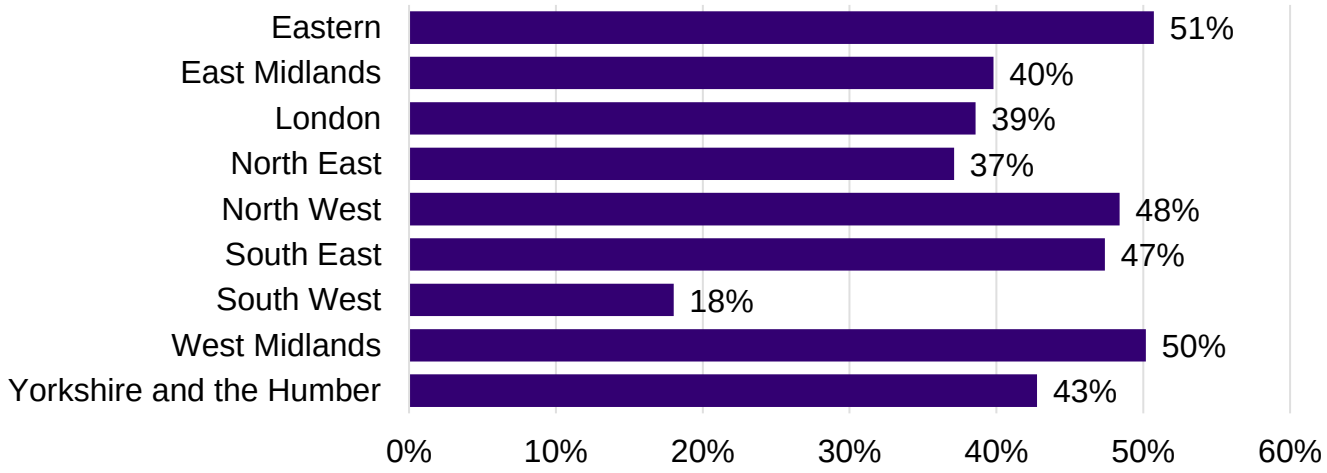
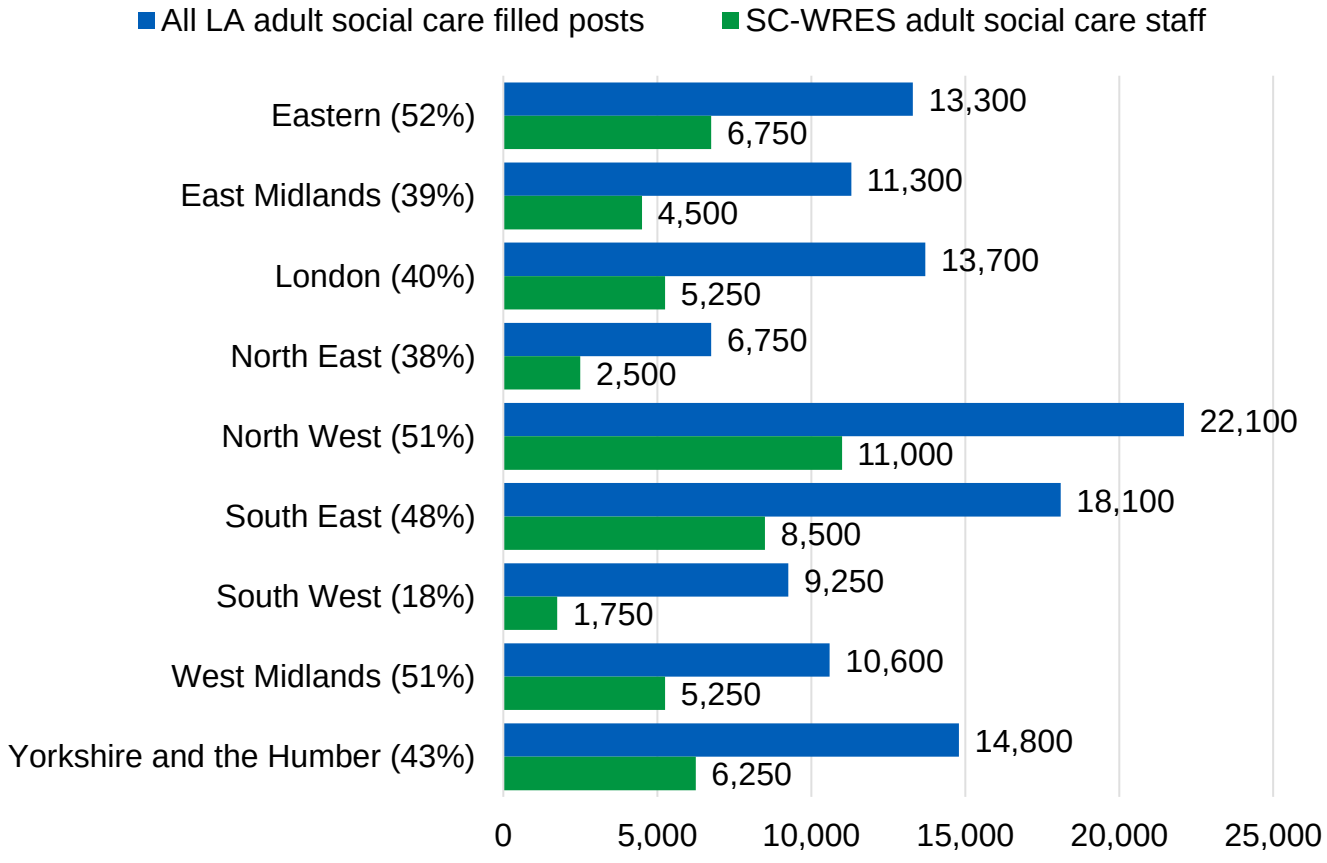


Chart 5. Numeric coverage of the adult social care workforce employed by local authorities that submitted data to the SC-WRES programme

SC-WRES Base. 73 adult social care local authorities, 43 children's social care local authorities
Source. SC-WRES, 2024 and ASC-WDS, 2024



The following chart shows the proportion of local authorities who responded to each indicator. A detailed response rate by adult and children's social care services is shown within each indicator section.

Table 5. Response rate by indicator after local authorities were removed due to incomplete or poor data quality
SC-WRES Base. 73 adult social care local authorities, 43 children's social care local authorities
Source. SC-WRES, 2024

	Adult social care		Children's social care	
Total LAs	**73**		**43**	
Staff overview	73	100%	43	100%
Indicator 1	69	95%	39	91%
Indicator 2	43	59%	28	65%
Indicator 3	64	88%	40	93%
Indicator 4	27	37%	17	40%
Indicator 5	41	56%	23	53%
Indicator 6	14	19%	7	16%
Indicator 7	10	14%	7	16%
Indicator 8	72	99%	43	100%
Indicator 9	71	97%	41	95%

3.3 SC-WRES Indicator 1: Pay bands

LA Adult employers

- **69** (95%) of LAs responded
- Information about **49,100** workers.

LA Children's employers

- **39** (91%) of LAs responded.
- Information about **31,900** workers.

Lots of factors could be affecting pay rates for someone working in social care, and their ethnicity is only one of them.

Of staff at employers responding to the SC-WRES, there was a smaller proportion of staff from a Black, Asian or minority ethnic background (14%) in the higher pay band of '£70,000 and over' compared to the 'less than £30,000' lower and '£30,000 to £69,000' middle pay bands (18% and 22% respectively). Therefore, staff from a Black, Asian or minority ethnic background were less represented in the highest pay band.

3.3.1 Response rate

Data availability for this indicator was high, with 95% (69 of 73) of adult local authority employers and 91% (39 of 43) of children's social care employers providing pay bands by ethnicity information.

There was a total of 11,300 staff whose ethnicity was not known to the local authority employer. These employees have been excluded from the analysis below.

There is pay band information, where ethnicity is known, for a total of 81,000 staff - 49,100 adult social care staff and 31,900 children's social care staff.

3.3.2 A note about causality

This indicator looks at pay bands by ethnicity. It should be noted that there are lots of factors that could be affecting pay rates for someone working in social care, and their ethnicity is only one of those factors. These factors are not collected within the SC-WRES. The following list gives examples of other factors:

- **Job role:** This indicator is not collected by job role, which would be the main factor in variations of pay rates. Average pay difference between ethnicities is more likely a reflection of the number of people in different job roles; for example, we know from indicator 9 that people with a white ethnicity were more likely to be in senior management roles which are typically higher paid. The issue here would not be unequal pay but unequal progression opportunities for people with Black, Asian or minority ethnic backgrounds.
- **Geographic location:** Areas with a higher cost of living tend to offer higher wages to account for the increased living expenses. Skills for Care estimates of adult social care pay rates show a north/south divide in pay rates.
- **Experience, qualifications and training:** An individual's level of experience, qualifications, and professional development can influence pay.
- **Demand for workers:** Pay rates can be influenced by the demand for workers. For example, for job roles or services where vacancy rates are high, employers may offer higher pay to attract people.
- **Level of responsibility:** Pay rates can be influenced by the level of responsibility associated with the role.
- **Sector-specific factors:** Certain types of care, such as working with people with higher levels of complex needs, may attract higher pay due to the specialised skills and emotional demands of the work.

It is important to consider these factors alongside the ethnicity of the worker when interpreting the results for this indicator.

3.3.3 Analysis by pay band

This indicator shows the ethnicity breakdown across 12 pay bands. For the purpose of this analysis these bands have been grouped into three. The chart below shows, within each pay band, the proportion of staff with a white ethnic background and the proportion of staff with a Black, Asian or minority ethnic background.

There was a smaller proportion of staff from a Black, Asian or minority ethnic background (14%) in the higher pay band of '£70,000 and over' compared to the 'less than £30,000' lower and '£30,000 to £69,000' middle pay bands (18% and 22% respectively). Therefore, staff from a Black, Asian or minority ethnic background were less represented in the highest pay band.

Chart 6. Responding staff in each pay band, summary of two ethnicity groups
Base. 69 adult social care local authorities and 39 children's social care local authorities
Source. SC-WRES, 2024

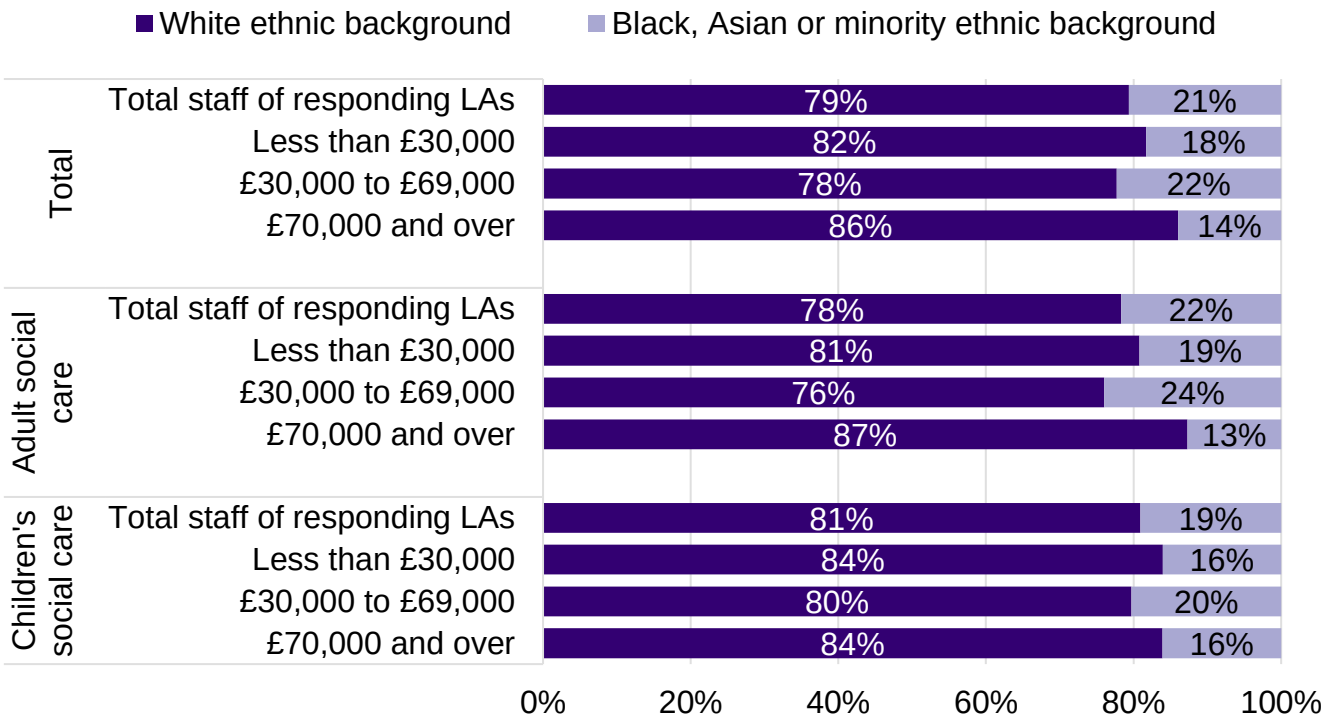


Table 6. Responding staff in each pay band, detailed ethnicity groups
Base. 69 adult social care local authorities and 39 children's social care local authorities
Source. SC-WRES, 2023

	Total staff of responding LAs	Less than £30,000	£30,000 to £69,000	£70,000 and over
Total of workforce				
White	79%	82%	78%	86%
Mixed/ multiple ethnic groups	3%	2%	3%	3%
Asian/ Asian British	6%	6%	6%	5%
Black/ African/ Caribbean/ Black British	11%	9%	12%	6%
Other ethnic group	1%	1%	1%	1%
Adult social care				
White	78%	81%	76%	87%
Mixed/ multiple ethnic groups	3%	2%	3%	2%
Asian/ Asian British	6%	6%	6%	4%
Black/ African/ Caribbean/ Black British	12%	10%	14%	6%
Other ethnic group	1%	1%	1%	0%
Children's social care				
White	81%	84%	80%	84%
Mixed/ multiple ethnic groups	4%	3%	4%	3%
Asian/ Asian British	6%	6%	5%	6%
Black/ African/ Caribbean/ Black British	9%	6%	10%	6%
Other ethnic group	1%	1%	1%	1%

3.3.4 Examples from phase 1 local authority action plans

The SC-WRES improvement programme requires employers to create action plans. They are a vital output of the SC-WRES programme and show how local authorities have translated their data report into improvement. Throughout this chapter there are notes from action plans that were submitted as part of the phase 1 2023 SC-WRES programme. They are included here to give an example of planned actions by employers. For more information about action plans please see section 4.3.

Coventry City Council aims to create a more inclusive workplace for people from a Black, Asian or minority ethnic background with:

- **Inclusive recruitment and selection policy**: This policy outlines a fair, objective, and transparent recruitment process that promotes inclusive practices.
- **Inclusive panels pool**: A pool of trained employees from diverse backgrounds is used to support recruitment and selection processes, particularly for higher-grade positions.
- **Recruiting for workforce diversity training**: This training equips recruiting managers with the knowledge and skills to minimise bias and promote diversity in recruitment and selection.

3.4 SC-WRES Indicator 2: Appointed from shortlist

LA Adult employers

- **43** (59%) of LAs responded.
- Applicants shortlisted **29,600**.
- Staff appointed **7,300**.

LA Children's employers

- **28** (65%) of LAs responded.
- Applicants shortlisted **19,400**.
- Staff appointed **4,350**.

Results from employers responding to the SC-WRES showed that staff with a Black, Asian or minority ethnic background were around half as likely to be appointed from shortlist than staff with a white ethnic background.

3.4.1 Response rates

Analysis of this indicator is based on 59% (43 of 73) of adult social care local authority employers and 65% (28 of 43) of children's social care local authority employers. Some local authorities did not have any data available for this indicator, and some were excluded based on data quality or deviations from the definition of the indicator.

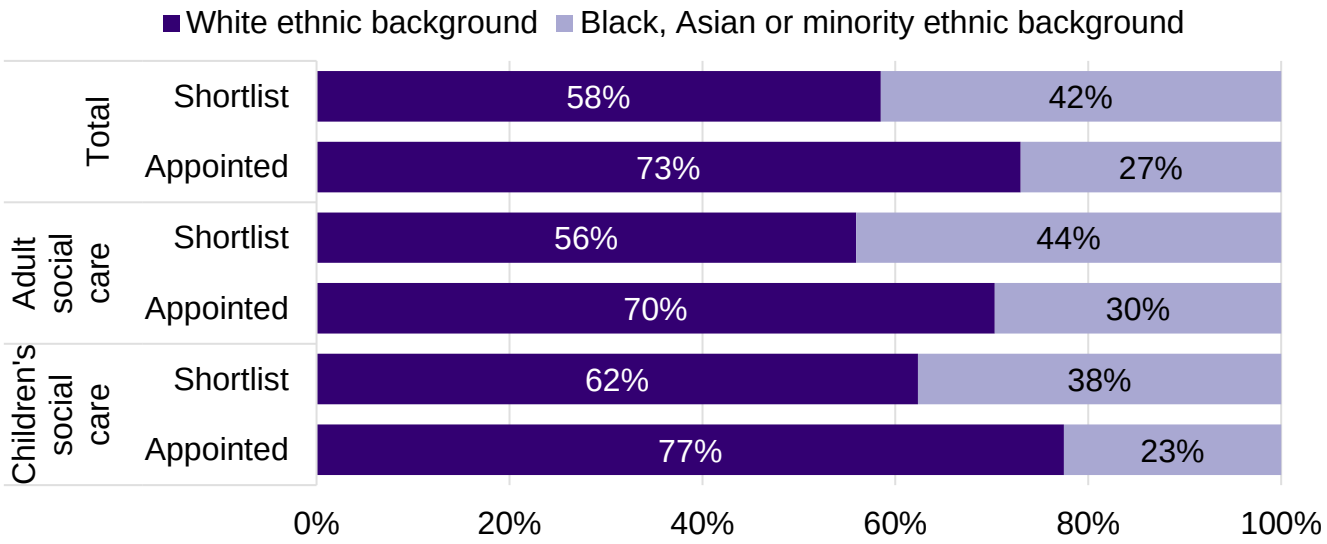
Analysis is based on the 49,000 staff whose ethnicity was known and were shortlisted, comprised of 29,500 shortlisted for adult social care roles and 19,500 shortlisted for children's social care roles. Analysis is also based on the 11,500 staff appointed, comprised of 7,500 people appointed to adult social care roles and 4,500 people appointed to children's social care roles.

3.4.2 Proportion of applicants shortlisted and appointed by ethnicity

The chart below shows that 58% of all applicants were from a white ethnic background and 42% were from a Black, Asian or minority ethnic background. Of those appointed, 73% were from a white ethnic background and 27% were from a Black, Asian or minority ethnic background.

Chart 7. Proportion of applicants shortlisted and appointed, summary of two ethnicity groups

Base. 43 adult social care local authorities and 28 children's social care local authorities
Source. SC-WRES, 2024



The table below gives more information between ethnicity groups. It shows that 26% of applicants shortlisted and 16% of staff appointed were from a Black, African, Caribbean or Black British ethnicity background. The table also shows that 9% of applicants shortlisted and 6% of staff appointed were from an Asian or Asian British ethnicity background.

Table 7. Proportion of applicants shortlisted and appointed, detailed ethnicity groups

Base. 43 adult social care local authorities and 28 children's social care local authorities
Source. SC-WRES, 2024

		Total	Adult social care	Children's social care
White	Shortlist	58%	56%	62%
	Appointed	73%	70%	77%
Mixed/ multiple ethnic groups	Shortlist	5%	5%	6%
	Appointed	5%	5%	5%
Asian/ Asian British	Shortlist	9%	9%	9%
	Appointed	6%	6%	5%
Black/ African/ Caribbean/ Black British	Shortlist	26%	28%	22%
	Appointed	16%	18%	12%
Other ethnic group	Shortlist	1%	2%	1%
	Appointed	1%	1%	1%

3.4.3 Proportion of staff appointed from shortlist

The table below shows the proportion of staff who were appointed by ethnicity. It shows that overall, 30% of staff from a white ethnic background who were shortlisted for a role were appointed compared to 15% of both Asian or Asian British and Black, African, Caribbean or Black British.

Table 8. Proportion of staff appointed <u>from</u> shortlist, detailed ethnicity groups
Base. 43 adult social care local authorities and 28 children's social care local authorities
Source. SC-WRES, 2024

	Total	Adult social care	Children's social care
Total known	**24%**	**25%**	**22%**
White ethnicity	30%	31%	28%
Staff with a Black, Asian or minority ethnicity	15%	17%	13%
Mixed/ multiple ethnic groups	21%	23%	18%
Asian/ Asian British	15%	16%	12%
Black/ African/ Caribbean/ Black British	15%	16%	12%
Other ethnic group	16%	14%	20%

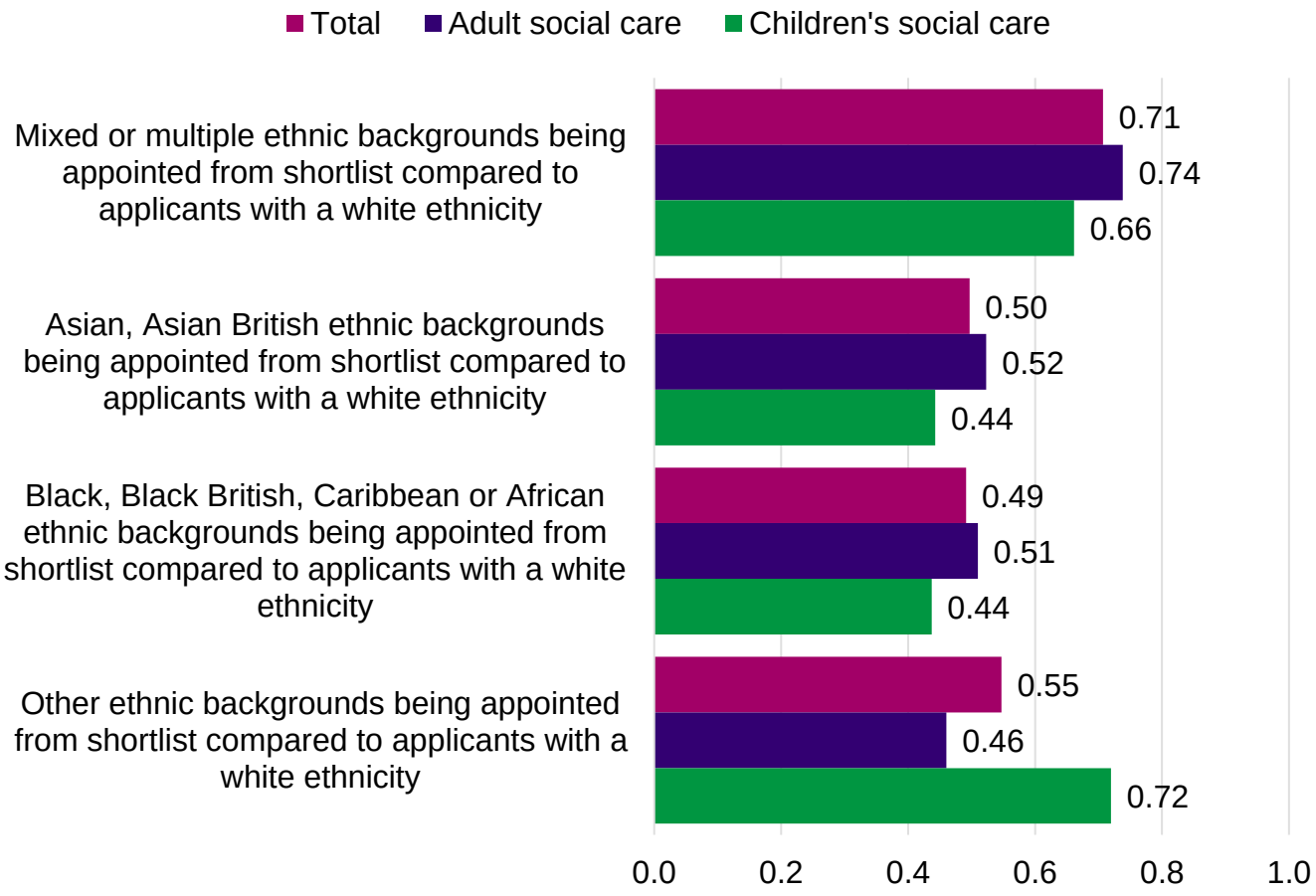
3.4.4 Relative likelihood[2]

Of responding employers, applicants from a Black, Asian or minority ethnic background were half as likely to be appointed from shortlist, across all employers, compared to applicants with a white ethnicity (a relative likelihood of 0.52). The likelihood was around the same for adult social care (0.54) and children's social care employers (0.48).

The table below shows the likelihood of people from different ethnic groups being appointed from shortlist, compared to staff from a white ethnic background, looking in more detail at the different experiences of people from different minority ethnic backgrounds.

[2] For an explanation of what relative likelihoods are and a detailed explanation on how to interpret them please see section 5.3 in appendix 1.

Chart 8. Relative likelihood of staff being appointed from shortlist compared with staff with a white ethnic background, detailed ethnicity groups
Base. 43 adult social care local authorities and 28 children's social care local authorities
Source. SC-WRES, 2024



The chart above show how the likelihood of being appointed from shortlist for people from different ethnic backgrounds compared to staff from a white ethnic background. We also looked at how this differs between people from different ethnic backgrounds. Staff from an Asian or Asian British ethnic background were equally as likely to be appointed from shortlist as applicants from a Black, African, Caribbean or Black British ethnic background.

3.4.5 Examples from phase 1 local authority action plans

Leeds City Council aims to create a more inclusive workplace for people from a Black, Asian or minority ethnic background with:

- **Be your best programme:** supports managers to embody council values such as bringing out the best in everyone, promoting opportunity and development for all and treating people fairly.
- **Manager training:** managers are equipped with a toolkit and held accountable for EDI performance.
- **Performance indicators:** the council's performance indicators, including a representative and engaged workforce, emphasise the crucial role of managers in achieving these goals.

3.5 SC-WRES Indicator 3: Disciplinary process

LA Adult employers

- **64** (88%) of LAs responded.
- **450** staff entered the formal disciplinary process (1% of all employed).

LA Children's employers

- **40** (93%) of LAs responded.
- **325** staff entered the formal disciplinary process (1% of all employed).

At responding local authorities, staff with a Black, Asian or minority ethnic background were 37% more likely to enter the formal disciplinary process, compared to staff with a white ethnic background (a relative likelihood of 1.37). Staff from adult social care were 19% more likely (a relative likelihood of 1.19) and staff from children's social care were 67% more likely (a relative likelihood of 1.67).

3.5.1 Response rate

Analysis of this indicator is based on 88% (64 of 73) of adult social care local authorities and 93% (40 of 43) children's social care local authorities. Some local authorities did not have data availability for this indicator.

Responses are based on 775 people across all local authority employers who entered the formal disciplinary process. This was comprised of 450 people from adult social care and 325 people from children's social care. This equates to 1.0% of the total workforce within the responding local authorities to enter the process.

3.5.2 Proportion of staff who entered the formal disciplinary process, by ethnicity

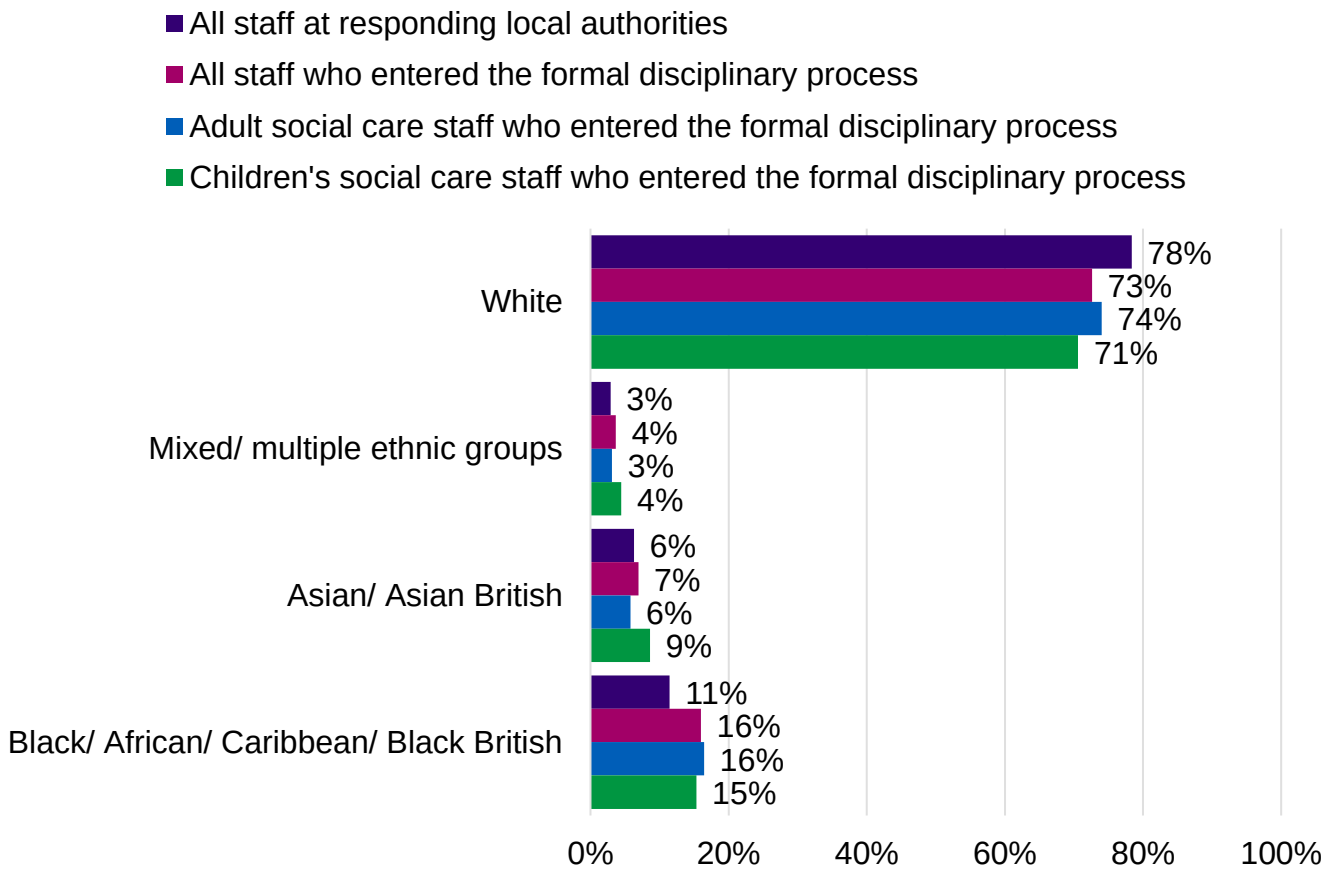
The chart below shows that 73% of staff who entered the formal disciplinary process in the last 12 months had a white ethnic background, 7% an Asian or Asian British ethnic background and 16% a Black, African, Caribbean or Black British ethnic background. All other ethnic groups are not shown due to small numbers and to protect anonymity.

The chart also shows the ethnicity profile of all responding local authorities, to add context to the information. The comparison shows that a lower proportion of staff who entered the formal disciplinary process had a white ethnic background (73%) than the profile of all workers at responding local authorities[3] (78%).

[3] Please note that this percentage is different from the one shown in chart 9. This is because chart 33 shows all responding LAs and this chart shows those that have responded to indicator 3, so a slightly smaller list of local authorities.

Chart 9. Proportion of staff who entered the formal disciplinary process, detailed ethnicity groups

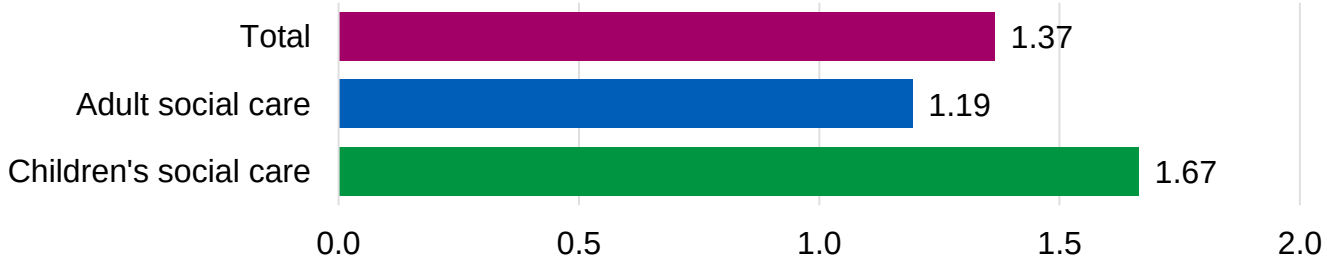
Base. 64 adult social care local authorities and 40 children's social care local authorities
Source. SC-WRES, 2024



Results from employers responding to the SC-WRES showed that staff with a Black, Asian or minority ethnic background were, relatively 37% **more** likely to enter the formal disciplinary process, compared to staff from a white ethnic background (1.37 likelihood). Staff from adult social care were 19% more likely (1.19 likelihood) and staff from children's social care were 67% more likely (1.67 likelihood).

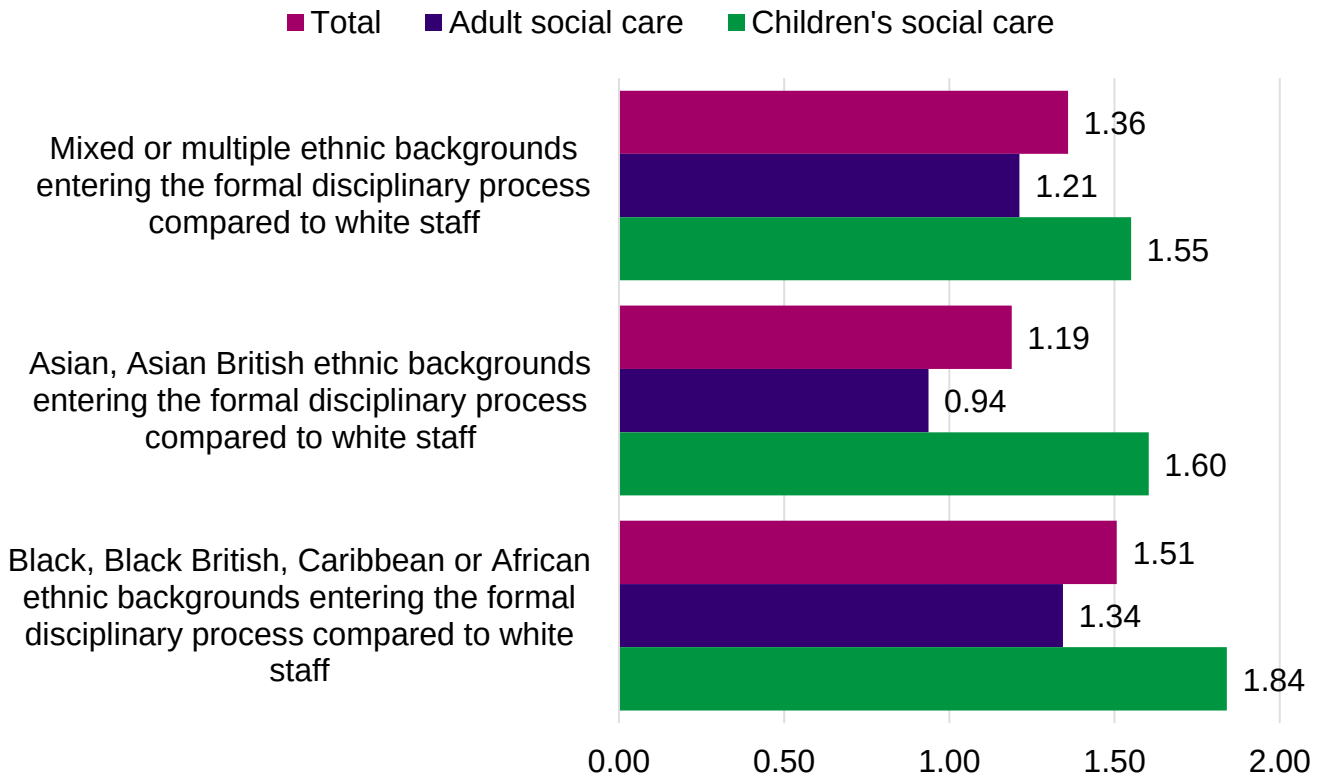
Chart 10. Relative likelihood of directly employed staff from a Black, Asian or minority ethnic background entering the formal disciplinary process compared to staff from a white background

Base. 64 adult social care local authorities and 40 children's social care local authorities
Source. SC-WRES, 2024



The chart below shows how experiences differ between ethnicity groups.

Chart 11. Relative likelihood of directly employed staff entering the formal disciplinary process compared to staff from a white ethnic background, detailed ethnicity groups
Base. 64 adult social care local authorities and 40 children's social care local authorities
Source. SC-WRES, 2024



Staff with Asian, Asian British ethnic backgrounds were 21% **less** likely to enter the formal disciplinary process compared to staff from Black, African, Caribbean or Black British ethnic backgrounds (a relative likelihood of 0.79). Staff from Asian or Asian British ethnic backgrounds were 30% less likely than staff from Black, African, Caribbean or Black British backgrounds in adult social care (a relative likelihood of 0.7) and 13% less likely in children's social care (a relative likelihood of 0.87).

3.5.3 Examples from phase 1 local authority action plans

Hertfordshire County Council promotes fair and unbiased disciplinary processes through:

- **Decision-making tool:** Sits alongside their disciplinary policy, to support reflection on unconscious bias and determining whether formal disciplinary action is the most appropriate course.
- **Decision tree:** Supports managers to demonstrate proportionate and unbiased decision-making when referring cases to formal disciplinary procedures.
- **Preventative approach:** Consideration will be given to preventative work, based on outcomes from deep dives, reflective practice and access to training.

3.6 SC-WRES Indicator 4: Fitness to practise

LA Adult employers

- **27** (37%) of LAs responded.
- **3,500 r**egulated profession roles.
- **<25** (0.6%) regulated professional staff who entered the fitness to practise process.

LA Children's employers

- **17** (40%) of LAs responded.
- **3,500** regulated profession roles.
- **50** (1.3%) regulated professional staff who entered the fitness to practise process.

At responding adult local authorities, staff in a regulated profession, from a Black, Asian or minority ethnic background were 8% more likely to enter the fitness to practise process compared to staff from a white ethnic background. This outcome was different in the children's social care sector, where staff in a regulated profession, from a Black, Asian or minority ethnic background were 114% more likely to enter the fitness to practise process compared to staff from a white ethnic background.

We do know that the results shown here are an accurate reflection of the responding local authorities however our conclusion is that we need to collect more data about this indicator to understand to what extent ethnicity has an effect on the likelihood of staff in a regulated profession entering the fitness to practise process. We have plans to support local authorities participating in the 2025 SC-WRES programme to better collect this information.

An important note about understanding or interpreting this information

In 2024 27 adult and 17 children's social care local authority employers provided data for this SC-WRES indicator. It was found that staff in a regulated profession, from a Black, Asian or minority ethnic background were **8%** more likely to enter the fitness to practise process compared to staff from a white ethnic background for adult employers and **118%** more likely for children's employers- a large difference in experience.

In 2023 11 adult and 9 children's social care local authority employers provided data for this SC-WRES indicator. It was found that staff in a regulated profession, from a Black, Asian or minority ethnic background were **80%** more likely to enter the fitness to practise process compared to staff from a white ethnic background for adult employers and **130%** more likely for children's employers.

These two different groups (or samples) of local authority employers show two quite different outcomes for staff with a Black, Asian or minority ethnicity and therefore this should not be interpreted as a trend.

We **do** know that the results shown here are an accurate reflection of the responding local authorities however **our conclusion is that we need to collect more data about this indicator to understand to what extent ethnicity has an effect on the likelihood of staff in a regulated profession entering the fitness to practise process. We have plans to support**

local authorities participating in the 2025 SC-WRES programme to better collect this information.

3.6.1 Response rate

Analysis is based on 37% (27 of 73) of adult social care local authorities and 40% (17 of 43) of children's social care local authorities. Data availability for this indicator was low, with around three fifths (62%) of the responding local authority employers not having the data to report.

The data shown here is based on a total of 6,950 staff in a regulated profession role where ethnicity was known, and 75 of those (1.0%) had entered the fitness to practise process in the past 12 months. This was comprised of 3,500 regulated profession staff working in adult social care, where fewer than 25 had entered the process (0.6%), and 3,500 regulated profession staff working in children's social care where 50 had entered the process (1.4%).

3.6.2 A note about low response rates

The following section explains the complications of having a small number of local authorities providing data for indicators.

Low base (or a small sample size): A low base means that we have a small number of local authorities telling us about their workforce for some indicators.

Low Response Rate: A low response rate shows that a large number of local authorities did not collect data for some indicators. For example, many did not collect data, by ethnicity, about entering the fitness to practise process and many did not run a staff survey and therefore did not ask their workforce about experience of harassment, bullying or abuse. This low level of data from responding local authorities can introduce bias because the local authorities who did respond might differ from those who didn't.

Together, both factors – small sample size and low response rate – can undermine the accuracy of detailed findings, meaning the results from responding local authorities may not be applicable to those who did not respond, so results from responding local authorities can't be applied to all 73 SC-WRES local authorities nor to the whole sector, because they may not be representative of this larger population/group of employers.

Small sample sizes and low response rates are also more susceptible to variation or skewing, meaning results could be influenced more heavily by outliers or unusual responses from responding local authorities, which limits our ability to come to meaningful conclusions and makes it harder to break down results into detailed ethnicity groups or onto adults and children's local authority employers.

We **do** know that the results shown here are an accurate reflection of the responding local authorities. And we have plans to support local authorities participating in the 2025 SC-WRES programme to better collect this information.

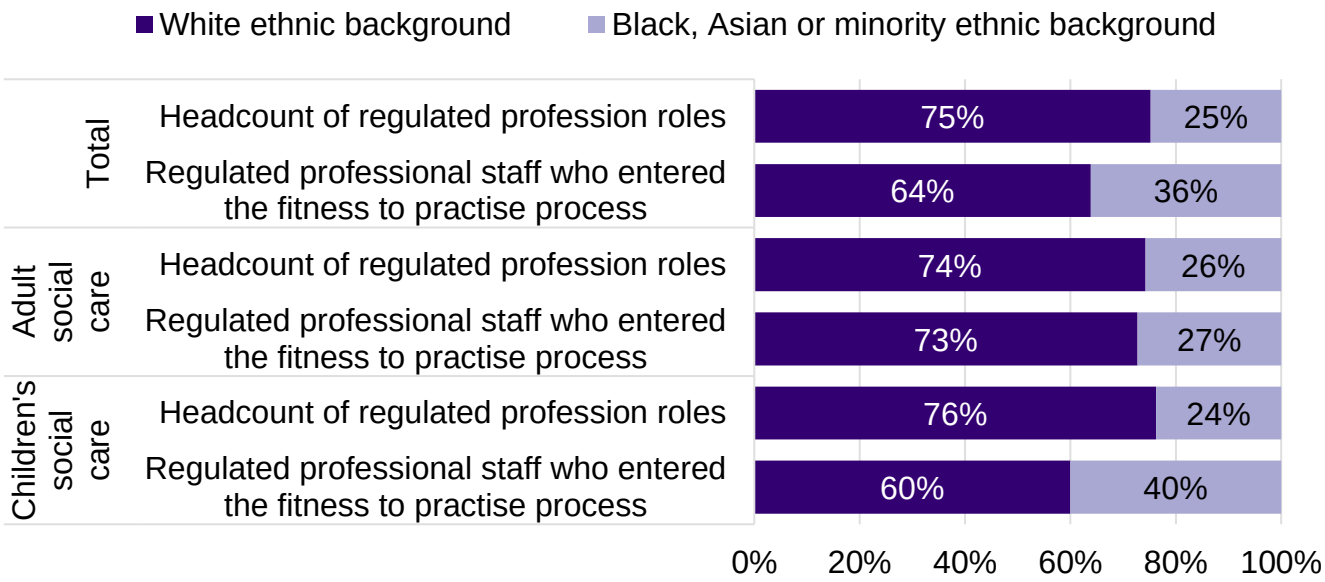
3.6.3 Regulated professionals who entered the fitness to practise process

The chart below shows that 64% of the 75 regulated profession staff who entered the fitness to practise process in the past year had a white ethnic background and 36% had a Black, Asian or minority ethnic background. Analysis is not shown by detailed ethnicity groups for this indicator due to low bases and to protect anonymity

Chart 12. Proportion of staff who entered the formal disciplinary process, summary of two ethnicity groups

Base. 27 adult social care local authorities and 17 children's social care local authorities

Source. SC-WRES, 2024



3.6.4 Relative likelihood

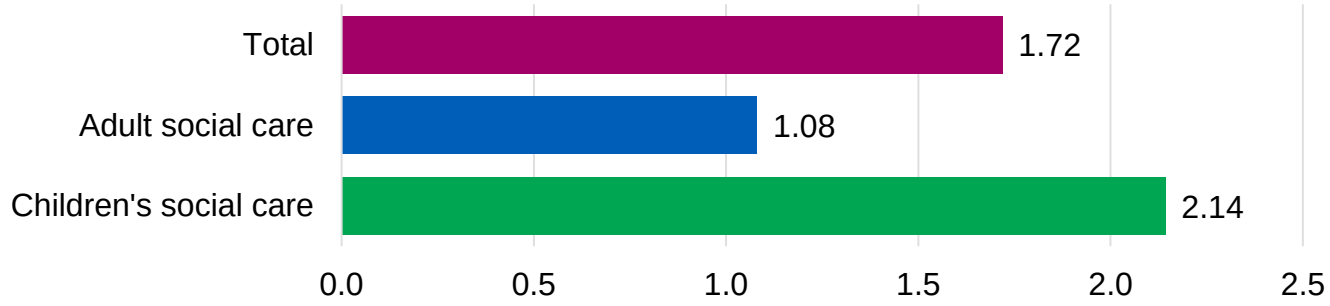
A relative likelihood is a number that indicates the extent to which two groups differ in their likelihood of experiencing an outcome. For SC-WRES, that is the likelihood of people from a Black, Asian or minority ethnic background experiencing the outcomes of each indicator compared to staff from a white background. The closer the number is to 1 the more similar the experiences are.

The relative likelihood of regulated professionals (at employers providing data to the SC-WRES) from a Black, Asian or minority ethnic background entering the fitness to practise process compared to staff from a white ethnic background differed between adult social care local authority employees and children's social care employees. The likelihood of entering the fitness to practise process was 8% higher for regulated professionals from a Black, Asian or minority ethnic background working in the adult social care sector compared to 114% higher in the children's social care sector.

Chart 13. Relative likelihood of staff in regulated professions from a Black, Asian or minority ethnic background entering the fitness to practise process compared to staff from a white ethnic background

Base. 27 adult social care local authorities and 17 children's social care local authorities

Source. SC-WRES, 2024



Unlike other indicators, there are not yet clear examples in action plans on fitness to practise . This will likely change with more action plan submissions and doesn't mean work is not happening in this area.

3.7 SC-WRES Indicator 5: Funded non-mandatory CPD

LA Adult employers

- **41** (56%) of LAs responded.
- **16,500** staff accessed funded non-mandatory CPD.

LA Children's employers

- **23** (53%) of LAs responded.
- **9,250 s**taff accessing funded non-mandatory CPD.

Results from employers responding to the SC-WRES showed that staff from a Black, Asian or minority ethnic background were 5% more likely to access funded non-mandatory continuous professional development (CPD) in the 12 months prior to the data collection period, as compared to staff from a white ethnic background (a relative likelihood of 1.05). Staff from a Black, Asian or minority ethnic background were 3% more likely in adult social care services and 9% more likely in children's social care services.

We know "stretch opportunities" (acting up, secondments, involvement in project teams) and CPD are important contributors to career progression, but these are often accessed informally. This metric supports a more transparent and reflective approach to how such opportunities are made available to staff.

3.7.1 Response rate

Analysis is based on 56% (41 of 73) of adult social care local authorities and 53% (23 of 43) of children's social care local authorities. Some local authorities did not have any data available for

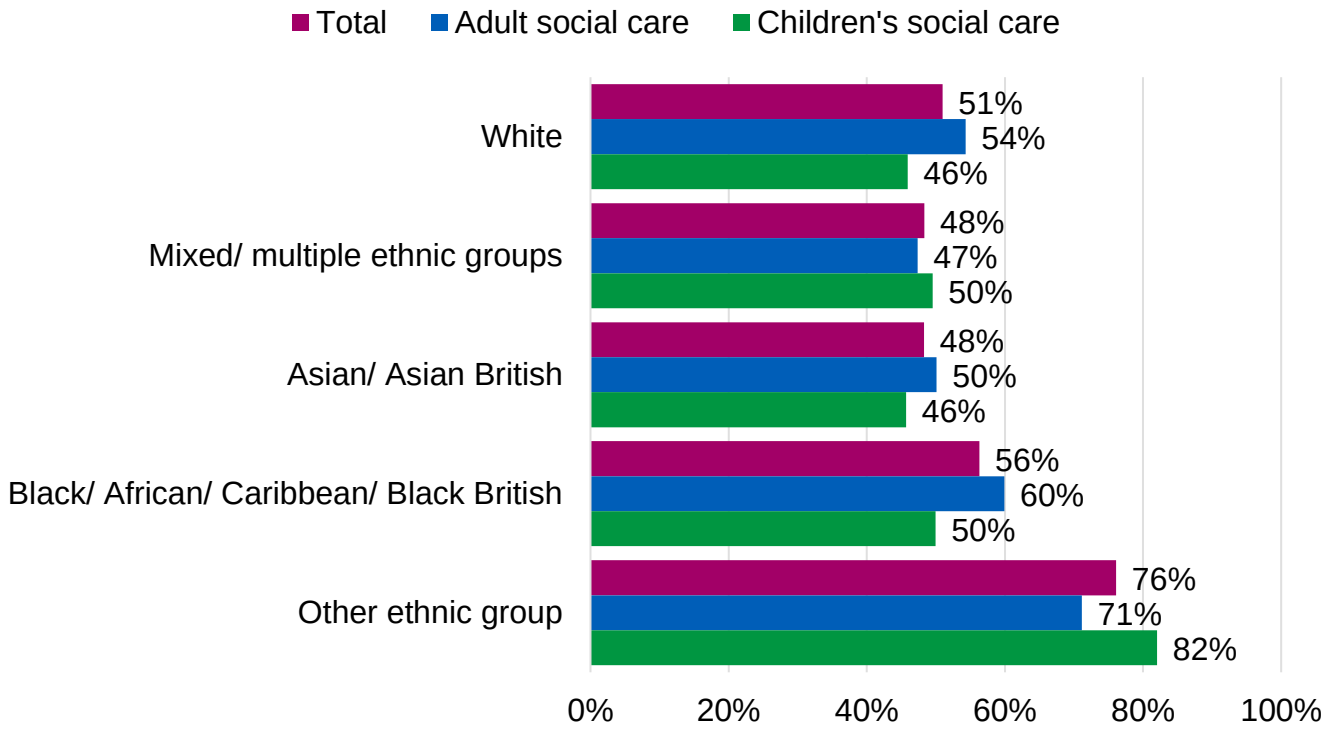
this indicator, and some were excluded based on data quality or deviations from the definition of the indicator.

The data shown here is based on 25,700 employees where their ethnicity was known who had accessed funded non-mandatory continuous professional development (CPD) in the last 12 months. This was comprised of 16,500 adult social care employees and 9,250 children's social care employees.

3.7.2 Staff accessing funded non-mandatory CPD, by ethnic group

Just over half (55%) of adult social care employees and just under half (47%) of children's social care employees accessed funded non-mandatory CPD in the last 12 months. The chart below shows the proportion all staff that accessed funded non-mandatory CPD by ethnicity.

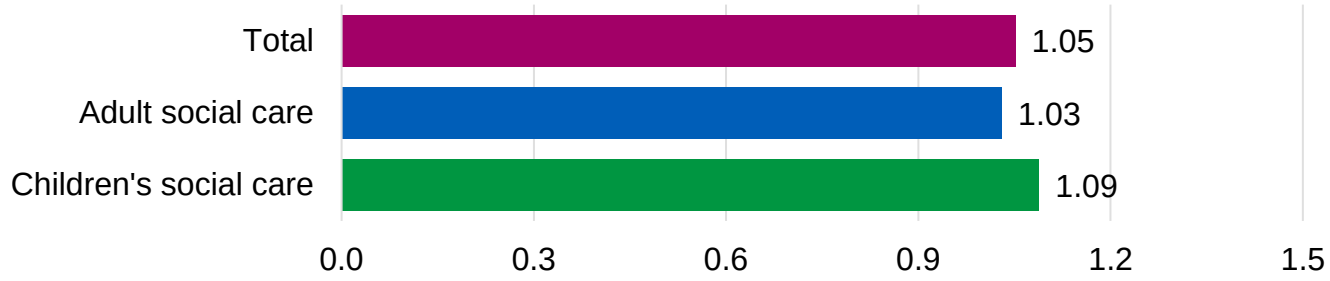
Chart 14. Staff accessing funded non-mandatory CPD, detailed ethnicity groups
Base. 41 adult social care local authorities and 23 children's social care local authorities
Source. SC-WRES, 2024



3.7.3 Relative likelihood

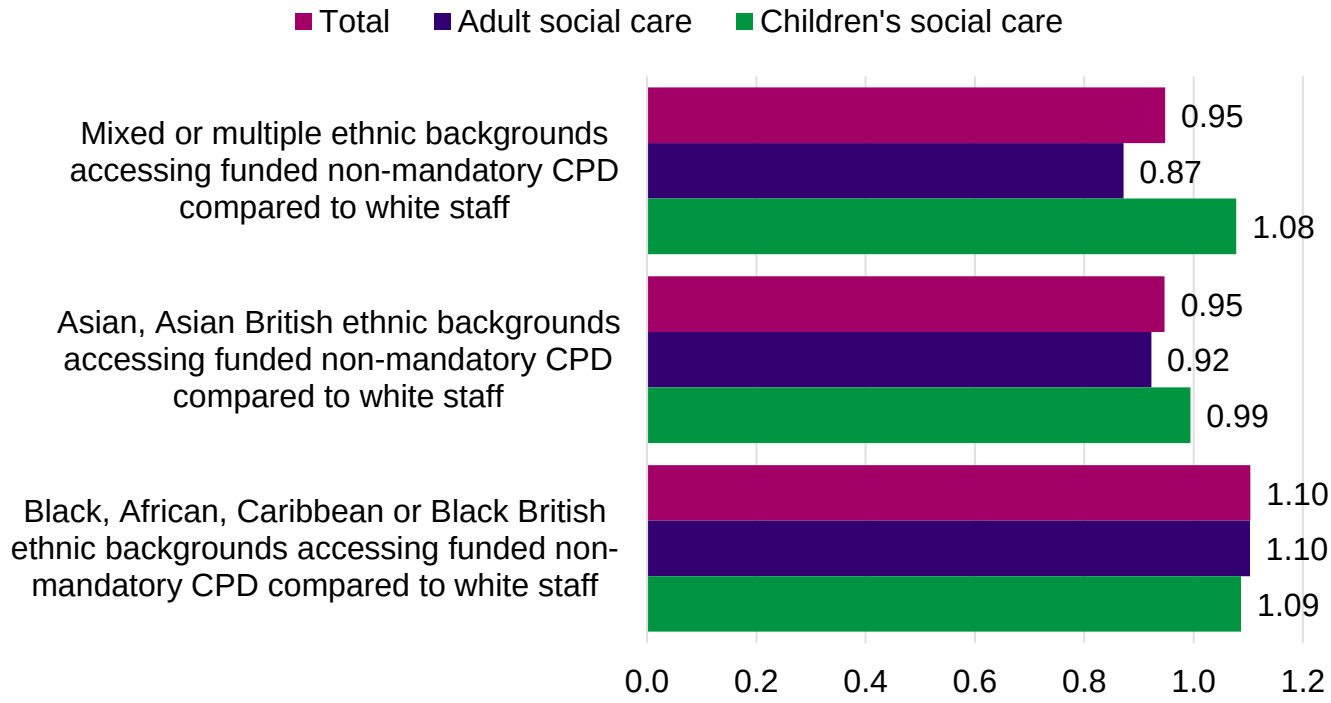
Results from employers responding to the SC-WRES showed that staff with a Black, Asian or minority ethnic background were 5% more likely to access funded non-mandatory CPD in the last 12 months as compared to staff with a white ethnic background (a relative likelihood of 1.05). The increased likelihood was 3% in adult social care services and 9% in children's social care services.

Chart 15. Relative likelihood of staff accessing funded non-mandatory CPD by service
Base. 41 adult social care local authorities and 23 children's social care local authorities
Source. SC-WRES, 2024



The chart below shows how the likelihood of accessing funded non-mandatory CPD for staff from different ethnic backgrounds compared to staff from white ethnic backgrounds.

Chart 16. Relative likelihood of staff accessing funded non-mandatory CPD, detailed ethnicity groups
Base. 41 adult social care local authorities and 23 children's social care local authorities
Source. SC-WRES, 2024



We also looked at how the likelihood of accessing funded non-mandatory CPD differed between people from different ethnic backgrounds. Staff from an Asian or Asian British ethnic background were slightly less likely to access funded non-mandatory CPD compared to staff with a Black, African, Caribbean or Black British ethnic background, with a relative likelihood of 0.86 (0.84 within adult social care and 0.91 within children's social care).

3.7.4 Examples from phase 1 local authority action plans

Brighton and Hove City Council promotes equal access to learning and career development through:

- **Fair learning opportunities:** Ensures learning and career development are consistently and fairly discussed in performance reviews for all staff.
- **Targeted support:** Line managers lead career conversations and offer job shadowing, mentoring, acting-up opportunities, and other development pathways, addressing barriers to access.

3.8 SC-WRES Indicator 6: Harassment, bullying or abuse from service users, relatives or the public

LA Adult employers	LA Children's employers	
▪ **13** (18%) of LAs responded. ▪ **4,050** staff completed LA staff survey. ▪ **525** staff experience harassment, bullying or abuse from service users, relatives or the public.	▪ **7** (16%) of LAs responded. ▪ **2,900** staff completed LA staff survey. ▪ **325** staff experience harassment, bullying or abuse from service users, relatives or the public.	We do know the results shown here are an accurate reflection of the responding local authorities however we need to collect more data to understand to what extent ethnicity has an effect on this indicator.

Within responding local authorities, staff from a Black, Asian or minority ethnic background were 35% less likely to experience harassment, bullying or abuse from people who use social care, relatives, or the public in the 12 months prior to data collection, compared to staff from a white ethnic background (a relative likelihood of 0.65). This experience was similar for adult social care employees at 34% less likely and children's social care employees at 40% less likely.

We do know that the results shown here are an accurate reflection of the responding local authorities, however our conclusion is that next year we need to collect more data about this indicator to understand to what extent ethnicity has an effect on the likelihood of staff experiencing harassment, bullying or abuse from people who use social care, relatives or the public. We have plans to support local authorities participating in the 2025 SC-WRES programme to better collect this information.

An important note about understanding or interpreting this information

In 2024 13 adult and 7 children's social care local authority employers provided data (of usable quality) for this SC-WRES indicator. It was found that staff from a Black, Asian or minority ethnic background were **36% less** likely to experience harassment, bullying or abuse from people who

use social care, relatives, or the public in the 12 months prior to data collection, compared to staff from a white ethnic background.

In 2023 6 adult and 5 children's adult social care local authority employers provided data (of usable quality) for this SC-WRES indicator. It was found that staff from a Black, Asian or minority ethnic background were **20% more** likely to experience harassment, bullying or abuse from people who use social care, relatives, or the public in the 12 months prior to data collection, compared to staff from a white ethnic background.

These two different groups (or samples) of local authority employers show two quite different outcomes for staff with a Black, Asian or minority ethnicity. Upon reviewing the data from both 2023 and 2024, it is evident that the two results are not directly comparable because the responses are from almost entirely different local authority employers. This shift in the sample group means that the data from each year reflects different sets of employers, which could introduce variations due to differing characteristics, contexts, or other factors specific to the employers in each group and the difference should not be interpreted as a trend.

Please also see section 3.6.2 about the effects of low bases and a small sample size. In summary a small sample sizes and low response rate (as seen in this indicator) are also more susceptible to variation or skewing, meaning results could be influenced more heavily by outliers or unusual responses from responding local authorities, which limits our ability to come to meaningful conclusions and makes it harder to break down results into detailed ethnicity groups or onto adults and children's local authority employers.

The 2024 results compared to the 2023 results could be due to these three factors - a different sample group, a small sample size and/or a low response rate - rather than reflecting true year-on-year changes.

Our conclusion is that next year, we need to collect more data about this indicator to understand to what extent ethnicity has an effect on the likelihood of staff experiencing harassment, bullying or abuse from people who use social care, relatives or the public.

We **do** know that the results shown here are an accurate reflection of the responding local authorities. And we have plans to support local authorities participating in the 2025 SC-WRES programme to better collect this information.

3.8.1 Response rate

Analysis is based on 18% (13 of 73) of adult social care local authorities and 16% (7 of 43) of children's social care local authorities. The information from these indicators was collected via a staff survey but not all local authorities carried out the survey.

The analysis below is based on 6,950 employees who completed the staff survey and whose ethnicity was known, from which 850 (12%) reported experiencing harassment, bullying or abuse from 'service users, relatives or the public' in the last 12 months. For adult social care,

4,050 employees completed the staff survey and 525 (13 %) of those reported experiencing harassment, bullying or abuse from ‘service users, relatives or the public’, and for children’s social care, 2,900 employees completed the staff survey and 325 (11.%) of those reported experiencing harassment, bullying or abuse from ‘service users, relatives or the public’.

Analysis is not shown by detailed ethnicity groups for this indicator, due to low bases and a small sample size, to protect anonymity.

3.8.2 Psychological safety

In the book Psychological Safety by Amy Edmonson, there is reference to people from minority ethnic backgrounds needing to feel psychologically safe to report bullying. Positive psychological safety enables staff to be confident that if they speak up, they will be heard, listened to and treated with respect rather than unseen and unheard. Although the response rate of local authorities was low, meaning most did not collect data in this area, it is important to consider the psychological safety of the staff who did respond to staff surveys ran by the local authority employers.

When supporting local authorities participating in the 2025 SC-WRES programme to better collect information about indicator 6 and indicator 7, we will encourage steps to consider and ensure that the workforce feels psychologically safe to report experiences of harassment, bullying or abuse.

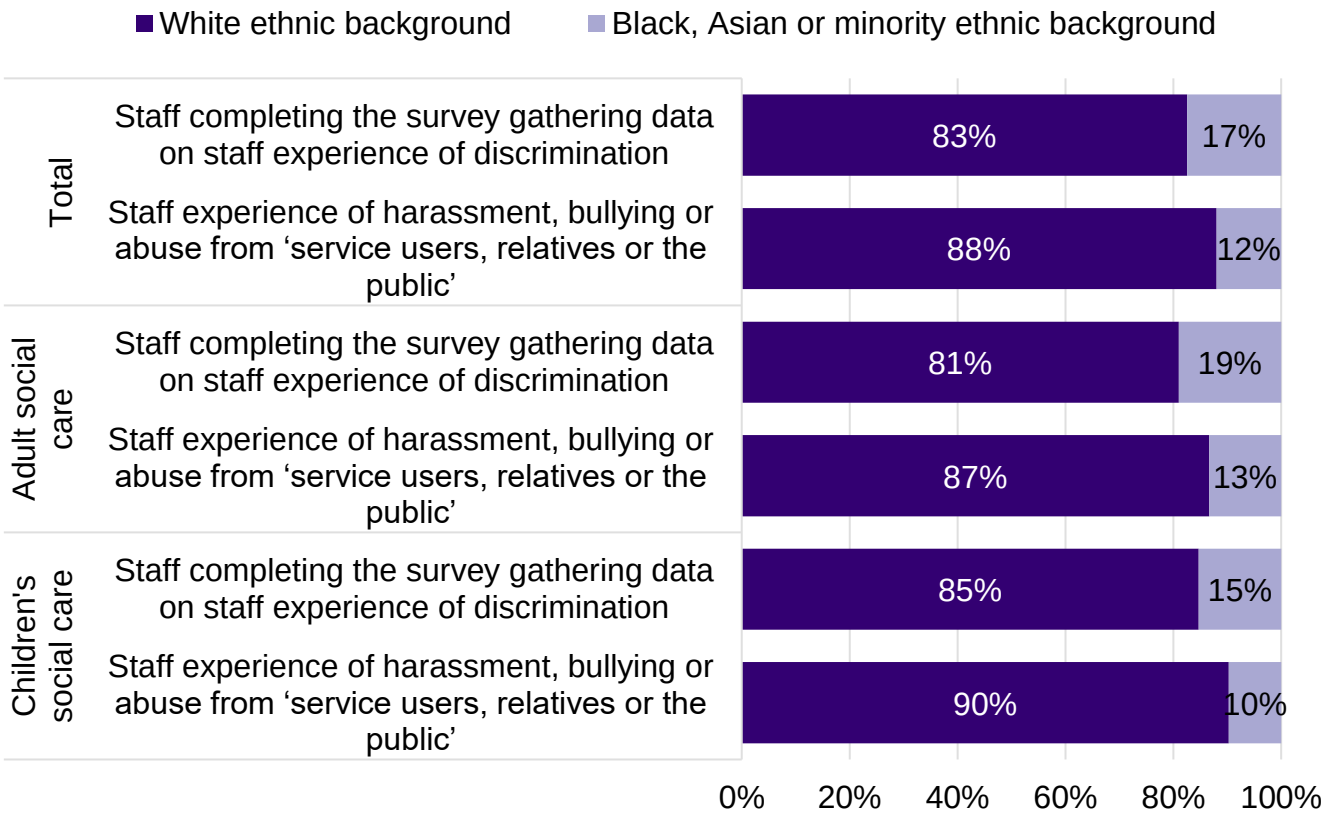
3.8.3 Ethnicity of staff reporting harassment, bullying or abuse from service users, relatives or the public

The chart below shows that of the 850 staff who reported experiencing harassment, bullying or abuse from service users, relatives or the public in the last 12 months, 88% were from a white ethnic background and 12% were from a Black, Asian or minority ethnic background.

Chart 17. Proportion of staff who reported experiencing harassment, bullying or abuse from service users, relatives or the public, summary of two ethnicity groups

Base. 13 adult social care local authorities and 7 children's social care local authorities

Source. SC-WRES, 2024

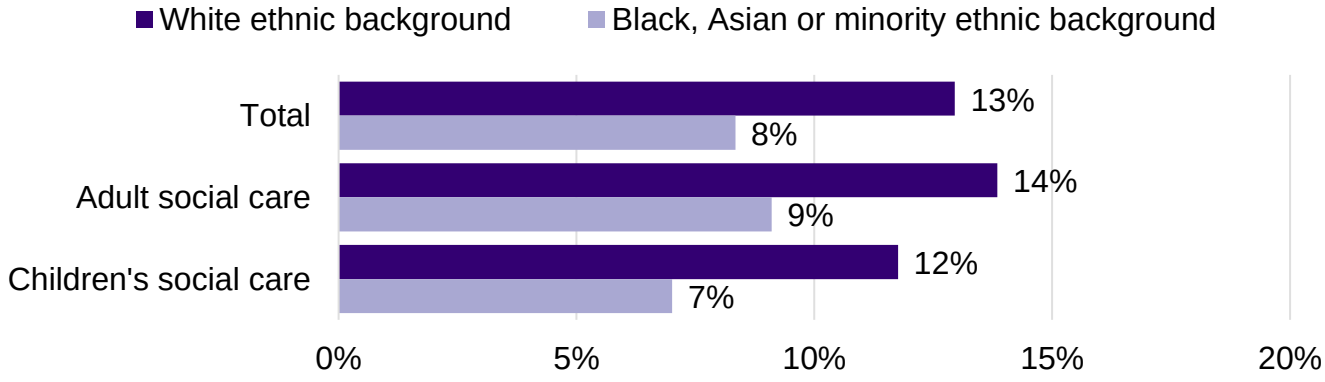


Overall, 12% of staff who completed the survey reported experiences of experiencing harassment, bullying or abuse. The chart below shows the ethnicity of staff who completed the survey and reported experiencing harassment, bullying or abuse. It shows that 13% of staff with a white ethnic background reported experiences of experiencing harassment, bullying or abuse compared to 8% of staff with a Black, Asian or minority ethnic background.

Chart 18. Proportion of staff who completed the staff survey and reported experiencing harassment, bullying or abuse by ethnicity and service

Base. 13 adult social care local authorities and 7 children's social care local authorities

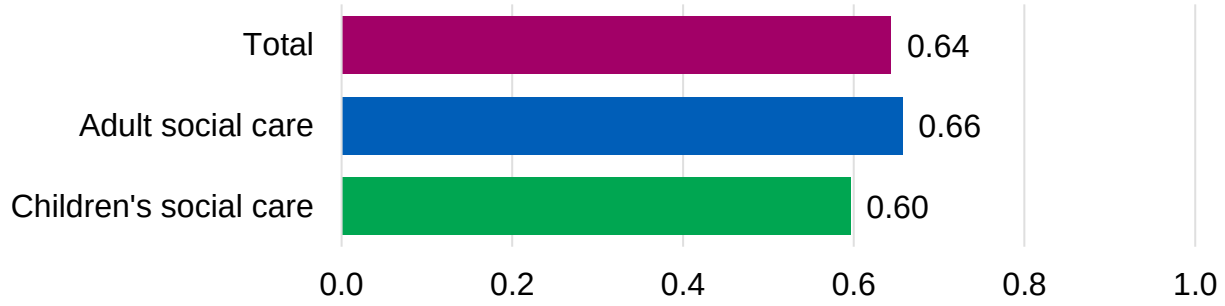
Source. SC-WRES, 2024



3.8.4 Relative likelihood

Of the people completing the staff surveys within responding local authorities, staff from a Black, Asian or minority ethnic background were 36% less likely to experience harassment, bullying, or abuse from people who use social care, relatives, or the public in the last 12 months, compared to staff from a white ethnic background (a relative likelihood of 0.64). This experience was similar for adult social care employees and children's social care employees, at 34% and 40% less likely respectively.

Chart 19. The relative likelihood of staff from a Black, Asian or minority ethnicity experiencing harassment, bullying or abuse from service users, relatives or the public compared to staff from a white ethnic background
Base. 13 adult social care local authorities and 7 children's social care local authorities
Source. SC-WRES, 2024



3.8.5 Examples from phase 1 local authority action plans

Lancashire County Council strengthens its approach to bullying and harassment through:

- **Staff Surveys:** Following staff surveys, addressing bullying, harassment and abuse has been highlighted as one of the top four priority areas within the whole organisation.
- **Updated Training & Frameworks:** Equalities training now includes SC-WRES - and the Managers Journey training programme includes components on Policy Essentials and Key Conversations that complement the SC-WRES.
- **Incident Reporting & Engagement:** A safety incident recording system now identifies harassment, bullying, and abuse related to race and other protected characteristics. Face-to-face training sessions also provide a platform for staff to share experiences and suggest improvements.

3.9 SC-WRES Indicator 7: Harassment, bullying or abuse from colleagues and managers

Adult and children's employers

- **10** (14%) of adult LAs responded
- **7** (16%) of children's LAs responded
- **5,800** staff completing adult and children's LA staff surveys
- Staff experienced harassment, bullying or abuse from:
  - colleagues: **300**
  - managers: **250**

We do know the results shown here are an accurate reflection of the responding local authorities however we need to collect more data to understand to what extent ethnicity has an effect on this indicator.

At responding local authorities, staff from a Black, Asian or minority ethnic background were 28% less likely to experience harassment, bullying or abuse from colleagues in the last 12 months compared to staff from a white ethnic background (a relative likelihood of 0.72).

At responding local authorities, staff from a Black, Asian or minority ethnic background were 12% less likely to experience harassment, bullying or abuse from managers in the last 12 months compared to staff from a white ethnic background (a relative likelihood of 0.88).

We do know that the results shown here are an accurate reflection of the responding local authorities however our conclusion is that next year, we need to collect more data about this indicator to understand to what extent ethnicity has an effect on the likelihood of staff experiencing harassment, bullying or abuse from colleagues and from managers. We have plans to support local authorities participating in the 2025 SC-WRES programme to better collect this information.

An important note about understanding or interpreting this information

In 2024 10 adult and 7 children's social care local authority employers provided data (of usable quality) for this SC-WRES indicator. It was found that staff from a Black, Asian or minority ethnic background were **28% less** likely to experience harassment, bullying or abuse from colleagues, and **12% less** likely from managers, in the last 12 months compared to staff from a white ethnic background.

In 2023 6 adult and 5 children's adult social care local authority employers provided data (of usable quality) for this SC-WRES indicator. It was found that staff from a Black, Asian or minority ethnic background were **30% more** likely to experience harassment, bullying or abuse from colleagues, and **90% more** likely from managers, in the last 12 months compared to staff from a white ethnic background.

These two different groups (or samples) of local authority employers show two quite different outcomes for staff with a Black, Asian or minority ethnicity. Upon reviewing the data from both 2023 and 2024, it is evident that the two results are not directly comparable because the responses are from almost entirely different local authority employers. This shift in the sample group means that the data from each year reflects different sets of employers, which could introduce variations due to differing characteristics, contexts, or other factors specific to the employers in each group and the difference should not be interpreted as a trend.

Please also see section 3.6.2 about the effects of low bases and a small sample size. In summary a small sample sizes and low response rate (as seen in this indicator) are also more susceptible to variation or skewing, meaning results could be influenced more heavily by outliers or unusual responses from responding local authorities, which limits our ability to come to meaningful conclusions and makes it harder to break down results into detailed ethnicity groups or onto adults and children's local authority employers.

The 2024 results compared to the 2023 results could be due to these three factors- a different sample group, a small sample size and/or a low response rate- rather than reflecting true year-on-year changes.

Our conclusion is that next year, we need to collect more data about this indicator to understand to what extent ethnicity has an effect on the likelihood of staff experiencing harassment, bullying or abuse from colleagues and managers.

We **do** know that the results shown here are an accurate reflection of the responding local authorities and we have plans to support local authorities participating in the 2025 SC-WRES programme to better collect this information.

3.9.1 Response rate

Analysis is based on 14% (10 out of 73) of adult social care local authorities and 16% (7 out of 43) of children's social care local authorities. The information from these indicators was collected via a staff survey but not all local authorities carried out the survey, so the response rate was lower than other indicators.

Analysis is based on staff where ethnicity is known. In total, this was 5,800 staff who completed the staff survey, 300 of whom reported experiencing harassment, bullying or abuse from a colleague and 250 of whom reported experiencing harassment, bullying or abuse from a manager.

Analysis is not shown by detailed ethnicity groups nor by adult social care/children's social care employers for this indicator, due to low bases and a small sample size, to protect anonymity.

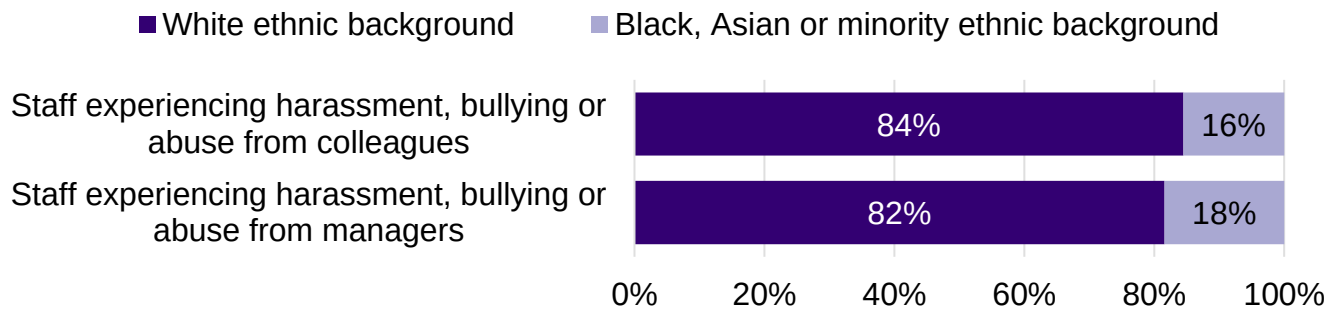
3.9.2 Ethnicity of staff experiencing harassment, bullying or abuse from a colleague or a manager

The chart below shows the ethnicity of the 300 staff who reported experiencing harassment, bullying or abuse from a colleague and the 250 staff who reported experiencing harassment, bullying or abuse from a manager in the last 12 months.

Chart 20. Proportion of staff who reported experiencing harassment, bullying or abuse from colleagues or managers, by ethnicity

Base. 10 adult social care local authorities and 7 children's social care local authorities

Source. SC-WRES, 2024

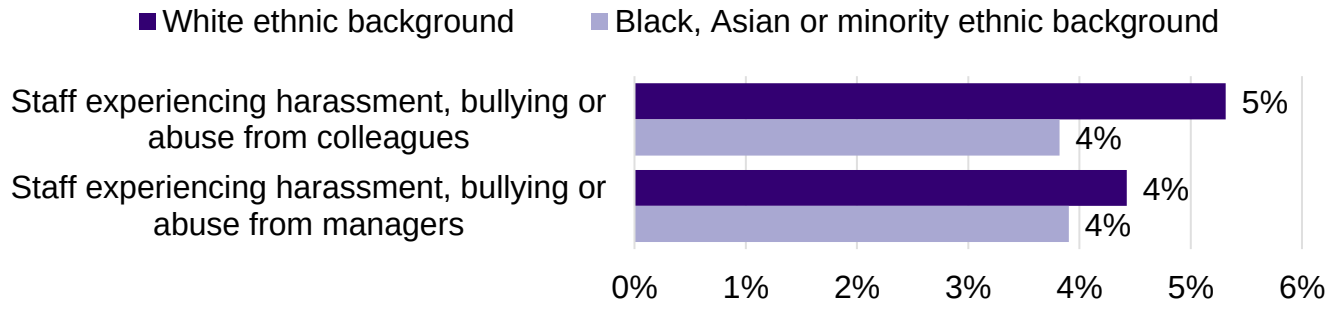


The chart below shows the ethnicity of staff who completed the staff survey and did report experiencing harassment, bullying or abuse.

Chart 21. Proportion of staff who completed the staff survey and reported experiencing harassment, bullying or abuse from colleagues or managers, by ethnicity

Base. 10 adult social care local authorities and 7 children's social care local authorities

Source. SC-WRES, 2024

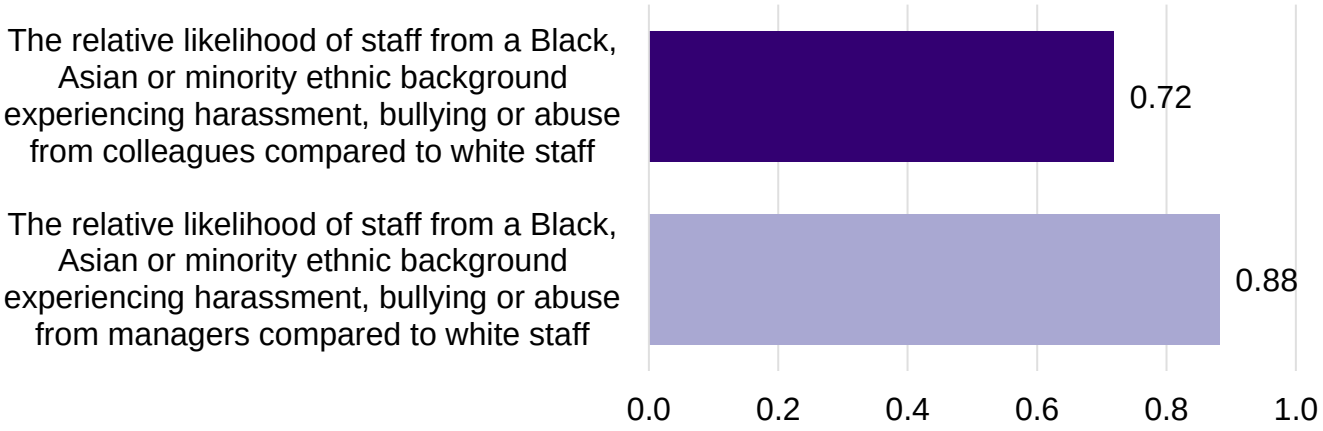


3.9.3 Relative likelihood

Of the people completing the staff surveys within responding local authorities, staff from a Black, Asian or minority ethnic background were 28% less likely to experience harassment, bullying, or abuse from colleagues in the last 12 months compared to staff from a white ethnic background (a relative likelihood of 0.72).

Staff from a Black, Asian or minority ethnic background were 12% less likely to experience harassment, bullying, or abuse from managers in the last 12 months compared to staff from a white ethnic background (a relative likelihood of 0.88).

Chart 22. Relative likelihood of staff from a Black, Asian or minority ethnic background experiencing harassment, bullying or abuse from colleagues or managers in last 12 months compared to staff from a white ethnic background
Base. 10 adult social care local authorities and 7 children's social care local authorities
Source. SC-WRES, 2024



3.9.4 Examples from phase 1 local authority action plans

One council strengthens anti-racism efforts through:

- **Qualitative Research & Staff Engagement:** Research and engagement with staff from global majority backgrounds led to the implementation of new guidance and the development of an eLearning module on Anti-Racism in Practice: Eliminating Racism at Work.
- **Reflective Practice Workshops:** Enhanced in-person workshops for Directors, Heads of Service, team managers, and practice supervisors to explore anti-racist practice and address racism in the workplace.

3.10 SC-WRES Indicator 8: Turnover of directly employed staff

LA Adult employers

- **72** (99%) of LAs responded.
- Based on **50,900** employees and **5,550** leavers.

LA Children's employers

- **43** (100%) of LAs responded.
- Based on **31,100** employees and **4,450** leavers.

Many factors could affect someone's likelihood to leave their role, and their ethnicity is only one of them.

Results from employers responding to the SC-WRES showed that the likelihood of staff from a Black, Asian or minority ethnic background, employed in adult social care local authorities, leaving during the last 12 months was around the same compared to staff from a white ethnic background (a relative likelihood of 1.03).

Results from employers proving data to the SC-WRES showed that staff from a Black, Asian or minority ethic background, employed in children's social care local authorities, were 21% more likely to leave during the last 12 months compared to staff from a white ethnic background (a relative likelihood of 1.21).

3.10.1 A note about causality

This indicator looks at the number of leavers in the past 12 months by an employee's ethnicity. It should be noted that there are lots of factors that can affect an employee's choice to leave, and their ethnicity is only one of those factors. These factors are not collected as part of the SC-WRES.

There is a chapter in the State of the adult social care sector and workforce report that looks at factors affecting care worker turnover rates. Its key findings were that the sector has difficulty retaining younger staff, care workers were more likely to leave soon after starting their role, or if they are on a zero-hours contract, and that care workers recruited internationally were less likely to leave.
There are also other factors that could affect an employee's propensity to leave their role, including:

- **Job satisfaction:** Low levels of job satisfaction, including dissatisfaction with the role, workload, or working environment.
- **Pay and benefits**
- **Workload and stress:** Social care roles can be emotionally and physically demanding. High levels of stress, burnout, and heavy caseloads could contribute to employees leaving.
- **Management and leadership**: Effective leadership plays a key role in retention.
- **Training and development opportunities**: Lack of career progression or insufficient training opportunities may lead employees to seek other opportunities where they can grow and develop.
- **Workplace culture and environment**: A negative workplace culture, including poor relationships between staff or lack of teamwork, can cause employees to leave.
- **Recognition and appreciation**: Employees who feel that their work is not recognised or valued are more likely to leave.
- **Personal circumstances**: Employees may leave for reasons unrelated to the job itself.
- **External job market conditions**: If there are better opportunities or competitive offers from other employers, employees may be more likely to leave for higher-paying or less stressful roles.

It is important to consider these factors alongside the ethnicity of the worker when interpreting the results for this indicator.

3.10.2 Response rate

Data availability for this indicator was high, with 99% (72 of 73) of adult local authority employers and 100% (43 of 43) of children's social care employers providing the number of leavers by ethnicity information for this indicator.

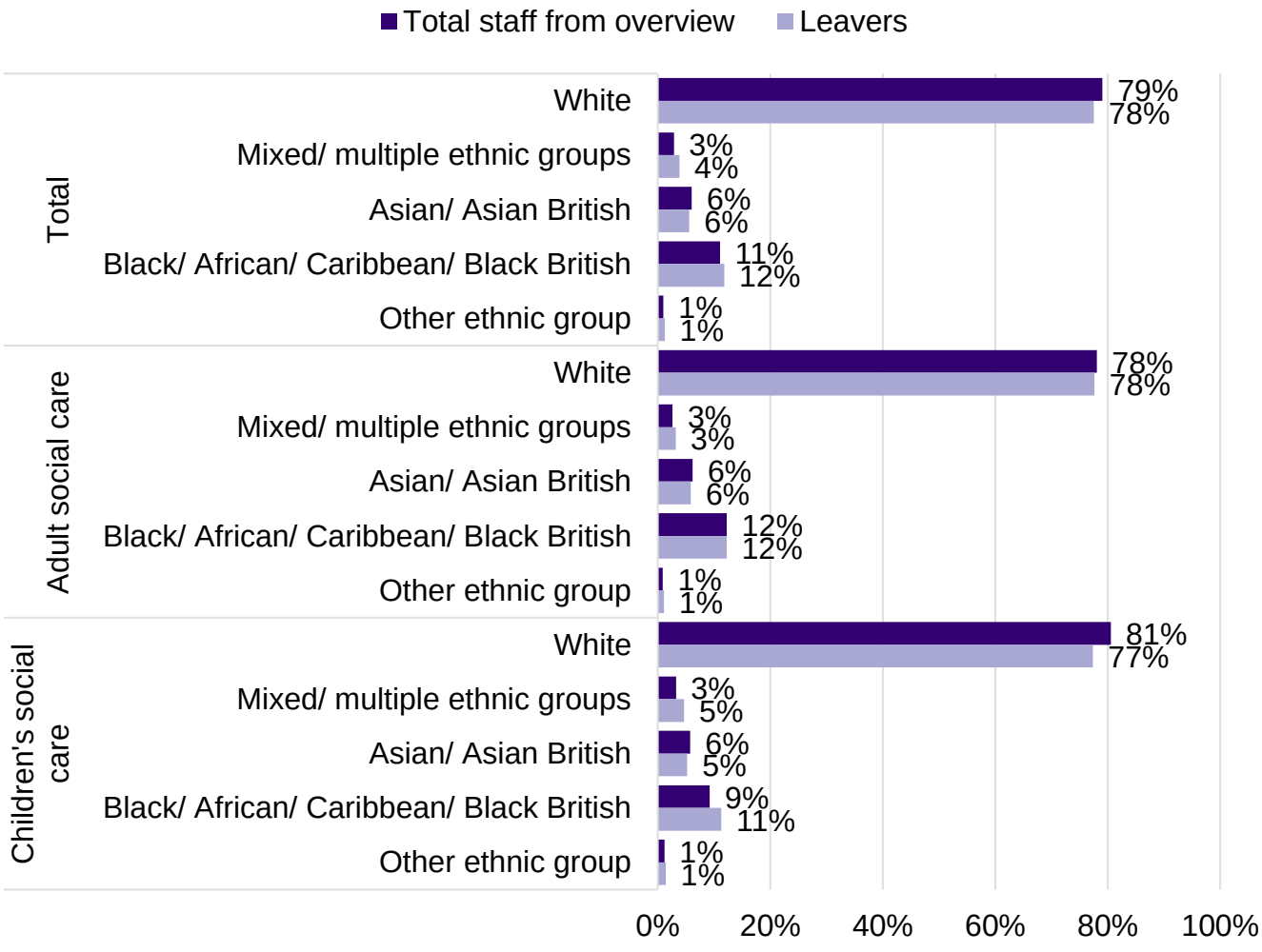
Analysis below includes staff where ethnicity was known. Analysis was based on 85,000 employees and 9,950 leavers in the past 12 months. This was 50,900 employees from adult social care and 5,550 leavers, and 34,100 employees from the children's sector and 4,450 leavers.

3.10.3 Proportion of leavers in the past 12 months

The chart below shows that the proportion of leavers by ethnicity closely matches that of the overall ethnic profile of responding local authorities.

Chart 23. Proportion of total staff from overview and leavers in the past 12 months, detailed ethnicity groups

Base. 72 adult social care local authorities and 43 children's social care local authorities
Source. SC-WRES, 2024

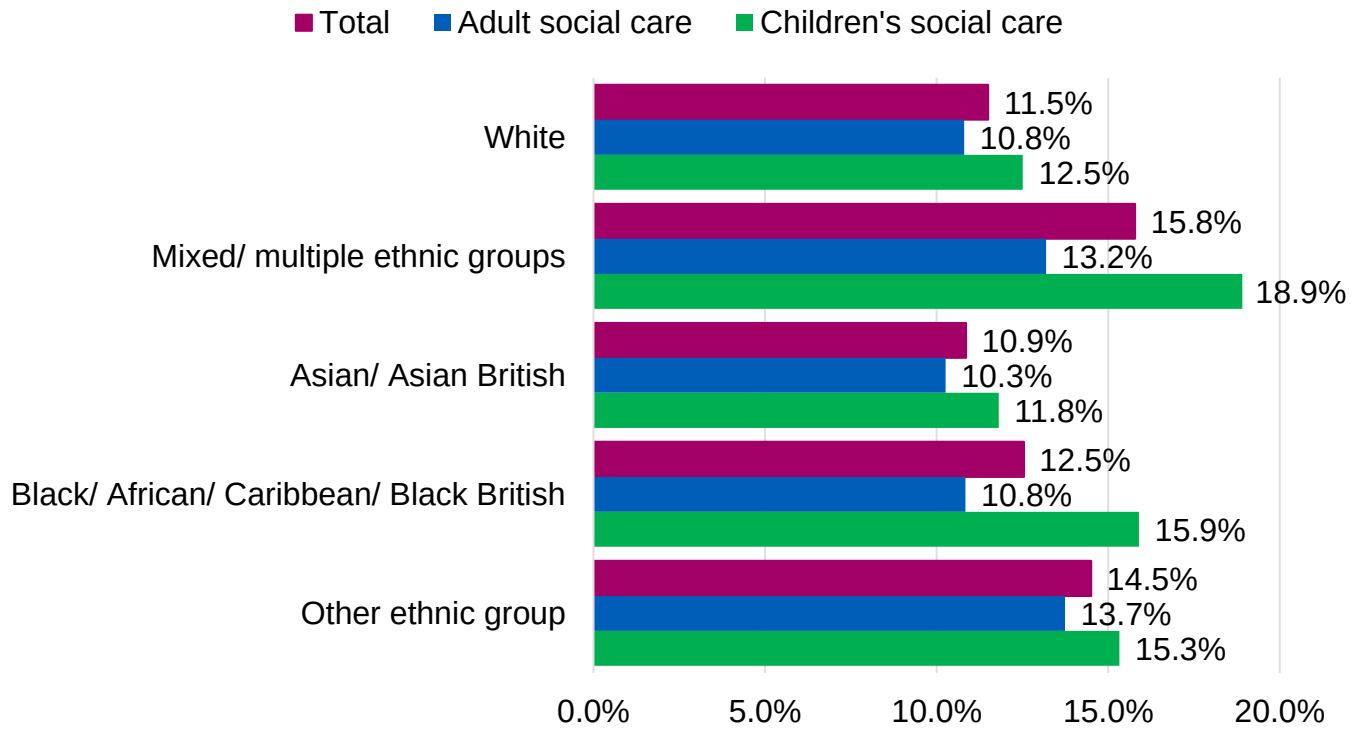


3.10.4 Turnover rate by ethnicity

To calculate the staff turnover rate for the SC-WRES, the number of leavers was divided by the number of employees. The number of employees is taken from the staff recorded in the staff overview question. The Skills for Care estimate of turnover of adult social care staff leaving their posts in the past 12 months within local authority employers was 12.5% in 2024/25.

The chart below shows turnover rates of different ethnicity groups for the responding local authorities. It shows that turnover rates were lower for adult social care employees than children's social care employees for all ethnicity groups shown below.

Chart 24. Staff turnover rate by ethnicity
Base. 72 adult social care local authorities and 43 children's social care local authorities
Source. SC-WRES, 2024



3.10.5 Relative likelihood

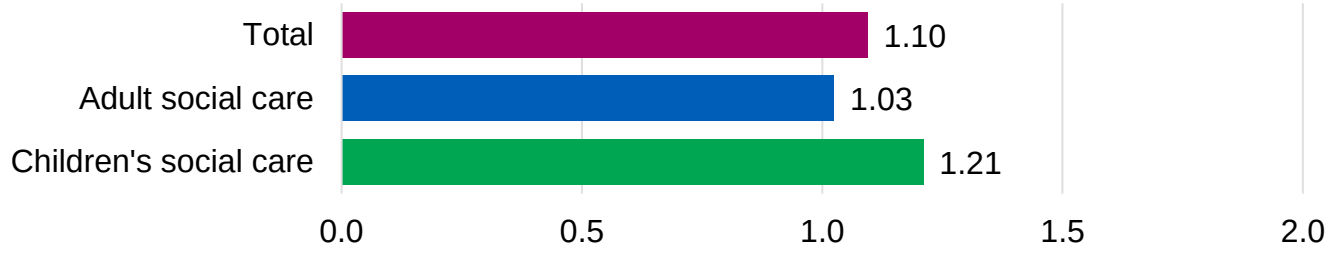
Results from employers providing data to the SC-WRES showed that employees from a Black, Asian or minority ethnic background were 10% more likely to leave their roles in the past 12 months compared to staff from a white ethnic background (a relative likelihood of 1.10).

The likelihood of staff from a Black, Asian or minority ethnic background, employed by adult social care local authority employers, leaving during the last 12 months compared to staff from a white ethnic background was around the same (a relative likelihood of 1.03).

Staff from a Black, Asian or minority ethnic background employed by children's social care local authority employers were 21% more likely to leave during the last 12 months compared to staff from a white ethnic background (a relative likelihood of 1.21).

Chart 25. Relative likelihood of staff leaving the organisation during the last 12 months by service

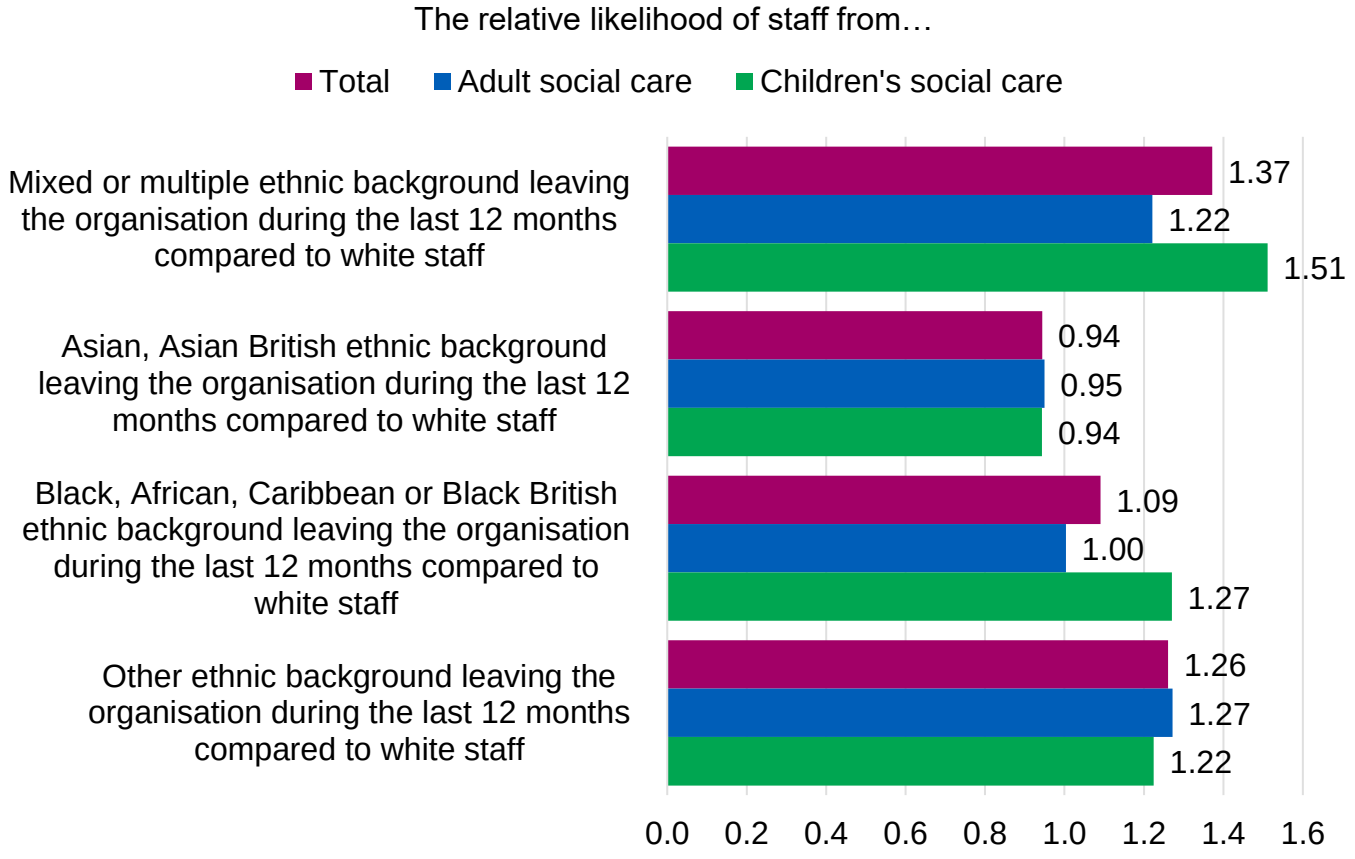
Base. 72 adult social care local authorities and 43 children's social care local authorities
Source. SC-WRES, 2024



The chart below shows the relative likelihood of people from different ethnicity groups leaving their role in the past 12 months compared to staff from a white ethnic background.

Chart 26. Relative likelihood of staff leaving the organisation during the last 12 months compared to staff from a white ethnic background by ethnicity

Base. 72 adult social care local authorities and 43 children's social care local authorities
Source. SC-WRES, 2024



Looking in more detail at the different experiences of people from different ethnic backgrounds, staff from an Asian or Asian British ethnic background were 6% more likely to leave their role in adult social care and 35% more likely in children's social care compared to staff from a Black, African, Caribbean or Black British ethnic background.

3.10.6 Examples from phase 1 local authority action plans

Richmond and Wandsworth Councils address staff retention:

- **Stay Interviews:** Conducted with newly qualified social workers (NQSWs) at the 6-9 month mark to improve retention. The interviews explore what attracts NQSWs to the role, what they enjoy and what challenges they face. It also assesses support needs and future career interests, aiming to address issues such as workplace discrimination.
- **Annual Review:** Themes collected from these interviews are reviewed annually by senior management, highlight the importance of supportive managers, cohesive teams, manageable caseloads and support when challenges arise in retaining staff.

3.11 SC-WRES Indicator 9: Senior manager membership

LA Adult employers

- **71** (97%) of LAs responded.
- **1,300** people in senior management roles.

LA Children's employers

- **41** (95%) of LAs responded.
- **950** people in senior management roles.

At responding local authorities, there was a smaller proportion of staff with a Black, Asian or minority ethnic background in senior management positions (12%) compared to the overall workforce (20%).

Staff from a Black, Asian or minority ethnic background were 45% less likely be in senior manager roles compared to staff with a white ethnic background (a relative likelihood of 0.55). Staff were around half as likely (48%) in adult social care (a relative likelihood of 0.52) and 39% less likely in children's social care (a relative likelihood of 0.61).

3.11.1 Response rate

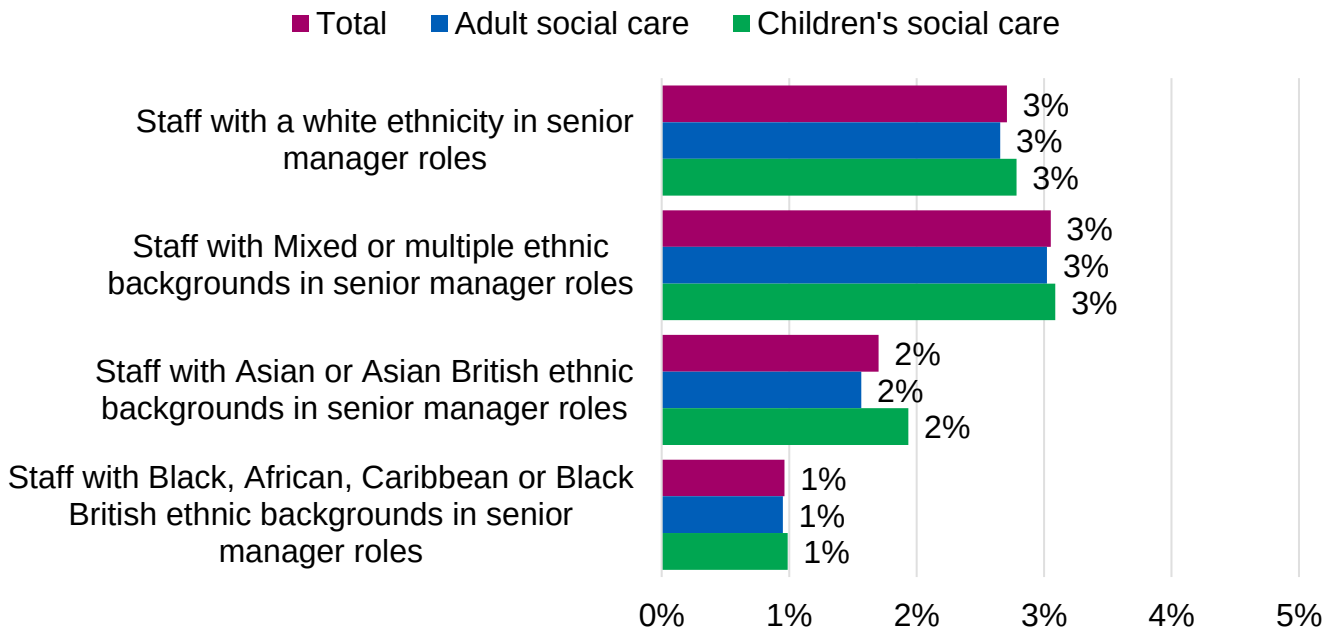
Analysis is based on 97% (71 of 73) of adult social care local authorities and 95% (41 of 43) of children's social care local authorities. Analysis is based on 2,250 staff with a known ethnicity in senior management roles, comprised of 1,300 staff from adult social care and 950 from children's social care.

Overall, 2% of total staff recorded by local authority employers were in senior manager roles (2% for adult social care and 3% for children's social care).

3.11.2 Number of senior manager roles by ethnicity

The chart below shows the proportion of all staff that were in senior management roles by ethnicity. It shows that across all employers, 3% of staff from a white ethnic background and 3% of staff from a mixed/multiple ethnic background were in senior membership roles.

Chart 27. Proportion of staff that were in senior management roles, by ethnicity
Base. 71 adult social care local authorities and 41 children's social care local authorities
Source. SC-WRES, 2024

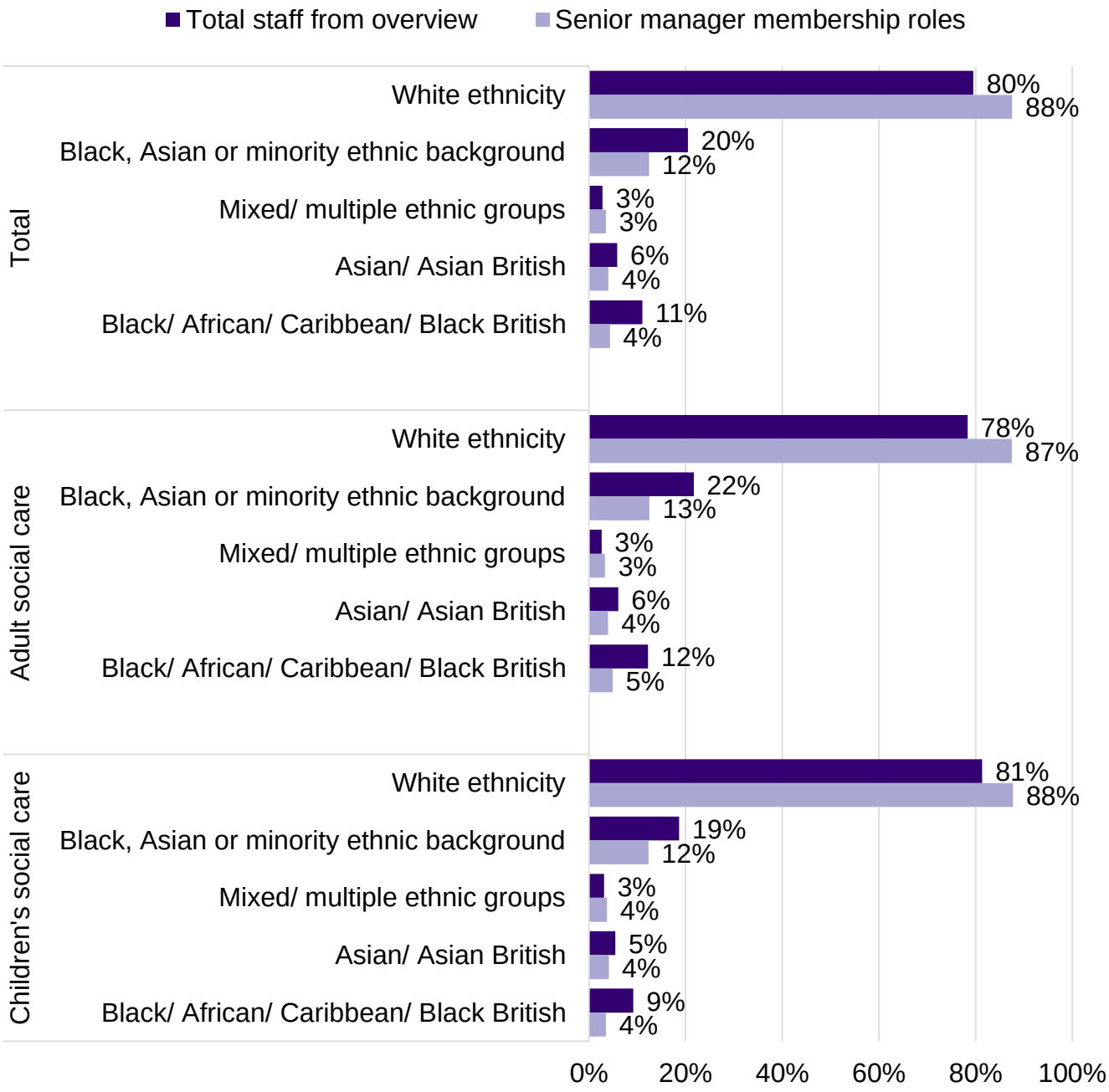


The chart below shows that, at responding local authorities, there was a smaller proportion of staff with a Black, Asian or minority ethnic background in senior management positions (12%) compared to the overall workforce (20%).

Chart 28. Ethnicity of staff in senior manager roles

Base. 71 adult social care local authorities and 41 children's social care local authorities

Source. SC-WRES, 2024



3.11.3 Relative likelihood

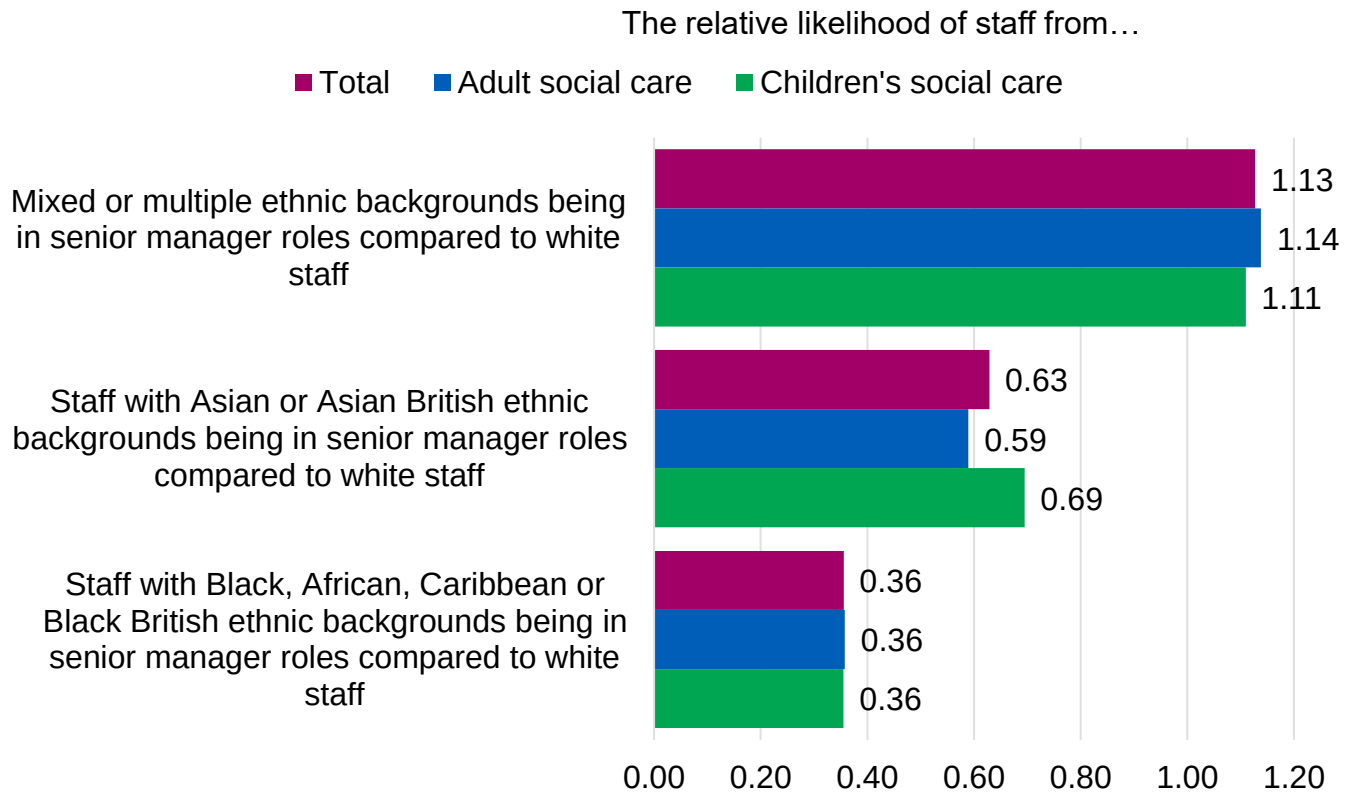
Results from employers providing data to the SC-WRES showed that employees from a Black, Asian or minority ethnic background were 45% less likely be in senior manager roles compared to staff from a white ethnic background (a relative likelihood of 0.55). They were 48% less likely in adult social care (a relative likelihood 0f 0.53) and 39% less likely in children's social care (a relative likelihood of 0.61).

The chart below shows that staff from a mixed/multiple ethnic background were 13% more likely to be in senior manager roles compared to staff from a white ethnic background (a relative likelihood of 1.13). However, staff from an Asian or Asian British ethnic background were 37% less likely (a relative likelihood of 0.63), and staff from a Black, African, Caribbean or Black British ethnic background were 64% less likely to be in senior manager roles compared to staff from a white ethnic background (a relative likelihood of 0.36).

Chart 29. Relative likelihood of staff being in senior management roles compared to staff from a white ethnic background by ethnicity

Base. 71 adult social care local authorities and 41 children's social care local authorities

Source. SC-WRES, 2024



3.11.4 Examples from phase 1 local authority action plans

One council considered what can be done to build an inclusive culture and widen the recruitment pool for senior roles through:

- **Senior leadership responsibilities**: Senior leaders are crucial in recognising barriers to progression and fostering an inclusive organisational culture.
- **Widening the recruitment Pool**: Collaboration with recruitment partners to cast a wider net for senior roles, aiming to attract a more diverse talent pool for senior positions.
- **Inspiring career progression**: Providing opportunities for staff to hear from diverse senior leaders, to inspire Black, Asian, and minoritised ethnic staff.
- **Supporting career advancement**: Offering coaching and mentoring programs to empower Black, Asian, and minoritised ethnic staff in developing their skills and confidence.

3.12 Changes over time

This section looks at the number of local authority employers that participated in the SC-WRES in 2021, 2023, and 2024, and analyses how the experiences of staff from Black, Asian, or minority ethnic backgrounds, compared to those of staff from a white ethnic background, changed over that period.

While this analysis looks at data from 2021, 2023, and 2024, it is important to note that this is not sufficient information to establish a trend that is representative of the whole sector and only a small number of local authorities are included. Instead, it represents a comparison over time, highlighting how the relative likelihoods have changed for the local authorities that responded in all three periods

3.12.1 Indicator 2: Appointed from shortlist

9
local authorities provided data on this indicate in 2021, 2023 and 2024.

Between 2021, 2023 and 2024, applicants from a Black, Asian or minority ethnic background, within the responding local authorities, have faced a decreasing likelihood of being appointed from the shortlist compared to white applicants, although the gap has fluctuated.

The likelihood of applicants from a Black, Asian or minority ethnic background being appointed from shortlist compared to applicants with a white ethnicity, within our sample, was 37% less likely in 2021, 51% less likely in 2023 and 39% less likely in 2024.

This analysis is based on nine local authorities: including eight local authorities providing information on their adult social care workforce and six providing information about their children's workforce **over the three years** of the SC-WRES.

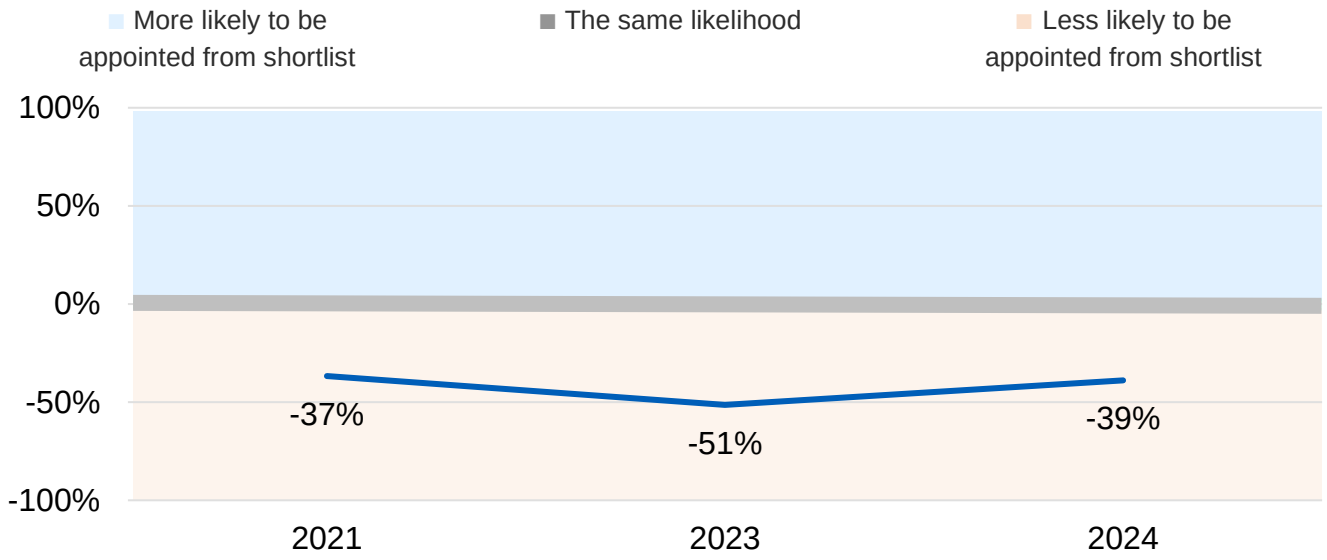
Information from the nine local authorities who provided data to the SC-WRES for this indicator, in 2021, 2023 and 2024 showed that **applicants from a Black, Asian or minority ethnic background were less likely to be appointed from shortlist, across all three years, compared to applicants from a white ethnic background.** The chart below shows the fluctuation in the likelihood over that time.

In 2021 applicants from a Black, Asian or minority ethnic background were 37% less likely to be appointed from shortlist compared to applicants from a white ethnic background (a relative likelihood of 0.63), in 2023 staff were 51% less likely (0.49 likelihood) and in 2024 staff were 39% less likely (0.61 likelihood).

Over the three years, applicants from a Black, Asian or minority ethnic background, within the responding local authorities, have faced a decreasing likelihood of being appointed from the

shortlist compared to white applicants, although the gap has fluctuated, from 37% less likely in 2021 to 39% less likely in 2024, with a dip to 51% less likely in 2023 (based on 9 local authorities).

Chart 30. Likelihood applicants from a Black, Asian or minority ethnic background being appointed from shortlist compared to applicants from a white ethnic background
Base. 8 adult social care local authorities and 6 children's social care local authorities
Source. SC-WRES 2021, 2023 and 2024



3.12.2 Indicator 3: Disciplinary Process

9
local authorities provided data on this indicate in 2021, 2023 and 2024.

Between 2021, 2023 and 2024, applicants from a Black, Asian or minority ethnic background, within the responding local authorities, were more likely to enter the formal disciplinary process, compared to staff from a white ethnic background. However the likelihood decreased over the three years.

In 2021 staff with a Black, Asian or minority ethnic background were, relatively 37% more likely to enter the formal disciplinary process, compared to staff from a white ethnic background, in 2023 staff were 29% more likely and in 2024 staff were 27% more likely.

This analysis is based on nine local authorities: nine local authorities providing information on their adult social care workforce and six also providing information about their children's workforce over the three years of the SC-WRES.

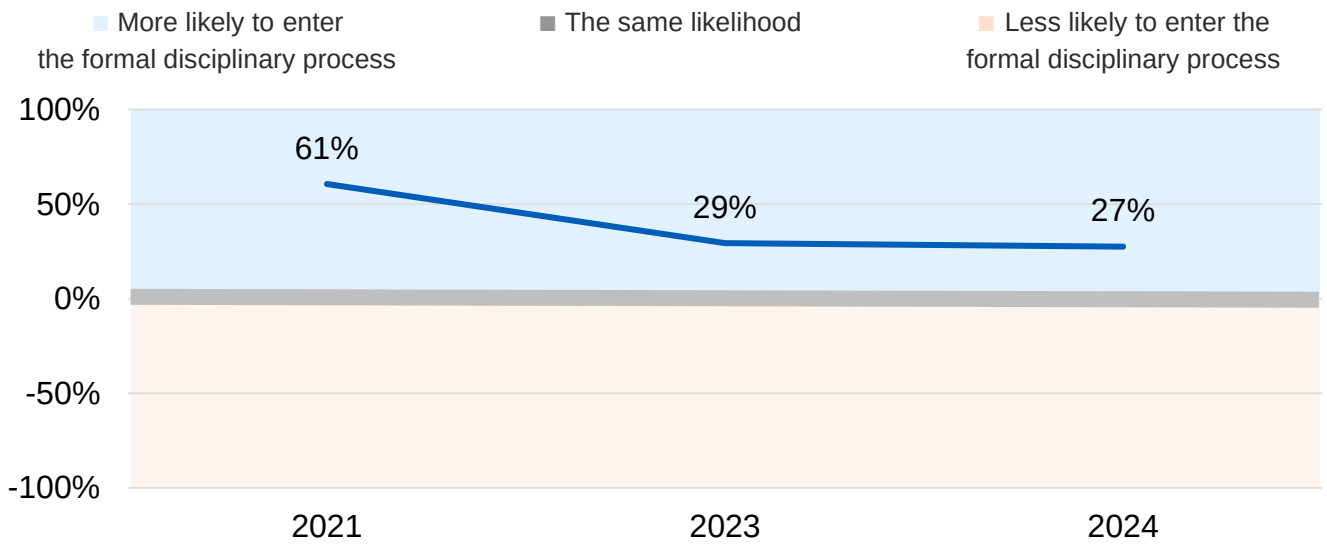
Information from the nine local authorities who provided data to the SC-WRES for this indicator, in 2021, 2023 and 2024 showed that **staff from a minority ethnic background were more likely to enter the formal disciplinary process over all three years, compared to staff from**

a white ethnic background in these nine local authorities. However, the likelihood decreased over the three years.

In 2021 staff with a Black, Asian or minority ethnic background were, relatively 37% more likely to enter the formal disciplinary process, compared to staff from a white ethnic background (1.37 likelihood), in 2023 staff were 29% more likely (1.29 likelihood) and in 2024 staff were 27% more likely (1.27 likelihood).

Over the three years, the likelihood of employees from a Black, Asian, or minority ethnic background from responding local authorities entering the formal disciplinary process compared to white employees decreased from 37% more likely in 2021 to 27% more likely in 2024.

Chart 31. Likelihood of staff from a minority ethnic background entering the formal disciplinary process compared to staff from a white ethnic background
Base. 9 adult social care local authorities and 6 children's social care local authorities
Source. SC-WRES 2021, 2023 and 2024



3.12.3 Indicator 8: Turnover of directly employed staff in the last 12 months

12
local authorities provided data on this indicate in 2021, 2023 and 2024.

Applicants from a Black, Asian or minority ethnic background, within the responding local authorities, were now more likely to leave their roles than they were in 2021.

In 2021 employees from a Black, Asian or minority ethnic background had the same likelihood of leaving their roles in the past 12 months compared to staff from a white ethnic background, in 2023 this had increased to 12% more likely and 11% more likely to leave their roles in 2024.

This analysis is based on 12 local authorities: 12 local authorities providing information on their adult social care workforce and seven also providing information about their children's workforce over the three years of the SC-WRES.

Information from the 12 local authorities who provided data to the SC-WRES for this indicator, in 2021, 2023 and 2024 showed that **staff from a minority ethnic background were now more likely to leave their roles than they were in 2021.**

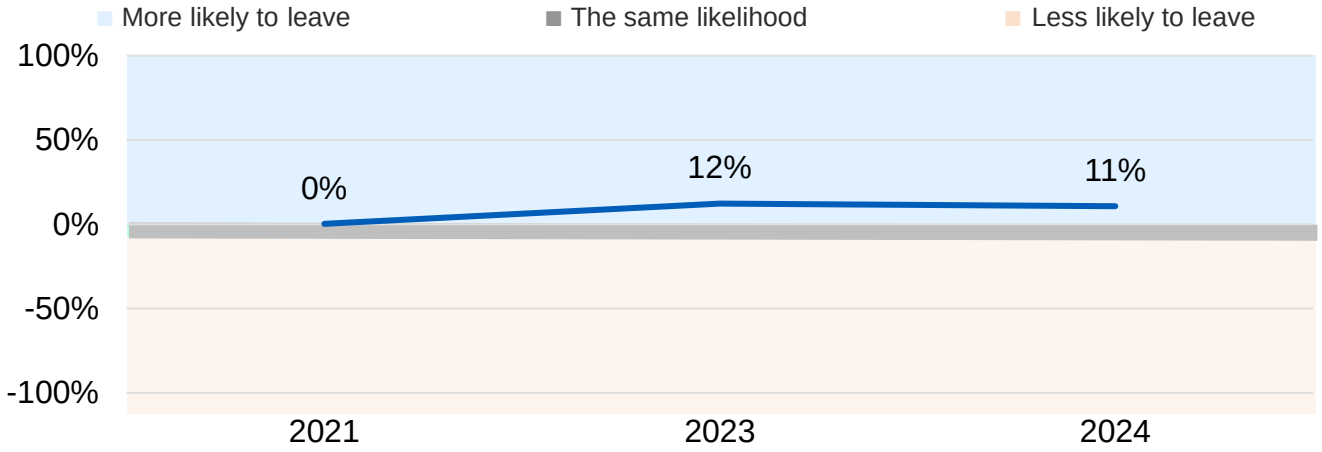
In 2021 employees from a Black, Asian or minority ethnic background had the same likelihood of leaving their roles in the past 12 months compared to staff from a white ethnic background (a relative likelihood of 1.0), in 2023 this had increased to 12% more likely (a relative likelihood 0f 1.12) and 11% more likely to leave their roles in 2024 (a relative likelihood of 0.11).

Over the three years, employees from a Black, Asian, or minority ethnic background have shown a slight increase in their likelihood of leaving their roles compared to white employees, moving from equal likelihood in 2021 to being about 11-12% more likely in 2023 and 2024.

Chart 32. Likelihood of directly employed staff from a minority ethnic background leaving the organisation during the last 12 months compared to staff from a white ethnic background

Base. 12 adult social care local authorities and 7 children's social care local authorities

Source. SC-WRES 2021, 2023 and 2024



3.12.4 Indicator 9: Senior manager membership roles

12
local authorities provided data on this indicate in 2021, 2023 and 2024.

Staff from a Black, Asian, or minority ethnic background were less likely to hold senior management roles compared with will from a white ethnicity in 2021, 2023 and 2024. The likelihood decreased over the three years.

In 2021 employees from a Black, Asian or minority ethnic background had the same likelihood of leaving their roles in the past 12 months compared to staff from a white ethnicity, in 2023 this had increased to 12% more likely and 11% more likely to leave their roles in 2024.

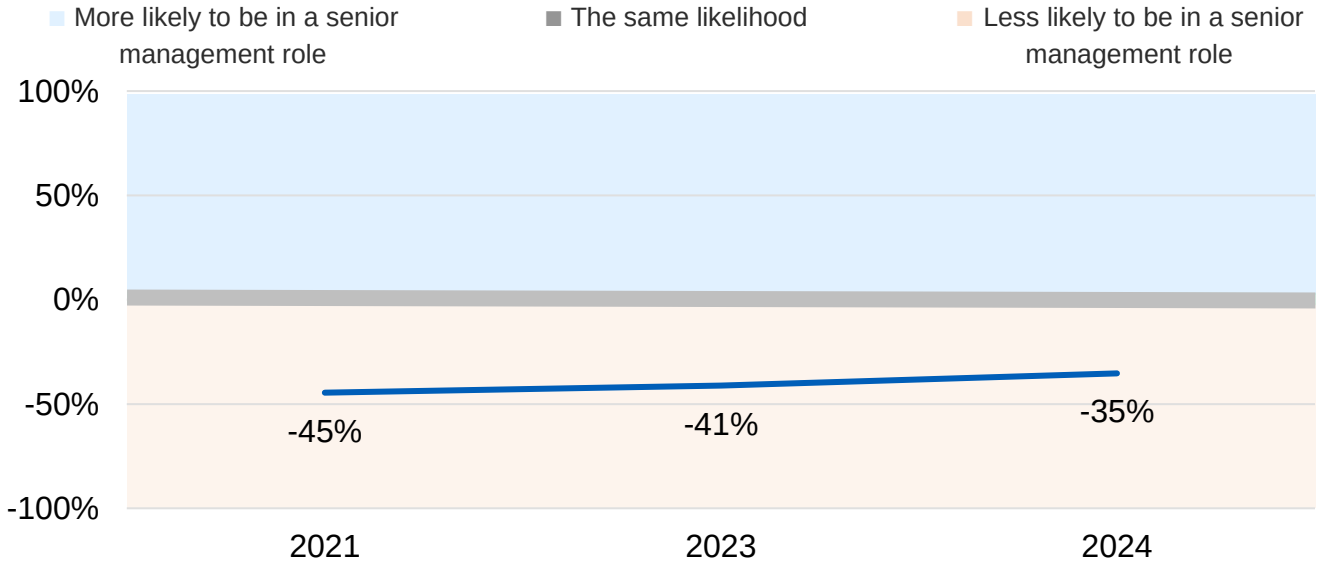
This analysis is based on 12 local authorities: 12 local authorities providing information on their adult social care workforce and seven also providing information about their children's workforce over the three years of the SC-WRES.

Information from the 12 local authorities who provided data to the SC-WRES for this indicator, in 2021, 2023 and 2024 showed that **staff from a Black, Asian, or minority ethnic background were less likely to hold senior management roles compared with the percentage of staff from a white ethnic background. The likelihood decreased over the three years.**

In 2021 employees from a Black, Asian or minority ethnic background were 45% less likely to be in senior management roles compared to staff from a white ethnic background (a relative likelihood of 0.55), in 2023 they were 41% less likely (a relative likelihood 0f 0.59) and were 35% less likely in 2024 (a relative likelihood of 0.65).

Although employees, from responding local authorities, with a Black, Asian or minority ethnic background were less likely to be in senior management roles compared to staff in all three years recorded, the gap is closing year on year.

Chart 33. Likelihood of staff from a Black, Asian, or minority ethnic background holding a senior management role compared to staff from a white ethnic background
Base. 12 adult social care local authorities and 7 children's social care local authorities
Source. SC-WRES 2021, 2023 and 2024



3.13 Lessons learnt, data

Data availability for some indicators and the capacity to analyse data (due to resource or confidence) was a challenge for many local authorities. Data education and support has become a growing aspect of the programme's work. We have refined guidance on all aspects of the data process to promote data literacy and a consistent and robust approach. For 2024/2025 we have begun to include step-by-step video guidance and tutorials on how to produce reports and how to carry this information across into the action plans.

Continuous improvement

4 What do we mean by a continuous improvement programme?

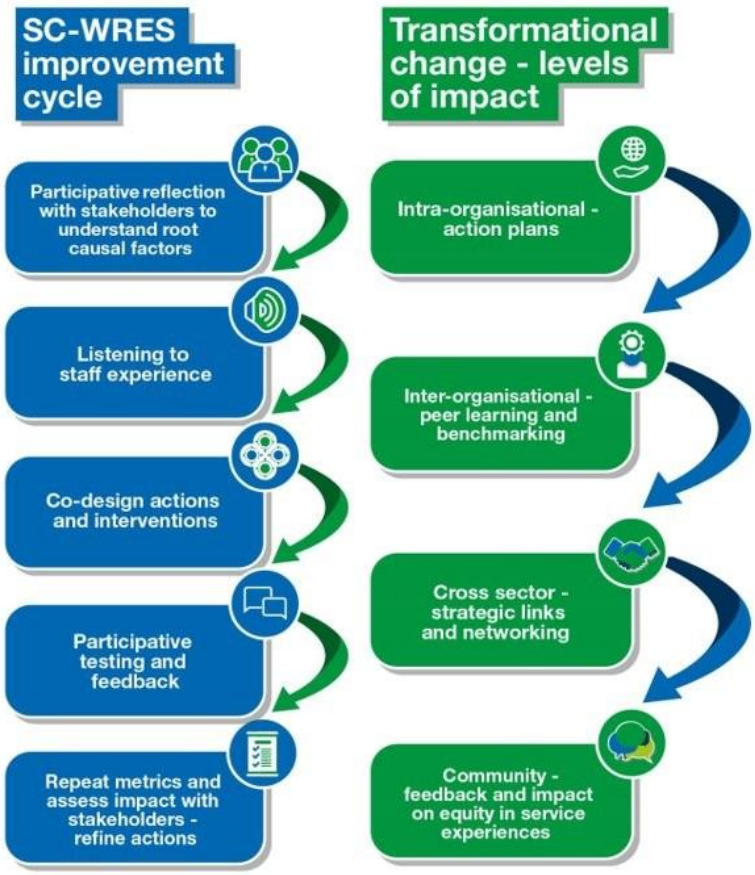
The SC-WRES is built on a continuous improvement approach, ensuring that progress is ongoing, structured and responsive to feedback. The programme is designed to evolve over time, with each of its three core elements, **data, peer support and action planning**, working together in a cycle of learning, reflection and enhancement.

In 2023/24, we strengthened our guiding principles and improvement model, making them more explicit to support evaluation and feedback at multiple levels. This approach ensures that improvements are integrated into the framework, enhancing delivery and impact within local authorities and, over time, improving outcomes for service users in the wider community.

By using this continuous improvement methodology, learning is an ongoing, adaptive process with distinct moments for reflection and enhancement, ensuring that the programme remains aligned with evolving priorities, strategic direction and available resources.

The SC-WRES improvement programme is designed to contribute and lead to transformational change. This multileveled approach is depicted below:

Diagram 3. Programme Continuous Improvement



The current SC-WRES model of continuous improvement[4] is evolving, and we want to highlight the operational importance and the aspirational next steps of the model more.

The SC-WRES has evolved. In 2021 we focused on data collection, in 2023 we introduced a continuous improvement methodology. We built on that in 2024 by bringing in a foundation in human rights, social justice and equality, and will build on the 5 key principles of a Human Rights-Based Approach to our work:

- **participation**
- **accountability**
- **non-discrimination and equality**
- **empowerment**
- **legality.**

We will share more details about this evolving model in the 2025/26 period.

Skills for Care is committed to developing a long-term impact evaluation and strategy to ensure meaningful race equity by learning what works. We currently have distinct evaluation phases which emphasise the interconnectedness of the work. This includes assessment of the need for the programme, evaluation and learning as we go (formative) and at the end (summative). We must learn what works so that we can achieve meaningful race equity.

With the breadth of local authorities participating and reflecting diverse communities and services, and with 13 local authorities participating in all three phases, we are getting a depth of insight (see section 3.12) into the application, change and impact of the SC-WRES which we can build on.

Insights from the wider social context, policy, and legislation surrounding social care, local government, and social justice are also crucial because Councils do not operate in a vacuum (discussed further in 4.2). For example, we have established a cross-sector ‘WRES’ national network with the NHS WRES team, ADASS, CQC, and Equality and Human Rights Commission, to share learning and best practices. This network will play a key role in developing an aligned approach to workforce race equality, recognising the interdependencies of the health and social care workforce, and fostering dialogue about the quality and impact of our work.

4.1 Building a sustainable programme

In 2023/24, the SC-WRES programme expanded to accommodate more local authorities, increasing the need for communication and support. We enhanced guidance, used different communication channels, clarified processes and boosted regional support.

[4] Continuous improvement is a systematic approach to enhancing processes, products, or services over time, based on reflection, data, engagement and continuous learning.

These stronger resources have been vital in implementing SC-WRES, especially as the engagement and involvement of local authority staff can vary throughout the 12-month period due to capacity, staff changes and change of priorities.

During phase 2, local authorities requested more regional focus and peer-to-peer support. In response, we facilitated regional meetings and introduced a “buddy-up” system to address specific issues and increase participation, especially in areas like the South-West, where participation could be increased.

Local authorities face resource and capacity challenges, which can limit their involvement in SC-WRES. To sustain the programme, we must demonstrate its value, reduce the burden on local authorities, and build a strong business case.

For long-term progress, strengthening data literacy and improvement capabilities is essential. Many local authorities lack the capacity to implement communication strategies or support sensitive discussions. Therefore, in 2024/25, we emphasised staff engagement in action planning and provided resources for building staff networks and examples of consultation through the Community of Practice.

In 2024, Skills for Care committed to participating in the SC-WRES Improvement Programme internally, as an organisation, to help better understand, analyse, improve and take action on race equity. We will be sharing our action plan and other information on our website in summer 2025 and have shared, consulted and gathered feedback from our staff teams. The special indicators that make up the SC-WRES data collection metric help to produce a clear picture of areas for improvements. While we are pleased to have committed to the programme, and some of the results were encouraging, they were disappointing in areas such as senior leadership representation, which is evident across the sector. We need to do better to ensure that Skills for Care is representative and diverse at all levels and better at finding ways to encourage diversity and opportunities for all. Here’s some further information about our EDI work.

4.2 Community of practice

The Community of Practice sessions are a key element of the improvement programme and provide a non-judgemental space, where confidentiality is encouraged, exclusively for local authorities to come together with their peers, subject matter experts and the SC-WRES team. Monthly sessions provide an opportunity to discuss the programme and receive guidance on understanding the indicators, developing local reports and action plans, and best practice while collaborating to solve challenges effectively.

Daniele Brennan, Equality and Workforce Wellbeing Manager, WRES Expert Phase 1 said

"It's been a good experience having the ability to join and access the community of practice sessions run by Skills for Care, even as a WRES expert, because how we operate as local authorities is different. Everyone has been kind, warm, and welcoming, and are there to support one another not only inside, but outside of the meetings too."

We actively involve and encourage the contribution of global majority leaders to the Community of Practice and encourage a climate where 'uncomfortable' conversations can be broached.

The Community of Practice sessions also help the SC-WRES team identify areas for improvement, with regular virtual polls conducted in the sessions that allow local authorities to feedback on the impact and usefulness of the session.

Diagram 4. Example schedule of the community of practice sessions and focus of the agenda

4.2.1 Evaluation of Community of Practice sessions

Community of practice session poll results
Over many Community of Practice sessions, we used standardised polling to assess the impact on participants' learning and confidence. We asked the same question at the start and end of each session.

Results showed increased confidence levels in both the session topics and the overall SC-WRES programme. Confidence generally increased as the programme developed.

For detailed methodology and confidence levels, see Appendix 1, section 5.6.

Community of Practice engagement and understanding
The SC-WRES team monitors attendees' engagement and understanding during each session, ensuring transparency with local authorities. We aim to improve this process with better software support in the future.

We assess session reception through live question and answers, Teams chat comments, and queries to the Equality and Rights inbox. We continually evaluate recurring themes and adjust message delivery as needed. We also review how the SC-WRES support function can better assist local authorities in understanding and progressing through the programme.

After each session, the SC-WRES team provides follow-up materials and resources identified as useful by local authorities. This "You said, we listened, we did" approach reinforces the value of the Community of Practice, instils confidence, and strengthens trust in the Improvement Programme.

National Community of Practice meetings have been well attended, with an average of 120 participants monthly. These meetings follow a structured schedule aligned with the improvement cycle, promoting consistency and peer learning.

Early adopters have enthusiastically supported mentoring new SC-WRES organisations, especially through breakout rooms during key stages like Action Planning. We aim to enhance this with better technology in the future. We have also expanded regional presence and collaborate with ADASS branches to facilitate smaller group meetings focused on regional priorities.

4.3 Action plans

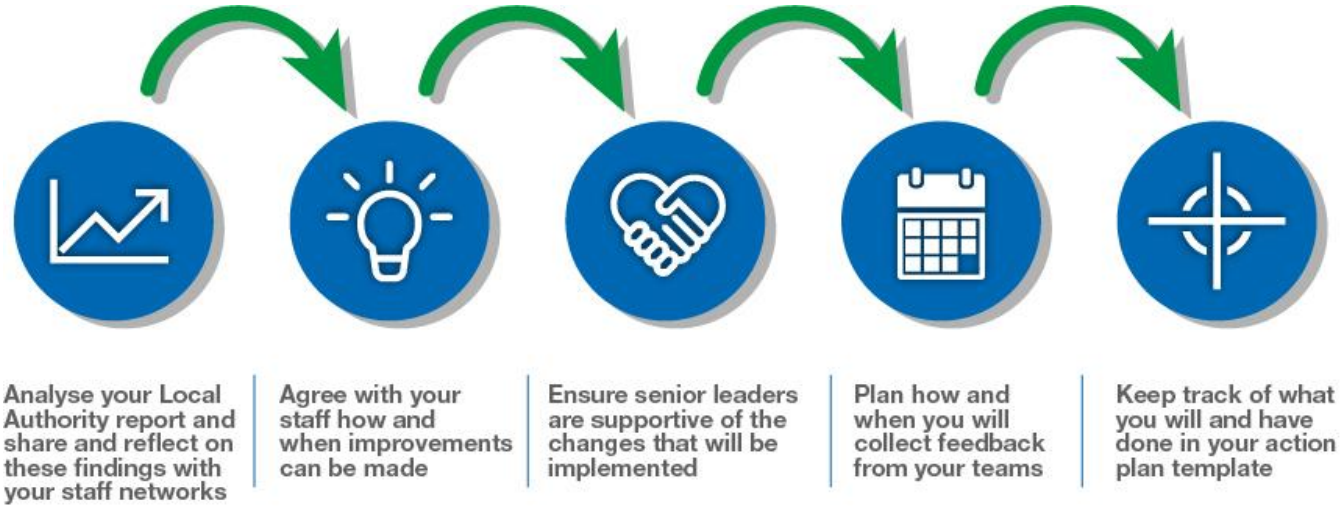
4.3.1 Action plan information, case studies and resources

Action plans are a vital output of the SC-WRES programme which show how local authorities have translated their data report into improvement. Once local authorities have their data findings the next step is to share these internally with senior leaders and staff networks, reflect and consult to agree on achievable actions and the development of an Action Plan (see diagram 4 above.)

The Excel data collection tool and supporting resources are used by employers to ensure that data findings are acted on within the continuous improvement framework. The data collection tool informs the individual data report which then informs the Action plan.

This is a diagram to illustrate the areas local authorities need to consider before they start their plan.

Diagram 5. Steps to creating and implementing an action plan



Action plans outline the short-term, mid-term and long-term actions local authorities will take to address the data findings related to each indicator. They also specify how actions will be tracked and determine when progress has been made. Not all actions are achievable within the first year of the plan and should be reviewed in subsequent phases of the SC-WRES continuous improvement programme. They should be underpinned by anti-racist strategy and vision and bring together the data analysis and engagement with staff. Local Authorities are guided through how each step in the SC-WRES improvement programme informs the next step and are provided with relevant tools and support.

4.3.2 Action plan case studies

Colum Conway, Chief Executive at Social Work England reflects their view on racism within the social care sector said

"Over the past two years, Social Work England has continued to analyse diversity data to give us greater insight into our fitness to practise processes. As part of this work we have collaborated and shared our insights with Skills for Care to support the Social Care Workforce Race Equality Standard (SC–WRES) to assist participating organisations to review their fitness to practise data and processes to help ensure fair and appropriate referrals. We have also shared our findings with key contacts across local authorities. This has led to rich discussions about shared challenges and local differences. We are using these insights to co-produce some 'fair referral principles' to support those making a referral. As a regulator, we strive to embed equality, diversity and inclusion into every aspect of how we regulate social work, we look forward to continuing to work with Skills for Care and the broader sector in taking joint action to bring these values into every aspect of social work".

Daniele Brennan, Equality & Workforce Wellbeing Manager, SC-WRES Phase 1 said

"At Dudley Council, we have set out a key commitment to influence our corporate qualities suite of work in line with the SC-WRES. Being a large, complex organisation, a subsequent amount of time and effort was spent on developing the subsequent action plan after data submission. To make this plan robust and successful, the following steps were followed, which would be advantageous to any local authority.

Keeping employees engaged during change by involving them in decision-making and creating a regular feedback loop gives them a sense of ownership and reduces resistance. Secondly, identify key stakeholders within the organisation, to help them draft and shape the action plan. Key stakeholders sit at all levels within organisations and aren't just at the top of the hierarchy. And finally, development and organisational rationale. Understand the 9 indicators metrics, and what they mean to your organisation. Where are your current strengths and weaknesses? In which indicator metric would you like to see the biggest impact? Following simple steps can stop this work being overcomplicated and lost."

Debra Bradshaw, Equalities Advisor, People Service from Lancashire County Council said

“Lancashire County Council has been involved with the Social Care Workforce Race Equality Standard (SC-WRES) since the test pilot phase in 2021. Being part of the programme has enabled the County Council, to complete further analysis of data within our adults and children's social care services, to address any additional areas that we need to put a spotlight on around race inequality within the organisation.

The biggest impact that SC-WRES has made, was by initially adding specific questions into our annual staff survey, which for the first time enabled us to capture data and gain feedback on any abuse, bullying or harassment that employees may have been facing. These questions came in as a direct response of being part of SC-WRES. The authority has been extremely proactive in its approach, enabling honest and at times difficult conversations to take place. The County Council has tackled the results head on, addressing the issues raised across all service responses not just those within social care. The organisation has now implemented 4 key priorities to address the findings compiled from the annual survey. The number one priority is to implement an organisational wide 'Zero Tolerance' approach to tackle inequality and discrimination and to re-enforce the importance of having a culture of inclusion, acceptance and respect.”

Effective Staff Engagement

Lincolnshire Council has developed a comprehensive communication strategy to share information about the SC-WRES and actively engage staff. They have adopted 'outside of the box' thinking, with innovative and varied approaches to ensure that the SC-WRES remains a visible and ongoing priority across the organisation. Their engagement initiatives include:

- **A SC-WRES section in their Inclusion Matters SharePoint**. A dedicated space for staff to access key resources and updates.
- **Bi-monthly SC-WRES staff engagement sessions**. Providing regular opportunities for discussion, feedback and collaboration.
- **Transparent sharing of summarised feedback data and findings**. Helping staff understand the impact initiatives
- **A podcast**. Raising awareness of the SC-WRES and sustaining ongoing conversations about workforce race equality.
- **Leadership updates**. Ensuring senior leaders remain actively involved in promoting and embedding the SC-WRES
- **Integration into key events**. Including SC-WRES in events such as Black History Month, to maintain visibility and reinforce the importance of race equality
- **Spotlight series**. Showcasing examples of best practice and celebrating diversity within the workforce.

By designing a staff engagement that helps ensure clear communication, robust feedback mechanisms, and continuous engagement from staff regarding the SC-WRES, Lincolnshire Council is proactively addressing disparities and fostering a more inclusive working environment.

Skills for Care strengthened the Action Plan process in 2023/24 by providing a structured template informed by clear criteria for what constitutes an effective plan. In addition, support sessions and peer learning opportunities are available through the monthly Community of Practice sessions. Local authorities submitted their Action Plans to Skills for Care, and we provided individual feedback on submitted plans and thematic feedback (see section 4.4 below) across plans on common strengths and areas for improvement, which can be found below. These plans will serve as a valuable reference point for this current phase 2 (2024/25) and revisiting these plans can offer insights in to progress made, highlight areas for further development, and help identify any challenges encountered.

4.4 Thematic action plan feedback

Skills for Care reviewed action plans from Phase 1 (2023/24) and provided thematic feedback to local authorities. Not all authorities submitted plans, so we identified barriers and ways to improve future engagement. We analysed 13 available plans to find common themes, highlighting key areas of progress and improvement. This feedback helps clarify what to include in action plans and how to strengthen them, aiming to increase engagement in Phase 2 (2024/25). We identified the following themes below.

4.4.1 Areas of progress

Stakeholders, governance and accountability
The SC-WRES was well integrated into broader corporate equality initiatives, developments, and wider EDI workforce strategies. This included collaboration with key stakeholders such as employee networks, unions, councillors, and regional EDI groups to strengthen accountability.

Workforce diversity improvement actions
Action plans strongly focused on indicators 1 and 2, with positive efforts directed at improving workforce diversity, recruitment and retention activities. Key initiatives included anti-racism training, reverse mentoring, talent development and Positive Action, as well as enhanced recruitment practices such as anti-bias interview panels and improved interviewer training.

Leadership
There was prioritisation of leadership development to build aspirations for progression amongst global majority staff within the organisation and to reduce bias, with programmes aimed at global majority staff and aspiring managers across Adults and Children's Social Care.
The importance of managers across Equality, Diversity and Inclusion (EDI) work was recognised, with research being conducted into their training needs, toolkits and support schemes that enable managers to take accountability for EDI outcomes.

4.5.2 Areas for improvement

There were gaps identified in initiatives designed to promote inclusive practice across all levels of the organisation such a fostering inclusive teams and development of senior leader's roles in EDI.

Plans could include more detailed reflection on past learning and the impact of previous actions, such as clear rationales behind specific interventions that reference the organisation's culture, to provide further context, as well as establishing clear links between the indicators and actions.

Utilisation of the Skills for Care action plan template would further improve the clarity and structure of future action plans.

4.5 Further resources

This section provides information about further resources from Skills for Care, the Care Quality Commission, Equality and Human Rights Commission, the NHS and key supports of the SC-WRES programme.

- **Skills for Care resources**

Please visit our Workforce Intelligence website to access reports and visualisations about adult social care, including information at various geographic levels and topic areas such as factors affecting turnover and international recruitment.

Please visit our Skills for Care website for more information and resources about supporting a diverse workforce, including

- Guidance on creating an inclusive organisation
- LGBTQ+ Learning Framework
- Values-based recruitment
- Our review of the benefits of recruiting and retaining a diverse workforce for organisations
- Moving up programme

- **Care Quality Commission resources**

To find out more about the CQC's Local Authority assessment framework please visit https://www.cqc.org.uk/guidance-regulation/local-authorities/assessment-framework

To find out more about humanity into action from the CQC please visit https://www.cqc.org.uk/about-us/our-updated-human-rights-approach

To read CQC's WRES Annual Report 2023 please visit https://www.cqc.org.uk/about-us/our-strategy-plans/equality-human-rights/data-standards/wres-report-2023

- **Equality and Human Rights Commission**

To read more about the Equality and Human Rights Commission Guidance on the Public Sector Equality Duty please visit https://www.equalityhumanrights.com/guidance/public-sector-equality-duty-psed

To read the EHRC report please visit https://www.equalityhumanrights.com/our-work/inquiries-and-investigations/experiences-health-and-social-care-treatment-lower-paid

To read the EHRC and Human Rights website please visit https://www.equalityhumanrights.com/human-rights/what-are-human-rights

- **NHS WRES and NHS Patient and Carer Race Equality Framework**

Find out about the NHS Patient and Carer Race Equality Framework to visit https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/pcref/

Find out more about the NHS Workforce Race Equality Standard https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/equality-standard/

- **Find out more about key supports of the SC-WRES programme**

ADASS- https://www.adass.org.uk/

ADCS- https://www.adcs.org.uk/

Black and Asian Leadership Initiative- https://thestaffcollege.uk/programmes/black-and-asian-leadership-initiative-bali/?interests=12

Leading in Colour: The Fierce Urgency of NOW- https://thestaffcollege.uk/leading-in-colour-the-fierce-urgency-of-now/

Anti-racist systems leadership to address systemic racism: Strategic Briefing (2024)- https://www.researchinpractice.org.uk/all/publications/2024/march/anti-racist-systems-leadership-to-address-systemic-racism-strategic-briefing-2024/

Leading for Longer: New report issues call to action on high turnover of leadership roles in children's services- https://thestaffcollege.uk/publications/leading-for-longer/?interests=41-40-14

Race Equality Foundation- https://raceequalityfoundation.org.uk/ and the London Anti Racism Collaboration for Health (LARCH)-https://raceequalityfoundation.org.uk/health-care/london-anti-racism-collaboration-for-health-larch/

London Anti-Racism Collaboration for Health (LARCH)- https://anti-racism.london/race-equity-maturity-index/

Anti-Racism Resources - BASW England- https://basw.co.uk/policy-and-practice/resources/anti-racism-resources-basw-england

Appendix 1: Methodology of analysis

5 Appendix 1, methodology of analysis

This appendix provides more information about the methodology of the 2024 SC-WRES data collection. It includes information about how we collected and analysed data, on response rates by region and per indicators, and the how the staff within responding local authorities compare to the total adult social care sector and the population of England.

5.1 Small numbers and data sharing

This report uses information based on aggregated data only and does not contain any identifying information relating to individuals. Data shown in this report are a total of all 73 responding local authorities. However, response rates vary by indicator, so if bases were low due to lower response rates for certain indicators, or due to filtering data quality, then data is supressed or not shown with a level of detail that could be unreliable.

Skills for Care's Workforce Intelligence team conducted the analysis of both ASC-WDS data and SC-WRES data. We are the leading source of workforce intelligence for the adult social care sector in England and are experts in adult social care insight. The Workforce Intelligence analysts follow the UK Statistics Authority's code of practice, and work to the standard of the 'five safes' making it a priority to keep these at the forefront of mind when conducting research, analysis, storing and sharing any research or data. We always make sure that our research and outputs are appropriate, trustworthy and that there is no risk of misuse or confidentiality breach. When creating outputs, we always adhere to statistical disclosure controls.

5.2 Data collection process

From 1 September to 30 October 2024, participating local authorities were asked to provide their SC-WRES data return. A number of local authorities were granted an extension into November.

Data was submitted to Skills for Care in an Excel data collection tool. Employers provided their data about the social care staff by ethnicity for nine indicators. When the local authority had prepared the data, they submitted via a OneDrive transfer.

Local authorities could choose to provide data about their adult social care, children's social care or both workforces. All 73 local authorities provided data about adult social care and 43 of the 73 also provided data about children's social care. Response rates varied between indicators, please see section 3.2 for more details.

As the local authority populated the data collection tool, they were presented with analysis of their own data. This analysis included charts and tables showing percentages and relative likelihoods for each indicator. This analysis was designed to be used by employers to inform their action plans.

Once Skills for Care received the data, we performed data quality checks, please see section 5.4 for more details.

5.3 Relative likelihood

The relative likelihood is the percentage (or proportion) of one group experiencing an outcome, divided by the percentage (or proportion) of another group experiencing an outcome. The closer a relative likelihood is to one, the greater equality there is between the two groups. If a likelihood is less than one, this means one group is less likely to experience an outcome than the other group, and vice versa.

If relative likelihood rate is less than 0.80 or more than 1.25, it is suggested that ongoing monitoring from analysts and priority for policy action could be considered.[5]

This year, we have provided percents alongside the relative likelihood calculation. For example, if the relative likelihood is 1.20 then that group is 20% more likely to have that experience than the other group; the relative likelihood is 0.80 then they are 20% less likely to have that experience.

5.4 Data quality checks and overview

One of Skills for Care's core values is to use our data and insight to provide a solid evidence base about the adult social care workforce and to understand trends. This helps to empower the sector to implement positive change.

Skills for Care's Workforce Intelligence team are committed to the three pillars of trustworthiness, quality and value, and to the principles of the Code of Practice for Statistics. As part of this, we have methods in place that help ensure we produce assured statistics. Several methods are used to quality assure the data that is collected as part of the SC-WRES, including checking and approving data at the point of collection, and further data quality checks are made when creating summary statistics and this report.

Rigorous data quality checks means data limitations are minimised, and our outputs are as reliable, up-to-date, accurate and consistent as possible.

Examples of the checks include comparisons to the ASC-WDS data to see if responses were within an expected range, cross-checking responses between indicators to check totals, and considering if the open-ended responses suggested the data was based on correct information with consistent definitions used across local authorities.

The outcome of each data quality check was reported back to each local authority. Data was either 'within expected range' or feedback was made. In many cases, the local authority

[5] https://www.gov.uk/government/publications/using-relative-likelihoods-to-compare-ethnic-disparities

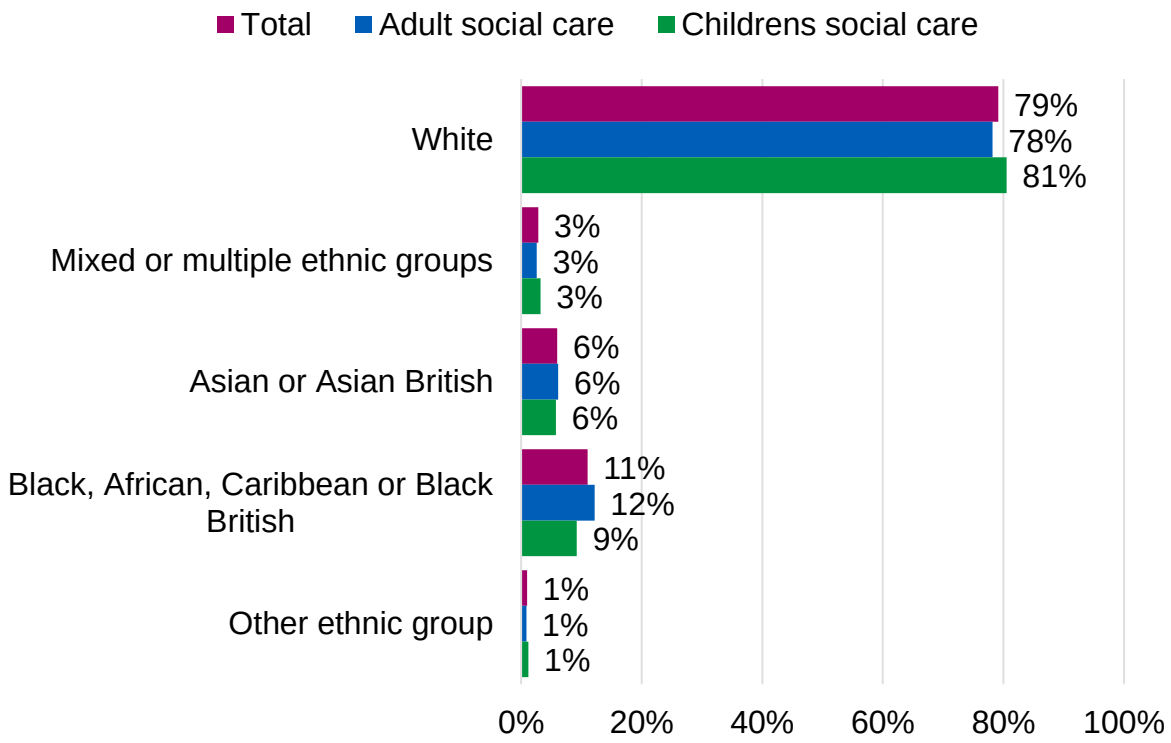
provided clarification, provided missing data, or confirmed the data was not going to be provided to this submission. Where data quality was not within the expected range, the data was excluded from this report.

5.5 Staff overview

The first question local authorities were asked was the number of staff they employ by ethnicity. There were 19 ethnicities on the list as well as 'not known'. These were then grouped into five groups. The following two charts show the ethnicity profile of the staff within the responding 73 (of 73) adult social care local authorities and 43 (of 43) children's social care local authorities. In total, there were 97,900 staff reported, comprised of 58,600 within adult social care and 39,300 in children's social care.

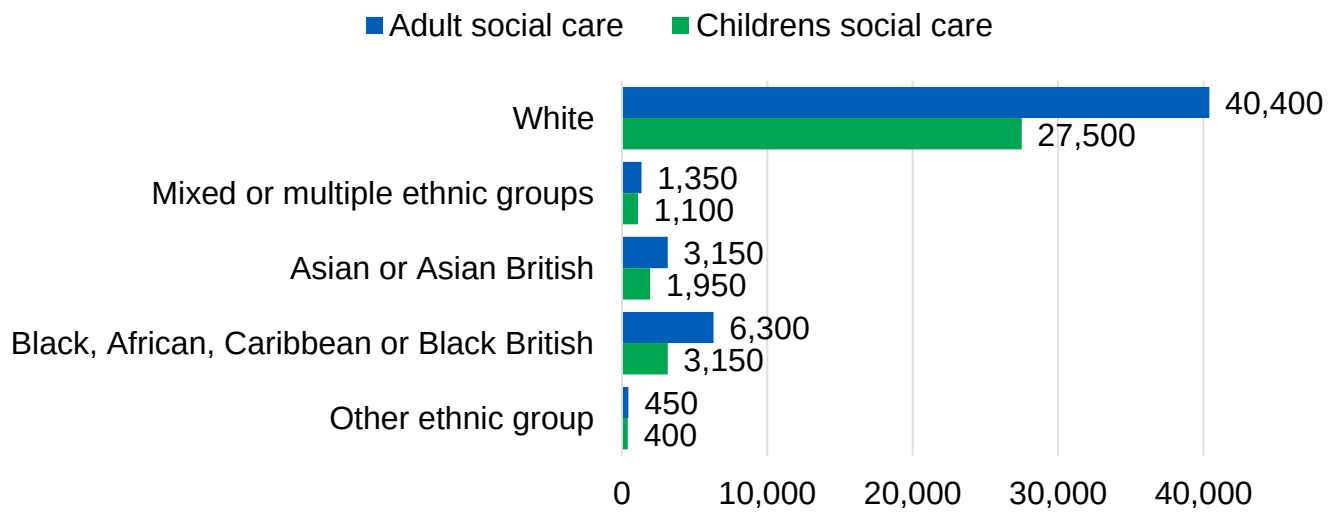
The chart below shows staff by five ethnicity groups. This chart excludes those where ethnicity was not known. The chart shows that the ethnicity groups were very similar between adult and children's social care, with a difference of only three percentage points. This will be, in part, due to the population of the local area and therefore the recruitment pool being the same for all employers.

Chart 34. Ethnic profile of responding local authorities as percentages
Source. SC-WRES, 2024



The chart below shows the same information but as a count of the number of workers who are included in the SC-WRES. Please see charts 4 and 5 in section 3.2 for information about representativeness of the SC-WRES and the whole adult social care local authority employed workforce.

Chart 35. Ethnic profile of responding local authorities, as numbers
Source. SC-WRES, 2024



5.6 Evaluation of community of practice sessions

Over the course of seven of the last eight Community of Practice sessions, a standardised polling method was employed to assess the impact of session content on participants' learning and confidence. The method involved posing the same question to attendees both at the start and end of each session. This approach allows for direct comparison of how participants' understanding and confidence have shifted because of the session's content.

Pre-session poll: At the start of each session, participants were asked to rate their confidence in the topic being discussed. The question was framed to capture their initial understanding and preparedness, with a scoring scale from 1 to 5 (1 being low confidence, 5 being high confidence).

Post-session poll: At the conclusion of each session, the same question was posed to the participants, allowing them to reflect on their learning and confidence after engaging with the session content. Again, participants rated their confidence on a scale of 1 to 5.

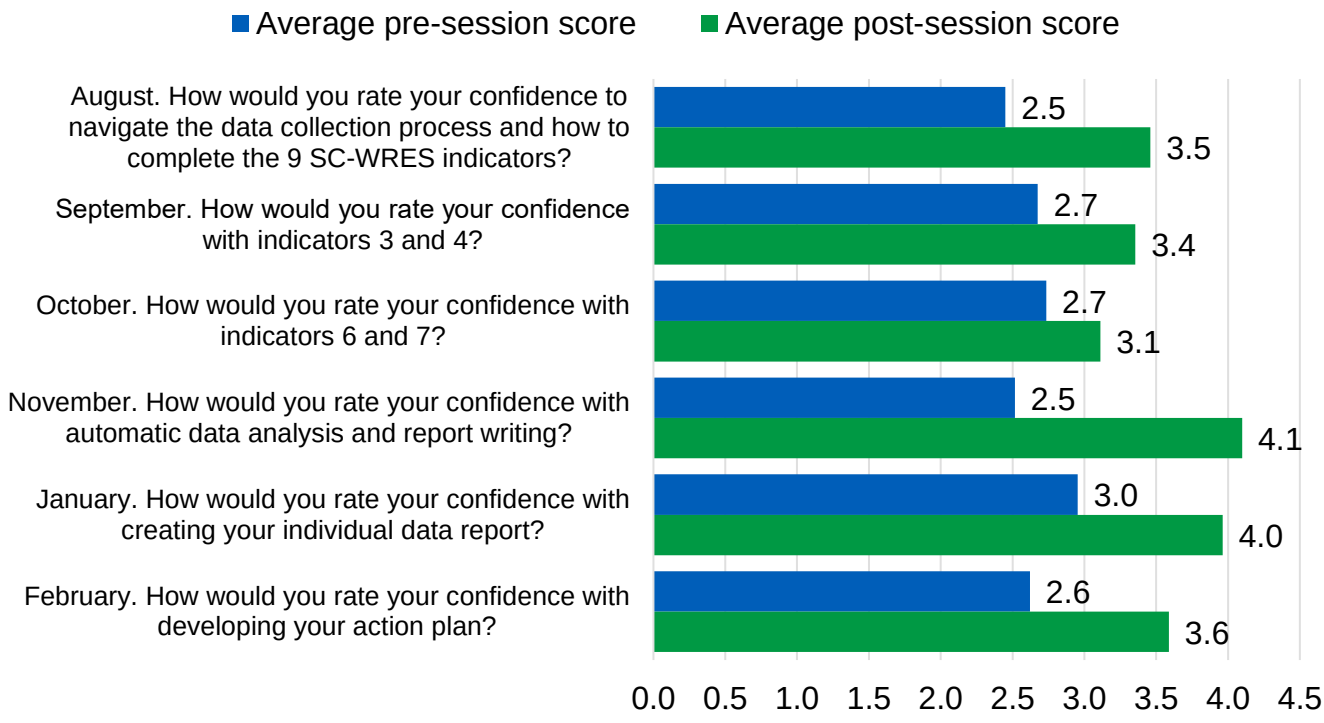
Reasoning behind the method: The pre- and post-session polling method was chosen to provide a clear, quantifiable measure of the session's effectiveness in enhancing participants' confidence and knowledge. The use of a consistent, simple scale (1-5) makes it easier to analyse trends across sessions, providing a clear understanding of areas where confidence improved.

Asking attendees to reflect on their confidence before and after the session encourages them to consider what they've learned and how their perception of the topic has evolved. This method also allows us to assess the immediate impact of the session content on the participants, focusing specifically on how it influences their confidence and learning.

The chart below shows the questions asked at each session, their average score pre- and post-session.

Chart 36. Average confidence in community of practice session topics, pre- and post-session

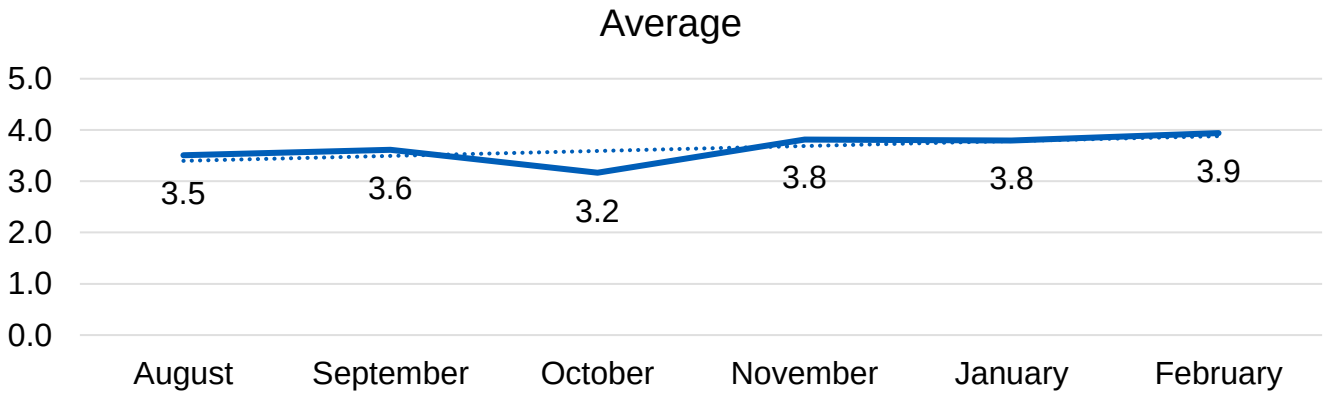
Source. Skills for Care evaluation of community of practice sessions



All sessions showed an increase in participants' confidence levels, with post-session averages consistently higher than pre-session scores.

Chart 37. Average confidence in the overall SC-WRES programme, at the end of each community of practice session

Source. Skills for Care evaluation of community of practice sessions



The chart above shows the average confidence in the overall SC-WRES programme after each of the community of practice sessions. The overall trend is that confidence increases as the programme develops.

Keeping informed and register your interest

To be kept up to date with the SC-WRES programme or to register your interest, as a local authority, to be involved in a future SC-WRES programme then please email us at equalityandrights@skillsforcare.org.uk

Skills for Care
West Gate
6 Grace Street
Leeds
LS1 2RP

T: **0113 245 1716**
E: **info@skillsforcare.org.uk**

skillsforcare.org.uk

facebook.com/skillsforcare

linkedin.com/company/skills-for-care

SC-WRES improvement guidance and action plan

The Social Care Workforce Race Equality Standard (SC-WRES) is a data-informed improvement programme which ensures action planning is locally relevant and that impact is evidenced over time. Reflecting on data gathered against the nine metrics of the SC-WRES provides a powerful window into your organisational culture, processes and practices which can drive improvement in the key areas that shape workforce equality.

1. Leadership (metrics 1 and 9)
2. Staff voice (across all metrics)
3. Culture (across all metrics)
4. Progression and staff development (metrics 2 and 5)
5. Recruitment and retention (metrics 2 and 8)
6. Performance and fairness (metrics 3 and 4)
7. Community impact (metric 9)

The SC-WRES pays particular attention to the quality of dialogue and decision-making through which strategic actions on workforce equality are developed, especially how co-produced, evidence-informed and accountable this is.
Reflection on the metrics generates causal and system questions which may not have been considered before and fosters sustainable solutions.

This document will take you through the stages of action planning we expect the organisation to establish.

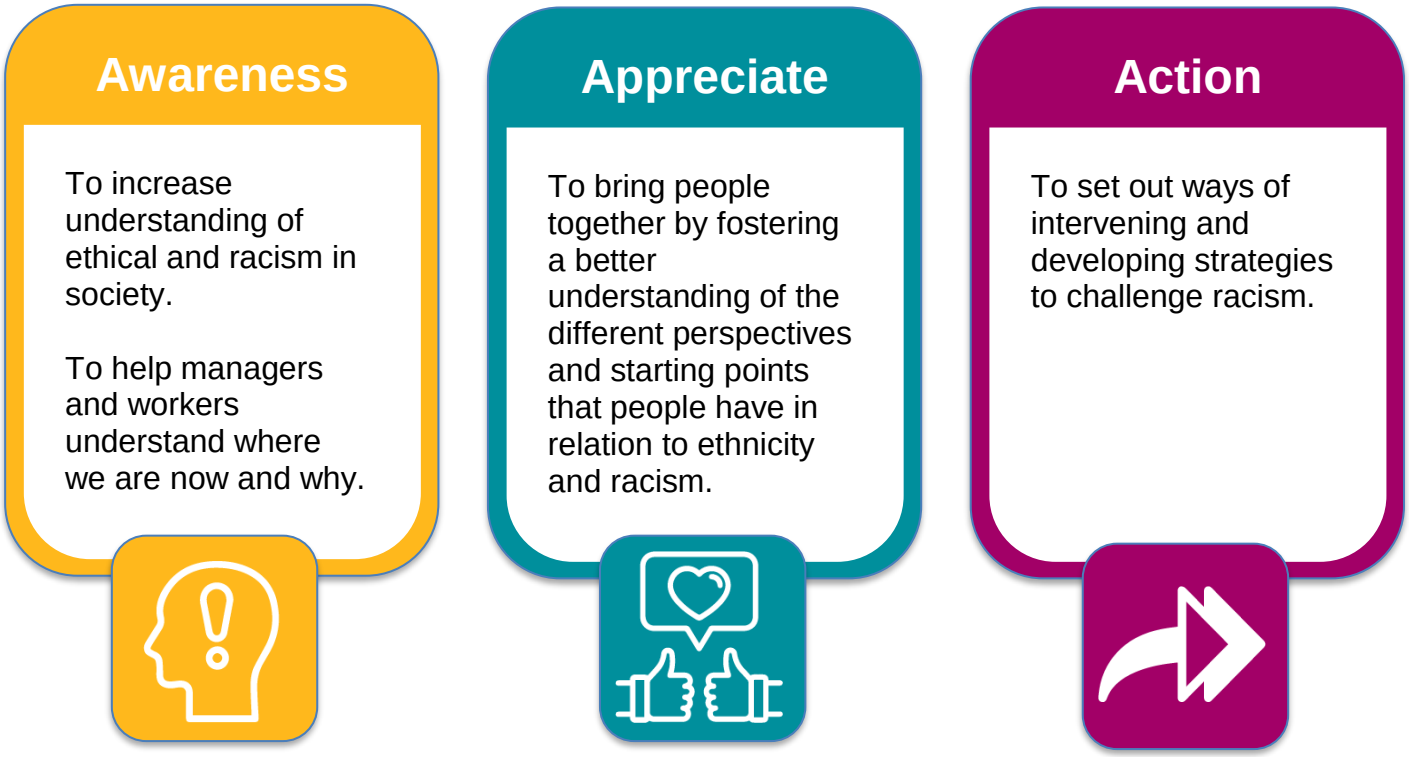
Step 1: Preparing the ground

Establishing a SC-WRES project group and lead member is the first step. The project group should include representatives from across the organisation, drawing on different areas of expertise as needed through the planning process, and develop a communication plan. Group members could include staff representatives, Principal Social Workers, human resources (HR) partners, equality diversity and inclusivity (EDI) leads and communications leads. It should hold the authority to convene meetings for action planning, set up consultations and support sign-off plans.

It's important to inform staff at all levels of the process and consider your current culture for engagement.

Skill for Care 3 A's Model is a useful tool to help staff to understand why it's important for everyone to engage in open and courageous conversations. It begins by helping people to become **aware** of the issues experienced by others. That can be in your organisation or in any sphere of your life and working practices. It also helps you to **appreciate** your own starting point. That will support you to be clear about where you want to get to so that you can explore the **action** that you can take to achieve this.

3 A's Model

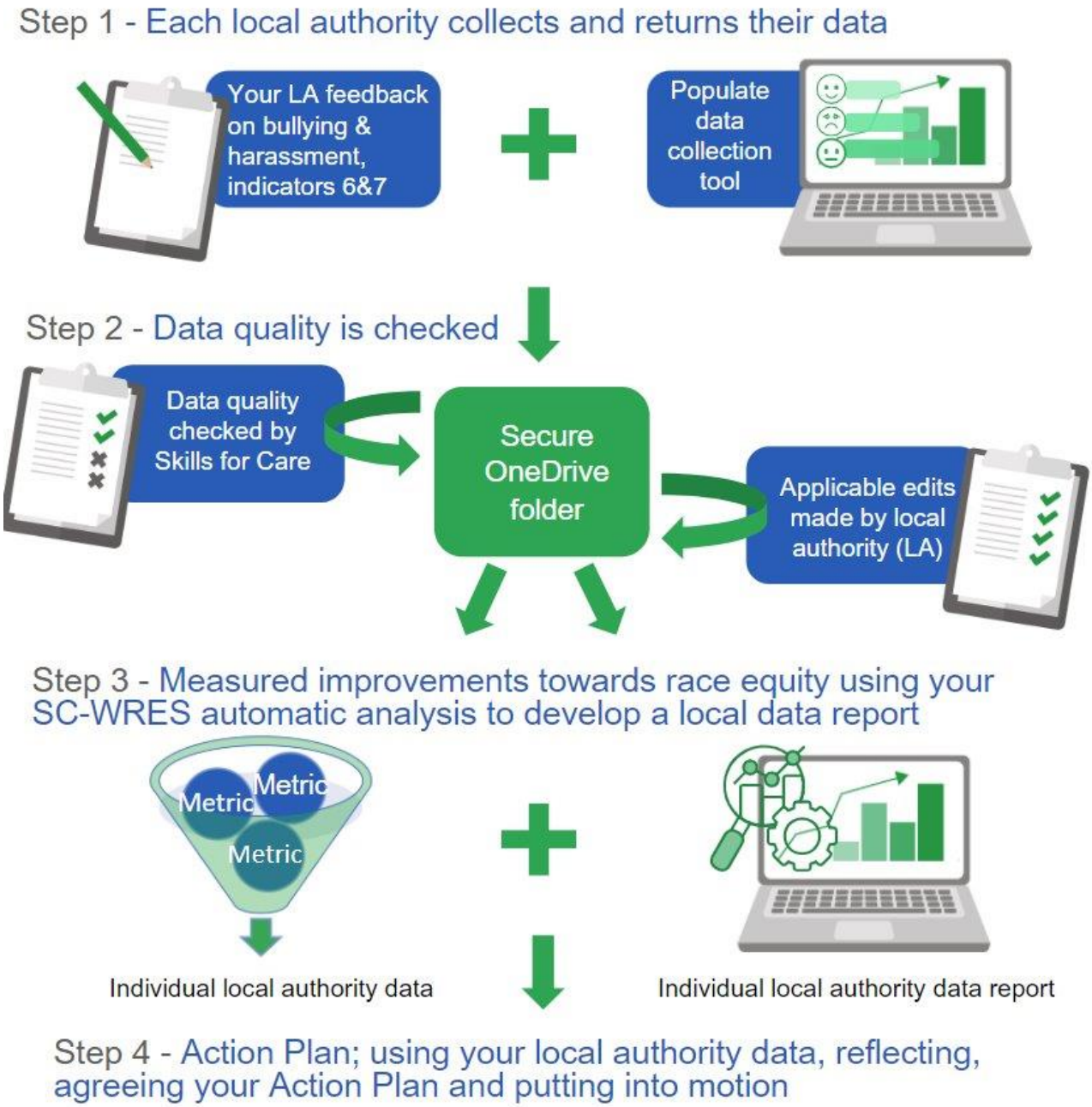


Step 2: Metric analysis and sense making

(SC-WRES project group lead)

Here the data from the nine metrics are discussed and preliminary findings are considered in the local context. Key messages and topics are identified for wider discussion. The following model illustrates the data collection, your local authority report and action plan process.

How to – data flow: Social Care Workforce Race Equality Standard (SC-WRES)



Step 3: Checking findings, data report and developing actions

(Wider consultation with staff and others)

Interpret your data and create a report using the 'Data Report template'. Share your findings widely within your organisation at all levels to gain feedback and potential solutions are gathered.

There are opportunities for SC-WRES leads to share emerging ideas within the monthly thematic sessions, SC-WRES Teams channel and other peer-to-peer support. You'll consider wider evidence and support available in relation to your issues and themes.

Step 4: Final action plan

(SC-WRES project group lead with selected staff advisor and other key decision makers)

There is deeper reflection on the preliminary decisions about solutions and how the organisation knows that what it plans to do will work and what success looks like. There should be interrogation by stakeholders to make this robust and sustainable. Use your 'Data Report' to inform and create your 'Action plan'.

Discussion would consider what interventions have worked in the past, what the evidence base is and issues of cost vs impact. Specific interventions, eg. leadership programmes and training, should be explored. A final priority list should be signed off, which forms a comprehensive plan.

If you submitted an Action Plan for 2023, you will be expected to review and update this and submit a new Action Plan for 2024 showing your learning, refreshed actions from your most recent data.

Step 5: Evaluation/continuous improvement

You establish an agreed approach to monitoring and gathering feedback on the impact of your action plans ensuring that this involves consultation with staff. **You will reflect on this learning in developing the next stage of your ACTION PLANNING.**

SC-WRES action plan

Phase 2 2024/2025

Name of Local Authority	Halton Borough Council
Senior Director responsible for the SC-WRES (sponsor)	Marie Lynch
Local Authority programme lead	Marie Lynch
Staff voice lead	Emran Ali
Principal Social Worker Adults	Debbie O'Connor
Number of (direct) employees	909

Please use this space to summarise how this action plan will be evaluated/continually reviewed? You can reflect here on any learning on implementing your action plan.

The SC-WRES sits on the EDI Working Group for oversight.

The report has been to SMT for their view and support. It will also be taken to the EDI Strategic Group and Health PPB for an awareness of the findings and to ask HR for support and help with any interrogation needed. This data is just for ASC and it should encourage others to check their areas.

To exercise with some caution as this is just the data at this stage.

To make use of the Recruiting Right resources, Recruiting the right people to better understand how our process can support diverse recruitment and retention across the board through benchmarking against this best practice.

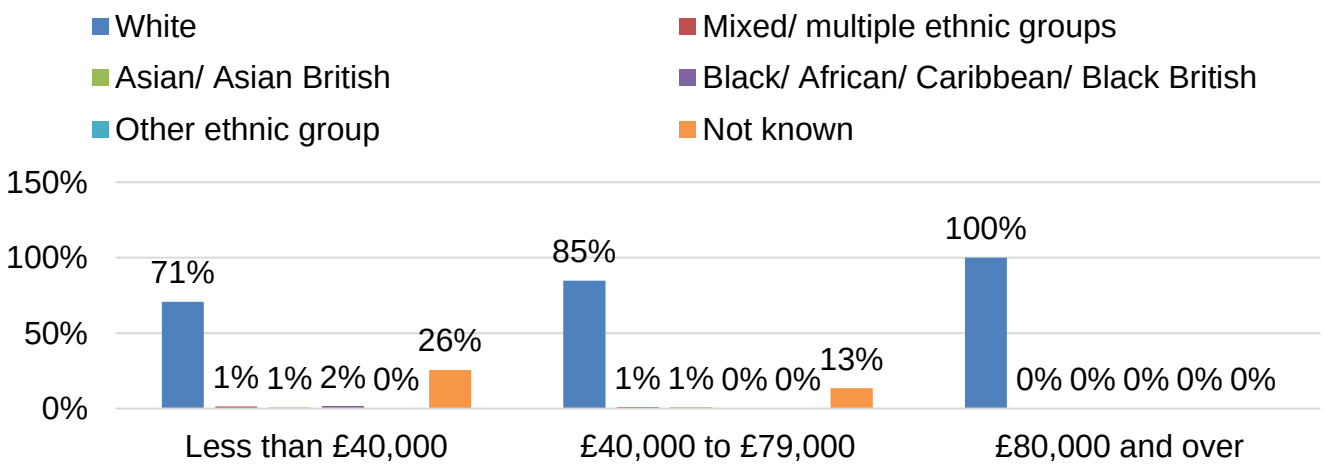
Change needs to take place across the authority. To be taken to the Management Team to get a wider buy in.

We have got the Comms and Engagement framework to source staff feedback.

Metric 1

Percentage of directly employed staff from a minority ethnic background within each pay band, compared with the percentage of white staff.

Indicator 1: Pay bands



Details of the action you'll take to identify change in this metric (See the 'Supporting resources' table for resources to support identification of actions.)	**Timescale to start seeing a change**	**How you'll know that this action is achieved**
To go in to colleges and universities with the offer of the Staff Support Network Groups. Let them know what we offer in Halton.	6 – 12 months	An increase in recruitment from our local communities.
To target schools, colleges, access courses and universities with Health and Social Care Students. Encourage them to do their placements within our Day Services, Halton Supported Housing Network and Care Homes. Promote Halton as being an employer of choice. To ask the Chairs of the staff network groups to be in a pool of staff to help to	6 – 12 months	To see an increase in student placements from minority ethnic groups who are then recruited in to permanent positions.

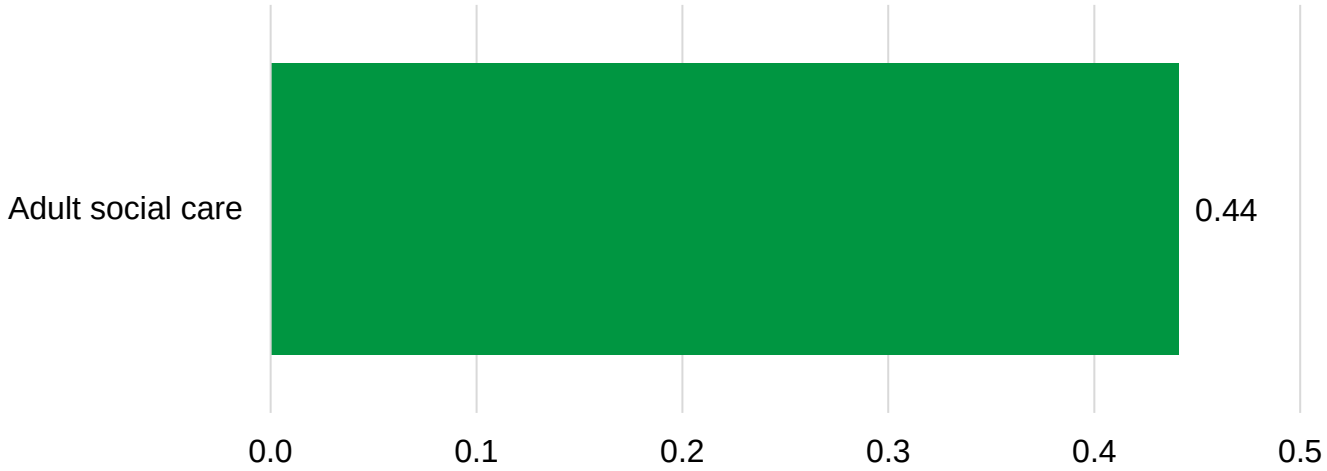
promote.		
To hold a recruitment event of our own in Runcorn Town Hall and to invite people to come in who are interested in Health and Social Care. To speak to our Comms Team and see if we can get a visual video loop attracting attention, videos, etc. This can also be added to our social media.	6 – 12 months	The event will have taken place and evidence through our social media.
To see if we can go in to schools as a service and speak to the Year 10 and Year 11 students about certain careers. We could hold taster sessions where people could do a couple of days of shadowing and work experience offers.	Ongoing	Already in place in certain parts of Social Care, and to promote further for Care Homes, Day Services and Halton Supported Housing Network. To role this out across the sector.
To do a student showcase in June 2025 across all of the universities within the Cheshire Merseyside Social Work Teaching Partnership.	3 months	To see an increase in recruitment of newly qualified staff from a diverse group of staff.
For the percentage of staff that are noted as not known or prefer not to say we will have a wellbeing offer for staff when the Practice Educator Mentor starts. They will link in with other staff who have already promoted a wellbeing offer. We need to promote more what we have already got, such as a Prayer Room, Breastfeeding Support Room and a dedicated fridge.	6 months	Practice Educator Mentor started in post on 14th May 2025 and for the wellbeing offer to be established and signed off by SMT by September 2025. To see an increase in recruitment of newly qualified staff from a diverse group of staff.
Reverse mentoring was launched in July 2024, with evaluation forms sent out in April and a reverse mentoring reunite event in May 2025. To reevaluate the process. We have developed videos which will be rolled out corporately across the council.	6 months	To help improve diverse mind-sets in middle and senior leaders. To promote discussion on how staff feel about EDI. Building and sharing on existing successes. Help challenge engrained views on what talent looks like.

Additional charts and any further detail

Metric 2

Relative likelihood of directly employed staff from a minority ethnic background being appointed from shortlisting in the last 12 months, compared to white staff.

Indicator 2: Appointed from Shortlist

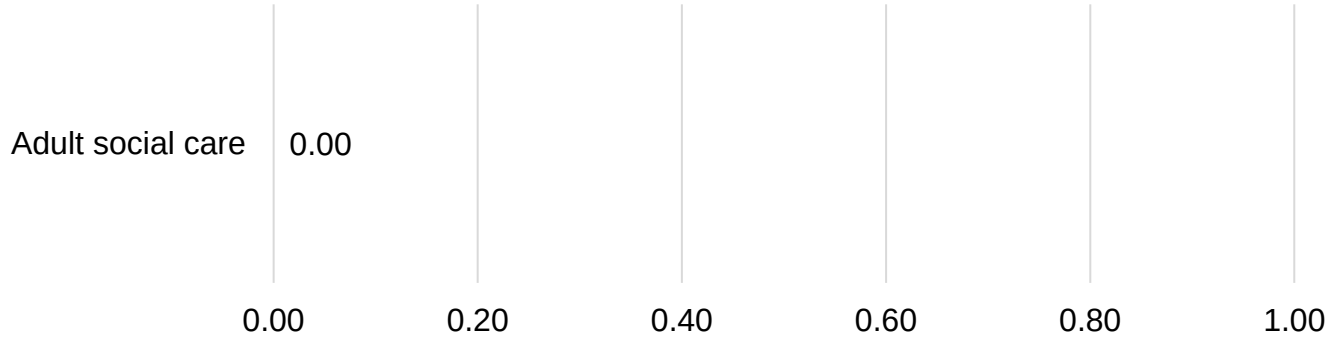


Details of the action you'll take to identify change in this metric (See the 'Supporting resources' table for resources to support identification of actions.)	Timescale to start seeing a change	How you'll know that this action is achieved
We are going to further analyse the data to get a greater understanding. This might involve the development of a task and finish group.	6 – 12 months	We will have a greater understanding and understand what sits behind the data.
To review the recruitment process and job advertisements with HR. To be clear with HR if an experienced or newly qualified Social Worker is needed for the post. Also to be clear on the applicants 'rights to work' in the UK.	6 – 12 months	There will be a change of more appropriate job applications received.
We are going to increase the diversity of our interview panels through asking staff who sit on the Staff Support Network Groups and people with lived experience to be involved in the interview panel.	3 months	We will have staff who sit on the Staff Support Network Groups and people with lived experience on the interview panel.
Additional charts and any further detail		

Metric 3

Relative likelihood of directly employed staff from a minority ethnic background entering the formal disciplinary process compared to white staff.

Indicator 3: Disciplinary Process



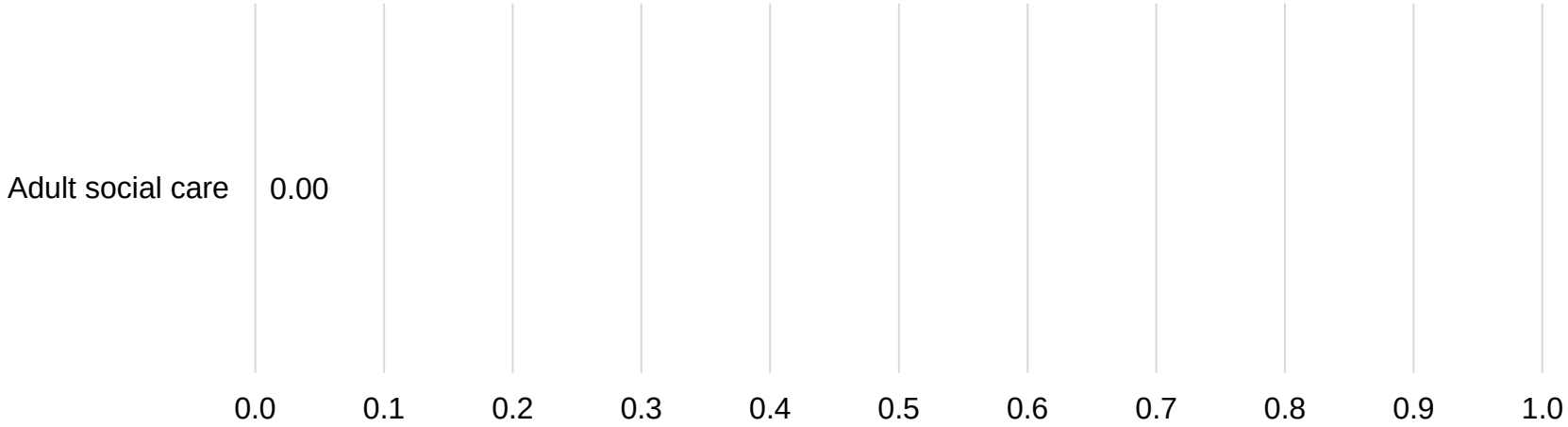
Details of the action you'll take to identify change in this metric (See the 'Supporting resources' table for resources to support identification of actions.)	**Timescale to start seeing a change**	**How you'll know that this action is achieved**
When we have an increased number of directly employed staff to reevaluate.	Ongoing	This will be ongoing for Social Care and we will review the corporate figures to identify any themes or trends.
To look at benchmarking against local comparisons and to compare with the national data that has been provided.	6 – 12 months	We will have identified any themes or trends with the local comparisons and the national data.

Additional charts and any further detail

METRIC 4

Relative likelihood of directly employed regulated professionals from a minority ethnic background entering the fitness-to-practice process in the last 12 months compared to white staff.

Indicator 4: Fitness to practice



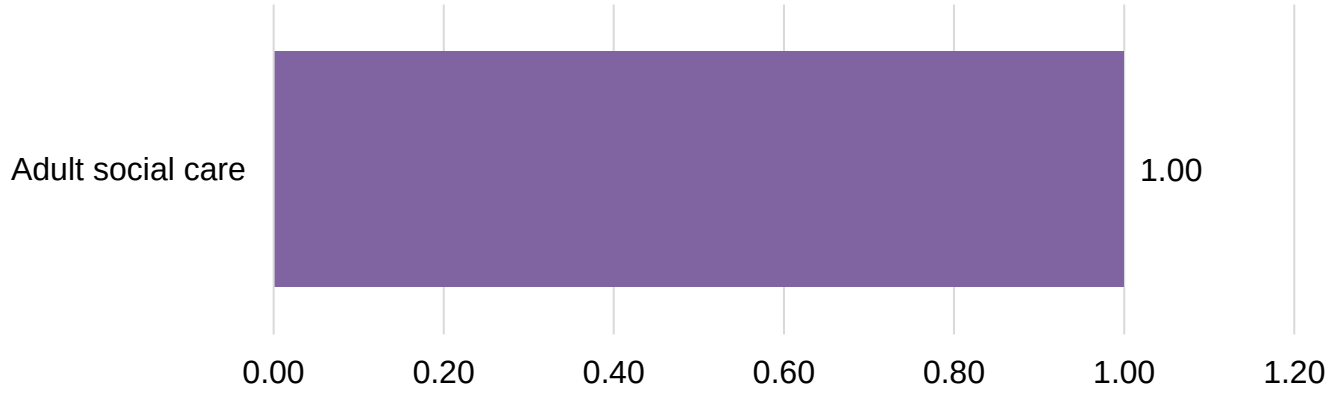
Details of the action you'll take to identify change in this metric (See the 'Supporting resources' table for resources to support identification of actions.)	Timescale to start seeing a change	How you'll know that this action is achieved
None identified at present. To review if this becomes an issue.	Ongoing	

Additional charts and any further detail		

Metric 5

Relative likelihood of directly employed staff from a minority ethnic background accessing funded non-mandatory continuous professional development in the last 12 months compared to white staff

Indicator 5: funded non-mandatory continuous professional development



Details of the action you'll take to identify change in this metric (See the 'Supporting resources' table for resources to support identification of actions.)	**Timescale to start seeing a change**	**How you'll know that this action is achieved**
Presently all staff have equal opportunities to access training irrespective of ethnicity. To reevaluate if this appears to change.	Ongoing	
We have supported a member of staff on the Moving Up Programme and we will be evaluating this.	Ongoing	We will keep building on offers for the wider workforce.
Neurodiverse staff have benefitted from additional coaching through access to work. This has supported the person supervising them as well. To keep reevaluating this process.	Ongoing	We will keep building on offers for the wider workforce.

Additional charts and any further detail

METRIC 6		
Relative likelihood of directly employed staff from a minority ethnic background experiencing harassment, bullying, or abuse from people who use social care, relatives, or the public in last 12 months compared to white staff Indicator 6: Harassment, bullying or abuse from people who use social care, relatives or the public in the last 12 months.		
Details of the action you'll take to identify change in this metric (See the 'Supporting resources' table for resources to support identification of actions.)	**Timescale to start seeing a change**	**How you'll know that this action is achieved**
When completing the data this indicator was blank. We did not know what the indicator was asking and thought that it was bringing the information through from somewhere else. We need to try and complete this indicator next time.	6 – 12 months	We will take this to the EDI group for further discussion.
To review the Bullying and Harassment Policy.	6 – 12 months	To review the action plan in six months.
When the Supervision Policy is reviewed to add 'Has there been any issues of bullying and harassment to share?'	6 – 12 months	To review the action plan in six months.

Additional charts and any further detail		

METRIC 7		
Relative likelihood of directly employed staff from a minority ethnic background experiencing harassment, bullying, or abuse from colleagues or managers in last 12 months compared to white staff Indicator 7: Harassment, bullying or abuse from colleagues or managers in the last 12 months.		
Details of the action you'll take to identify change in this metric (See the 'Supporting resources' table for resources to support identification of actions.)	**Timescale to start seeing a change**	**How you'll know that this action is achieved**
When completing the data this indicator was blank. We did not know what the indicator was asking and thought that it was bringing the information through from somewhere else. We need to try and complete this indicator next time.	6 – 12 months	We will take this to the EDI group for further discussion.
To review the Bullying and Harassment Policy.	6 – 12 months	To review the action plan in six months.
When the Supervision Policy is reviewed to add 'Has there been any issues of bullying and harassment to share?'	6 – 12 months	To review the action plan in six months.

Additional charts and any further detail		

METRIC 8

Relative likelihood of directly employed staff from a minority ethnic background leaving the organisation during the last 12 months compared to white staff

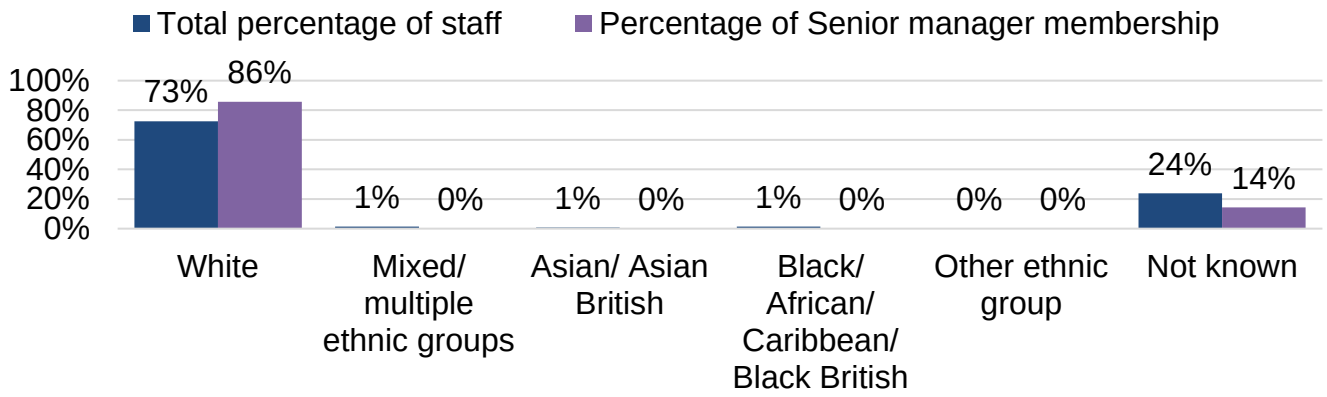
Indicator 8: Turnover of directly employed staff in the last 12 months

Details of the action you'll take to identify change in this metric (See the 'Supporting resources' table for resources to support identification of actions.)	Timescale to start seeing a change	How you'll know that this action is achieved
There is no evidence to suggest that people are leaving from a minority ethnic background in any greater numbers than white staff. We will continue to monitor.	Ongoing	Liaise with HR to determine whether there is any increase.
To review the exit interview proforma as a Corporate approach and to consider having people from the Staff Support Network Groups to facilitate these.	6 – 12 months	To receive anonymised themes and trends of why people are leaving. This will hopefully help to retain staff and offer assurance.
Additional charts and any further detail		

METRIC 9

Percentage of directly employed staff from a minority ethnic background in senior manager membership roles compared with the percentage of white staff

Indicator 9: Senior management membership roles



Details of the action you'll take to identify change in this metric (See the 'Supporting resources' table for resources to support identification of actions.)	**Timescale to start seeing a change**	**How you'll know that this action is achieved**
As part of the recruitment campaign to ensure that everybody feels welcome to apply for the roles.	Ongoing	To ensure publications within social media target all areas of our community in terms of advertising positions.
Encourage staff from minority ethnic backgrounds to attend ADASS training for Inspiring Leaders and the Moving Up training.	6 – 12 months	To work jointly with ADASS, Skills for Care, HR and training.

Additional charts and any further detail		

Please detail any other action/activities that you'll roll out to support the SC-WRES

The SC-WRES National report has been shared in the ASC Monthly Mashup in June 2025 to raise awareness and goes out to all ASC staff.

To raise awareness of the SC-WRES, the Director of Care Management to present to the Adult Social Care Service Planning Event.

Staff Engagement

Do you have a staff engagement plan or policy?	Yes

Please summarise the key points from the staff engagement plan/policy

Communications and Engagement Framework

- Scope of the Communications and Engagement Framework
- Our Commitment
- How we communicate and engage
- Internal Communication and Engagement
- The role of our elected Members
- Community Communication and Engagement – our next steps
- Engagement Participation Levels
- Delivering the framework
- Accountability to the Community

Co-Production Framework

- What we mean by co-production
- Making meetings accessible
- Values
- Behaviours
- Diversity and who needs to be involved
- Equality
- How we will have conversations and keeping in touch
- How we will continue meeting and making plans together
- Learning as we go

EDI networks

- To create, promote and sustain an equal society and environment.
- A culture where people of all backgrounds and experience feel appreciated and valued.
- We are committed to seeking to employ a workforce that reflects the diverse community that we serve and are part of.
- Staff Network Groups (SNGs)
    - A safe place to engage in a confidential and welcoming environment.
        - Disability and Neurodiversity
        - Race Equality
        - LGBTQIA+
        - Religion and Faith
- Reverse Mentoring

Action Plan signed off by	Marie Lynch
Position / Role	Director of Care Management, Safeguarding and Quality
Date	11/06/2025

Supporting resources

Recruitment support webpages

Our tools and resources can help you recruit and retain people who have the right values for your organisation and the adult social care sector.

Find information on recruitment planning, attracting people and value-based recruitment practices.

Metrics 1 and 2

Visit:
www.skillsforcare.org.uk/RecruitmentSupport

https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Supporting-a-diverse-workforce/Supporting-a-diverse-workforce.aspx

Supporting a diverse workforce: Understanding racism (skillsforcare.org.uk)

A positive culture toolkit for adult social care

Our toolkit will support you at different stages of your workplace culture journey to establish, maintain and improve your workplace culture so that it's inclusive, compassionate and collaborative.

Metric 3

Visit:
www.skillsforcare.org.uk/CultureToolkit

Other useful links

Visit:
The SC-WRES Report 2023

LGBTQ+ learning framework (skillsforcare.org.uk)

For further information, please contact equalityandrights@skillsforcare.org.uk or visit www.skillsforcare.org.uk/SC-WRES

REPORT TO:	Health & Social Care Policy & Performance Board
DATE:	23rd September 2025
REPORTING OFFICER:	Executive Director, Adults
PORTFOLIO:	Adult Social Care
SUBJECT:	Halton Borough Council Adult Social Care - Care Quality Commission (CQC) Assessment Outcome
WARD(S):	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide PPB with details of the outcome of Halton Borough Council's Adult Social Care CQC Assessment.

2.0 **RECOMMENDATION: That the Board:-**

i) note the contents of the report and associated appendices and presentation.

3.0 **SUPPORTING INFORMATION**

3.1 Halton's CQC Assessment process officially began back in October 2024 when CQC informed us of the initiation of the assurance process, which involved the submission of our Self-Assessment and Information Return. This assessment process culminated in an onsite CQC visit, which took place 17th – 19th March 2025.

3.2 This onsite visit consisted of individual interviews with a number of officers and Members, along with group discussions with representatives from Adult Social Care Teams, staff and manager drop-in sessions and a number of individuals with lived experience. Outside of the onsite visit, CQC also had discussions with our partners and undertook a review of a number of case files and spoke to individuals in receipt of services.

3.3 The final report was published on 4th July 2025 ***(Appendix 1)*** and Halton's Adult Social Care Services have been rated overall as **Good**. This rating has been informed by judgements made from across a number of themes and quality statements, such as working with people and providing support.

3.4 As with any assessment, there will be areas where we need to make improvements and these will be addressed, if they haven't already been and details can be found in the Improvement Plan that has been developed ***(Appendix 2)***, however having been rated as 'Good' is an achievement we should all be very proud of and is testament to the hard work and dedication of our staff and partners in delivering the best outcomes for the people of Halton.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications arising directly from the CQC Assessment. Any policy implications arising from issues included within the Assessment and associated Improvement Plan will have been/will be identified and addressed via the relevant reporting process.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 As with the policy implications, there are no other implications arising directly from the assessment. Any finance implications arising from issues included within the Assessment and associated Improvement Plan will have been/will be identified and addressed via the relevant reporting process.

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

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**
The CQC Assessment and associated Improvement Plan is directly linked to this priority.

6.2 **Building a Strong, Sustainable Local Economy**
Not Applicable.

6.3 **Supporting Children, Young People and Families**
Not Applicable.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**
Not Applicable.

6.5 **Working Towards a Greener Future**
Not Applicable.

6.6 **Valuing and Appreciating Halton and Our Community**
Not Applicable.

7.0 **RISK ANALYSIS**

7.1 None associated with this report.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with this report.

9.0 **CLIMATE CHANGE IMPLICATIONS**

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

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

10.1 None under the meaning of the Act.

Halton Borough Council: local authority assessment

How we assess local authorities

Assessment published: 4 July 2025

About Halton Borough Council

Demographics

Halton is a unitary authority in the county of Cheshire. Since 2014 Halton has been one of the six local authorities that make up the Liverpool City Region Combined Authority. Halton straddles the river Mersey and is made up of the twin towns of Widnes and Runcorn together with the villages of Hale, Moore, Daresbury and Preston Brook.

Halton is home to nearly 129,000 residents and the population size has increased by 2%, from around 125,700 in 2011 to 128,200 in 2021. This is lower than the overall increase for England (6.6%). The wider trend shows that the population is ageing, as the number of residents who are 65 years and over has increased by 38.5% since 2011.

Less than 5% of Halton's population is ethnically diverse, with the majority being White (96.50%) and smaller communities identifying as Mixed or multiple ethnicities (1.39%), Asian or Asian British (1.12%), Black, Black British, Caribbean, or African (0.40%), and other ethnicities (0.59%). Halton has an Index of Multiple Deprivation (IMD) score of 8, placing it in decile 8. A local authority with a decile of 1 means it is in the least deprived group (lowest 10%), while a local authority with a decile of 10 means it is in the most deprived group (highest 10%).

Halton is part of the Cheshire and Merseyside Integrated Care System (ICS), which includes Liverpool, Wirral, Knowsley, Sefton, Warrington, Cheshire East, St Helens and Cheshire West, essentially encompassing the wider Merseyside region.

Halton Borough Council has had a Labour majority since its creation in 1974 with 50 of the 54 councillors representing the Labour party.

Financial facts

- The local authority estimated that in 2023/24, its total budget would be **£233,004,000**. Its actual spend for that year was **£333,991,000**, which was **£100,987,000** more than estimated.
- The local authority estimated that it would spend **£63,036,000** of its total budget on adult social care in 2023/24. Its actual spend for that year was **£68,980,000,** which was **£5,944,000** more than estimated.
- In 2023/2024, **20.65%** of the budget was spent on adult social care.
- The local authority has raised the full adult social care precept for 2023/24, with a value of **2%**. Please note that the amount raised through adult social care precept varies from local authority to local authority.

- Approximately **2710** people were accessing long-term ASC support, and approximately **450** people were accessing short-term adult social care support in 2023/24. Local Authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

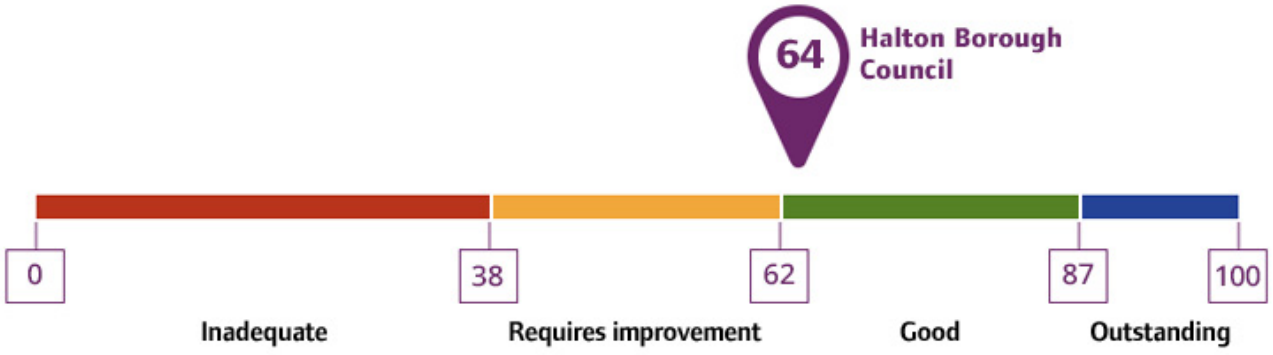
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

Halton Borough Council

Good



Quality statement scores

Assessing needs

Score: 2

Supporting people to lead healthier lives

Score: 3

Equity in experience and outcomes
Score: 3

Care provision, integration and continuity
Score: 2

Partnerships and communities
Score: 2

Safe pathways, systems and transitions
Score: 3

Safeguarding
Score: 3

Governance, management and sustainability
Score: 2

Learning, improvement and innovation
Score: 3

Summary of people's experiences

People received assessments from teams trained in how to meet their needs and waiting times for assessment had reduced over the previous year. People sometimes had to wait for an assessment or review of their needs, but staff took a risk-based approach and people with urgent needs were responded to promptly. People told us examples of how staff had supported them to achieve their outcomes and they found staff to be knowledgeable and compassionate. However, some people also told us about changes in staff which led to them having to tell their story multiple times.

In relation to home care services, people had a limited choice of service provider due to there being only one main home care provider contracted by the local authority. At the time of our assessment, the local authority was putting a new contractual framework in place which included more home care providers and increased people's options. National data from the Adult Social Care Survey (2023-2024) showed 57.02% people felt they had a choice over services which was significantly worse than the England average (70.28%).

People had positive experiences when interacting with the Prevention and Wellbeing service at the local authority's 'front door' and although there were waiting list for occupational therapy assessments, when people received this, they were supported to maintain their independence. The local authority had completed recruitment to occupational therapist posts and the waiting list for assessment had reduced over the previous 18 months.

People told us their experience of transitioning from children's to adults services was mostly positive however a partner told us some families did not know how to access the transitions service when they were not automatically referred, and they did not feel information was readily available outside of the transitions team.

Feedback from unpaid carers was mostly positive, with carers telling us they had received assessments from the local authority and were updated regularly with information which could support them in their caring role such as caring groups. Carers told us they knew who to contact in the local authority if they needed to do so. However, some unpaid carers also told us they did not have emergency plans in place should they be unable to continue in their caring role.

People told us work on co-production was in its infancy, with some people having been consulted for strategies such as the Carer's Strategy, and other people telling us they had not been made aware of any consultations or co-production work.

Summary of strengths, areas for development and next steps

We saw good support for adult social care at all levels in the local authority in the context of challenging financial conditions and increasing demand for adult social care. There was strong leadership from the Chief Executive and Executive Director for Adult Services and a split between the children and adult directorate had increased the prominence of adult social care at senior leadership level. The local authority was moving from a culture of providing high support for people towards a strengths-based model and there was more to do to fully embed this across all services. Some leaders told us they needed to move on to a prevention-based focus at all levels and move on from a culture of wanting to over support people to eliminate risks in their lives

The local authority had redesigned their 'front door' to adult social care to create the Prevention and Wellbeing Service which was supporting a co-ordinated service from referral through to the completion of an appropriate level of assessment. There were clear pathways in place for care assessments which were undertaken by the teams who also undertook longer-term work with people, such as the Complex Care teams, the mental health team and the transitions team.

Staff were completing assessments in a strengths-based way and the local authority had verified this through a series of case and practice audits. There was a corporate Transformation Programme in place which had elements of work for adult social care which had a specific team and plan to deliver this. The transformation in adult social care was focussed on working with people with a learning disability to redesign services to function in a more strengths-based way such as moving on from long-term day services. This was in progress and there was limited feedback as to the programme's effectiveness and the wider impact for people at the time of our assessment.

Safeguarding processes ensured people's ongoing safety and there had been a multi-agency risk approach introduced to support people where concerns about risks present did not meet the threshold of a safeguarding enquiry. The local authority had completed work to ensure staff were making safeguarding personal, as per national guidance.

There were mixed processes in place for people moving from children's to adult services with some people having an assessment from aged 14, and others transitioning at 18 where they had mental health needs. This meant some people did not receive a planned transition in line with best practice and were assessed only once they had reached adulthood. There was a dedicated transitions team in place who worked with people from the age of 16 where they had a learning disability.

The local authority had limited care provision within the area although there were steps being taken to increase the choice of home care provision for people with a new commissioning framework due to commence after our assessment. Staff told us people often had to move out of the area for specialist residential care such as dementia plus care, although there was good availability of general residential and nursing care homes within the local authority area. People did not usually have to wait for care as staff had good links with care homes in neighbouring authorities to ensure the timeliness of care. The local authority was working with its care providers to improve the quality of care people received with a robust quality assurance process in place.

The local authority had processes in place to support people being discharged from hospital. Partners told us there was currently an average of 22% of patients within hospitals who have no criteria to reside, however there was a partnership approach to working with the local authority to address any delays to a person's discharge. There were new processes being trailed during our assessment, such as daily board rounds to see if these led to improvements. The local authority had worked with health partners to set up a jointly funded intermediate care and reablement service and staff told us this was supporting people to regain their independence after a period of hospital admission. Short and Long Term Support (2023-2024) national data said 96.43% people aged 65+ remained at home 91 days after discharge from hospital into reablement or rehab which was better than the England average (83.70%).

The local authority had undertaken some work to hear the voices of seldom heard people within the community. They had liaison officers in place who were building relationships with the Gypsy, Traveller and Roma community and providing support such as benefits and housing advice. The local authority acknowledged there was more work to do to ensure equity in outcomes for all people in the borough.

The local authority used feedback from people's experiences to identify and address areas for improvement. For example, a Care Home Development Group was looking at ways to improve the quality of provision and the experiences of people in residential care settings; and there was an Occupational Therapy workplan focussed on improving the amount of feedback received from people to further enable development of the service.

The local authority had a strong culture of learning and development and using research to inform their decision making. Staff were enthusiastic about their work and passionate about providing good care and support for people in Halton. Staff told us they were well-supported and there was a 'grow your own' approach which was clearly embedded throughout the local authority. There were clear career pathways and development opportunities in place.

Theme 1: How Halton Borough Council works with people

This theme includes these quality statements:

- Assessing needs
- Supporting people to live healthier lives
- Equity in experience and outcomes

We may not always review all quality statements during every assessment.

Assessing needs

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Key findings for this quality statement

Assessment, care planning and review arrangements

The local authority provided routes for people to access care and support services with self-referral options by phone, online or through a professional referral. Referrals were received into the 'front door' which had been redesigned into a new Prevention and Wellbeing Service (PWS). The PWS had been in place for a year at the time of our assessment and local authority data told us there had been a 47% reduction in people contacting the front door going on to need long-term services following the introduction of the PWS. This was a multi-disciplinary team consisting of social workers, community care workers, occupational therapists and wellbeing officers.

There was a separate referral process to refer into the mental health social work team, although referrals were also accepted through the PWS and transferred to the mental health team where a person had a mental health diagnosis. Professionals could also refer directly to the Halton Intermediate Care and Frailty Service (HICaFS) by phone or by email and partners told us this was effective.

Initial Care Act assessments were completed by the PWS who triaged referrals and held twice-daily huddles to discuss work and ensure fast and effective referrals to the appropriate service. Interim care planning arrangements were made for people within the PWS including a first review of this support after 6-8 weeks. If people required longer-term support, they had a review or reassessment from the Complex Case Teams. There were processes to transfer work between internal local authority teams with any disputes about the responsible team being discussed by managers.

People also received Care Act assessments from mental health social workers who were co-located with secondary mental health teams. There was a dedicated Transitions team who worked with young people from the age of 16 to 25 to support them in transitioning from children's to adult services using a named worker approach where a person maintained the same allocated worker to the age of 25. The Complex Care team and mental health teams did not use a named worker approach, and some people told us they could have multiple social workers which resulted in them telling their story numerous times.

Staff told us they were well trained and were able to carry out Care Act assessments for people with varying needs and care plans we reviewed evidenced this. Where staff had specialist knowledge they worked with people with those needs, despite the Complex Care teams being generic in nature. People told us their social workers were knowledgeable and skilled within their roles.

There were Visual Impairment Rehabilitation Workers who held specialist qualifications and were based within the Complex Care teams. The rehabilitation workers worked with people with sight loss to support them to maintain their independence. There was a Positive Behaviour Service who worked with people with learning disabilities and autistic people where their placement may be at risk of breakdown. This was a dedicated team of behaviour analysts and practitioners who specialised in understanding communication and behaviour, with additional training to effectively support people in this area. Staff told us the Positive Behaviour Service assess a person's communication and needs and work with them on a long-term basis to enable people to live more fulfilling lives. We heard examples of where people had restrictions on them removed following the team's assessment and support.

People told us their assessment was person-centred, focusing on their wellbeing, although some people also told us they felt staff were rushed and ran out of time when speaking to them, which meant their experiences may not be fully understood. Staff described to us how they worked in a person-centred way to enable a person to make their needs and wishes clear through their Care Act assessment and support planning. Strengths based practice had been a focus for the local authority, and they had arranged a programme of training from an external provider for staff to support their knowledge. A leader told us they had been undertaking targeted reviews of care plans, and these evidenced the strength-based culture within the local authority had been well-embedded. We reviewed care plans and assessments which were person-centred and highlighted a person's desired outcomes.

People's needs were reviewed to check they continued to be met. Staff in frontline teams completed first and annual reviews with people, and a reviewing team had been set up to provide additional support in completing annual reviews due to the local authority identifying they were not successfully completing all reviews annually with the current staff resource. This had made a significant impact on the local authority's ability to complete a review of people's care plans at least annually and data from Long and Short Term Support 2023-24 (SALTS) showed 94.88% people had received a review of their support which was significantly better than the England average (57.77%). Where people's needs had changed, staff carried out a reassessment and made changes to their care plans. Data from the Adult Social Care Survey (2023-2024) showed 64.60% people were satisfied with their care and support which was similar to the England average (62.72%).

Timeliness of assessments, care planning and reviews

The local authority provided data which showed 25 people were waiting for a Care Act assessment in February 2025. This was a reduction from 53 people who were waiting in October 2024. There were 282 people waiting for an annual review as of February 2025 according to data provided by the local authority. The local authority told us the maximum waiting time for a review had reduced from 602 days in October 2024 to 138 days in February 2025.

The local authority had adopted a 'waiting well' framework to ensure waiting lists were prioritised and allocated effectively. People waiting for assessment or review were RAG (red, amber, green) rated to inform the urgency of allocation. There were dedicated duty workers in place daily within the teams who gathered information to inform priority. Staff told us wellbeing packs were sent to people waiting for an assessment to give them information and contact numbers. Staff also told us people were contacted regularly to see if anything had changed and to monitor risk.

Providers and partners told us when a person had an allocated worker from the local authority, they received a timely response, however they could find people had a long wait for a re-assessment or review of their needs. Providers told us they understood people were allocated to a worker based on the urgency of their need and where a person's needs had changed significantly providers told us a person received a quicker response from the local authority.

There were no waits for an assessment for hospital discharge and the average time between allocation to a worker and discharge taking place was 7 days according to data provided by the local authority (February 2025). The local authority told us the 7 days from allocation to discharge could include where a person required further medical intervention, engagement with families for best interest decisions and sourcing placements for discharge. Staff told us Care Act assessments for people in hospital started within 24 hours of receiving a referral from the hospital ward and they would begin to collate information and meet with the person and their family. This process was mirrored for people in mental health hospitals where social workers were informed about admissions and attended the initial assessment meeting on the ward, they would then attend multi-disciplinary meetings to understand a person's readiness for discharge and commence assessment if required.

Local authority data showed access to occupational therapy assessment was improving and waiting lists had reduced from 409 in July 2023 to 122 in February 2025. The local authority attributed this to the set-up of the Prevention and Wellbeing Service (PWS) and the appointment of a Principal Occupational Therapist to oversee this. The PWS had implemented a screening process via dedicated duty workers to determine the priority of a referral and staff told us this had meant people were seen more quickly and risk identified sooner. There were twice daily huddles to discuss referrals and ensure a person was seen by the appropriate discipline within PWS. We saw plans which were in progress to continue the improvement in reducing waiting times for people for Occupational Therapy assessments through new services such as GP drop-in assessment spaces.

Assessment and care planning for unpaid carers, child's carers and child carers

The needs of unpaid carers were recognised as distinct from the person with care needs. Staff told us they would discuss a carer's assessment with unpaid carers and undertake this if the carer consented, they would also undertake annual reviews of carers assessments if this was due according to the recording system. There were also dedicated carer's assessors within the Prevention and Wellbeing Service (PWS) who completed a carers assessment if there was not an allocated social worker. Staff told us carers had the option for their assessment to be completed by the allocated worker or by an independent assessor if this was a person's preference.

People gave us mixed feedback on the effectiveness of carer's assessments as they felt the carer's assessment had a positive impact on their health and wellbeing, but people also told us they did not have a contingency plan in case of being unable to continue in their caring role. Data from the Survey of Adult Carers (2023-2024) in England showed 44.00% carers were satisfied with social services which was better than the England average of 36.83%.

Local authority data showed 6 people were waiting for a carer's assessment with a maximum wait time of 8 days from contact to allocation (February 2025). The median wait time for a carer's assessment was 0 days. Unpaid carers told us they did not necessarily have an allocated worker at the local authority however they knew how to contact the local authority and would do so if needed. Partners told us carers had fed back they could wait a long time on the phone to the local authority to request a carer's assessment and the local authority had implemented a drop-in at the partner offices so carers could access help from the local authority directly during these sessions.

Help for people to meet their non-eligible care and support needs

People were given help, advice and information about how to access services, facilities and other agencies for help with non-eligible care and support needs. The Prevention and Wellbeing Service provided advice and signposting to broader wellbeing services before they needed statutory care. Staff told us they used a person-centred approach to identify services a person could access, such as reablement and Voluntary, Community and Faith Sector Enterprises (VCFSE), without requiring a Care Act assessment.

The local authority had commissioned services from partners to support people with their non-eligible needs when accessing assistance would support them to maintain their independence at home, such as social prescribing, community connectors and welfare and benefits advice. There was a Prevention Panel where staff could discuss with colleagues and management to identify ways to support people with their non-eligible needs and staff told us this was a useful resource in learning about services to support people staff may not have known about. Staff also told us the online recording system prompted referrals which could be made within the system to services to support people with their non-eligible needs.

Eligibility decisions for care and support

The local authority's framework for eligibility for care and support was transparent, clear and consistently applied. The local authority had the Care Act eligibility criteria clearly displayed on their website for people to read. We saw processes and guidance which were clear for staff to follow when applying eligibility criteria. The local authority had not had any appeals against eligibility decisions made within the previous 12 months (February 2025). We reviewed people's assessments completed by the local authority and found people's eligible needs were clearly documented.

Financial assessment and charging policy for care and support

The local authority's framework for assessing and charging adults for care and support was clear, transparent and consistently applied. There was guidance in place with amounts which were charged and the key principles for determining if a person should contribute to the cost of their care. There was an appeal process in place should a person be dissatisfied with the outcome of their financial assessment which was overseen by elected members and the reviewing team. People told us when they had spoken to the financial assessment team they received clear guidance in a timely manner.

The local authority had wait times for completion of financial assessments although they told us some of this was due to waiting for applications or evidence to be returned from people to enable the assessment to be completed. The local authority told us the completion of financial assessments could be delayed where supporting evidence was not received from people or people were awaiting financial Deputies to be appointed by the Court of Protection. There were 55 financial assessments awaiting completion with a median wait time of 30 days across residential and home care assessments, with a maximum wait time of 305 days for residential assessments and 298 days for home care assessments (February 2025). This demonstrated progress in the timescales for completion of financial assessments from October 2024 where the median wait time was 43 days and there were 100 financial assessments awaiting completion.

The local authority had amended their financial assessment process to offer a person a telephone assessment within 2 working days of a referral and the person would be provided with a provisional charge during the call to ensure people were able to plan for likely financial costs of care. The final assessed charge would be provided in writing once any required evidence had been received. The local authority had plans to introduce an online calculator to allow people to obtain an estimated charge prior to services being put into place.

Provision of independent advocacy

Timely, independent advocacy support was available to help people participate fully in care assessments and care planning processes. The local authority had an Advocacy Hub which was accessible via the Healthwatch Halton website. There was information on what advocacy was, including the different types such as Independent NHS Complaints Advocacy (ICAS) and Independent Mental Health Advocacy (IMHA), and how to get in touch to access it.

Partners told us they were able to deliver advocacy services in a timely manner. Staff told us about good relationships with advocacy providers and this supported positive outcomes for people. An example was provided where a person was re-referred for advocacy and an advocate was allocated who they had previously worked with, which prevented them having to tell their story again.

Supporting people to live healthier lives

Score: 3

3 - Evidence shows a good standard

What people expect

I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.

I am supported to plan ahead for important changes in my life that I can anticipate.

The local authority commitment

We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support.

Key findings for this quality statement

Arrangements to prevent, delay or reduce needs for care and support

The local authority worked with people, partners and the local community to make available a range of services, facilities, resources and other measures to promote independence, and to prevent, delay or reduce the need for care and support. The Prevention and Wellbeing Service (PWS) contained Wellbeing Officers who worked with people to identify where they could be supported by Voluntary, Community and Faith Sector Enterprises (VCFSE) as opposed to accessing formal services and support. The triage process within the PWS involved managing referrals and signposting people to appropriate services such as community meals, moving and handling support and welfare and benefits advice to reduce the need for formal care and support unless it was necessary.

Leaders told us there was more to do in promoting this preventative, strength-based culture within Halton, as the prevailing one was underpinned by an expectation that the local authority would look after people through the provision of services and other formal support. The PWS had been formed as the new 'front door' to adult social care. The local authority's own data showed a 47% reduction in the number of people contacting adult social care and going on to receive a Care Act assessment and longer-term support since the PWS had commenced in February 2024.

The local authority had a range of preventative services for unpaid carers including activities arranged though VCFSE providers. Carers gave us mixed feedback about access to preventative services, with some attending groups for unpaid carers and finding these useful, and others telling us they were unable to attend groups due to their caring role. Staff told us the Carer's assessor within the PWS was working to address this by holding community drop-ins for carers to discuss their needs. Data from the Survey of Adult Carers in England (2023-2024) showed carers accessing support groups or someone to talk to in confidence was somewhat better than the England average at 41.67% against the England average of 32.98%.

Staff told us the mental health team had a focus on preventative measures to support people and to prevent crisis. Mental health social workers worked closely with the mental health outreach team, the PWS, housing, and drug and alcohol services to support a person holistically. Staff also told us about providing 'professional support' to give a flexible response to people, guiding them and supporting their independence outside of formal care services. We reviewed people's care plans which demonstrated the effectiveness of this approach in supporting them to achieve positive outcomes.

The local authority provided a Vision Rehabilitation Service which supported people with a visual impairment in the community to maintain their independence, reduce isolation and prevent harm or risk of injury by providing suitable equipment to meet their needs. The local authority had also commissioned an Integrated Sensory Support Service to provide specialist support for people with sensory loss which included information and advice, rehabilitation, training and equipment to support independence.

Staff gave examples of working with people to regain their independence following a diagnosis of visual impairment, supporting a person holistically to reduce their needs. The rehabilitation officers also supported people with welfare benefit maximisation and help to access social groups and events to prevent or reduce loneliness. There was a follow up service provided by a partner organisation to continue working with people following involvement from the local authority rehabilitation officers and the service undertook a joint review with the local authority after 12 weeks of support.

The local authority had a prevention strategy in place and had committed to looking at tackling health inequalities and barriers to a good life. The local authority had worked with Think Local Act Personal's national personalisation experts to co-produce strategies around this looking at increasing independence and improved wellbeing for people. Partners told us about a health improvement team who were working as part of this to promote healthy lives to reduce a person's future need for social care support.

As a wider preventative measure in response to increased poverty in the area, the local authority had funded two additional posts to support people who had accumulated debt for unpaid care charges. The service supported people to check they had accurately identified all their disability related expenses, maximised their welfare benefit entitlements and helped them to create a payment plan for their outstanding care charges. The local authority told us they had received positive feedback from people who had used the service, saying it had alleviated their worries about debt and helped them to better manage their finances.

The local authority was exploring the expansion of technology enabled care and was undertaking a pilot scheme jointly with Cheshire and Mersey Integrated Care Board to look at trialling technology, initially within supported living schemes, to provide people with greater independence. The pilot was ongoing at the time of our assessment, but staff told us it would be a positive step to supporting people to live more independently. The local authority had an existing provision of care alarms which supported people to access help in an emergency which was widely available. Staff told us they had worked with partners to look at new and emerging technology which could reduce a person's need for formal support such as medication dispensers.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver intermediate care and reablement services that enabled people to return to their optimal independence. The local authority had worked with health partners and used Better Care Funding (BCF) to set up the Halton Intermediate Care and Frailty Service (HICaFS) which provided reablement, intermediate care, and urgent community response services. HICaFS was a multi-disciplinary team which included physiotherapists, Occupational Therapists, reablement workers, social workers and community care workers to enable holistic assessment of a person either in their home or at the intermediate care facility. Partners told us this had streamlined the approach to intermediate care and brought together teams who were previously working in silos to provide better outcomes for people.

Referrals into HICaFS were received into the single point of access and triaged to determine the level of risk and which members of the multi-disciplinary team were most appropriate to respond. Staff told us there was a prioritisation system in place to triage referrals and respond within 2 hours or up to 72 hours dependent on a person's need. Staff told us the service was focused on preventing, reducing on delaying needs and setting personalised goals for people to maintain their independence.

Adult Social Care Outcomes Framework (ASCOF) data showed 3.18% people aged 65+ received reablement or rehabilitation services after discharge from hospital which was similar to the England average of 3%. Staff told us they considered reablement as a first service when supporting a person on discharge from hospital to ensure a person could be supported at home to regain their independence. Short and Long Term Support (2023-2024) national data said 96.43% aged 65+ remained at home 91 days after discharge from hospital into reablement or rehab which was better than the England average (83.70%).

Access to equipment and home adaptations

People were able to access equipment and minor home adaptations to maintain their independence and continue living in their own homes. The local authority Occupational Therapy team were placed within the Prevention and Wellbeing Service (PWS) at the 'front door' of adult social care. This meant when referrals were received to adult social care they were screened and allocated during the daily huddle for an equipment assessment if this was indicated which enabled a quicker response to be provided. The local authority provided data which showed 98% equipment was delivered and 100% of minor adaptations were completed within 7 days of a referral being received by the Prevention and Wellbeing Service (PWS). The local authority had no waiting lists for assessment or equipment provided by specialist Visual Impairment Rehabilitation Officers.

The local authority had waiting lists for a full assessment by an occupational therapist which was for more specialist equipment and home adaptations. However, since the implementation of the PWS and recruitment to occupational therapist posts the waiting list had reduced from 409 in July 2023 to 122 at the time of our assessment (February 2025). The local authority told us they had had trouble in occupational therapist recruitment, but this had been resolved and there had been a steady reduction in waiting lists demonstrated over the previous 18 months. We reviewed documents which evidenced the local authority had a policy and process in place to support people to apply for funding for adaptations such as Disabled Facilities Grants. Data provided by the local authority showed a median wait time for equipment to be delivered of 14 days with a maximum wait of 355 days for home adaptations (October 2024).

Provision of accessible information and advice

People could access information and advice on their rights under the Care Act and ways to meet their care and support needs, including for unpaid carers and people who funded or arranged their own care and support. Staff told us the local authority commissioned care and support for people who self-funded their care if they wanted the local authority to do so, including care home placements where this was appropriate to meet a person's needs. Staff told us they would share information packs with people or direct them online to access information if they had the means to do so. However, partners told us the local authority website could be frustrating to people who couldn't find what they needed but there was ongoing work to improve this through joint working around digital inclusion outreach by local authority staff providing face to face contact at a partner office. The local authority had created a 'Living Well in Halton' guide which was available for staff to share electronically or in print for people who did not have internet access.

Partners told us there was a 'useful information' booklet which was given to unpaid carers to direct them towards Voluntary, Community and Faith Sector Enterprise (VCFSE) partners as well as containing information about carers assessments and what to expect. People told us they felt the information provided by the local authority was good and they received regular updates to ensure information was up to date. National data from the Adult Social Care Survey showed 72.22% people who used services found it easy to find information about support which was somewhat better than the England average (67.12%). The Survey of Adult Carers in England said 85.42% of unpaid carers in Halton found information and advice helpful which was similar to the England average (85.22%).

Direct payments

There was good uptake of direct payments, and they were being used to improve people's control over how their care and support needs were met. The Adult Social Care Outcomes Framework (ASCOF) shows 40.95% people who used services received direct payments which was significantly better than the England average (25.48%). Local authority data demonstrated the number of people receiving direct payments had increased steadily each month from October 2023 to October 2024. Unpaid carers told us they had received a one-off direct payment which they had used to arrange breaks from their caring role.

The local authority had clear policies in place to provide guidance for staff and people on the use of direct payments. Leaders told us the direct payment policy was broad which enabled people to have choice and control over which services they accessed. Staff told us people may choose to use direct payments to personalise their support and gave examples of people using direct payments to access different day services of their choice. Staff also told us people used direct payments to access home care agencies of their choosing outside of the local authority's primary provider of home care which allowed people to have increased personalisation of their care however staff told us there were limited agencies who accepted the local authority rates and therefore people may have to 'top-up' their care by funding the difference.

The local authority had identified issues with the recruitment and retention of Personal Assistants (PAs) for people to employ using Direct Payments. There was a workplan in place to address this through the Direct Payments Forum which had recently been set up and also looked at practices in neighbouring local authorities to inform decision making. The Forum workplan was co-produced with people who used Direct Payments who also participated in the Forum meetings. The local authority was also completing outreach with education providers to give information on a career as a PA so that people leaving education were aware of this as an occupation as well as advertising PA vacancies on their website for visibility. Staff gave examples of people they had supported to employ PAs to give people flexibility in their support.

Equity in experience and outcomes

Score: 3

3 - Evidence shows a good standard

What people expect

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority had an understanding of its local population profile and demographics. It analysed equality data on people accessing social care and staff told us their collection of data on Equality, Diversity and Inclusion (EDI) had improved recently and this was providing a better picture of who was accessing local authority services and their outcomes. The local authority considered people's protected characteristics when completing case file audits to ensure people's outcomes were equitable. The local authority had signed up to the Social Care Workforce Race Equality Standard (SC-WRES) and leaders told us this was a long-term project and their workplan was being developed.

The local authority had identified some seldom heard groups in the area including carers, members of the Gypsy, Roma and Traveller community and refugees and people seeking asylum. There was an EDI work plan in place and partners told us the local authority was keen to improve links with people from seldom heard communities as part of this. The local authority's EDI strategic group met monthly and had, as part of their work, commissioned training for all staff on EDI. The local authority had used data on seldom heard groups who may access services to provide guidance for staff on tailored support available for people including people who identify as LGBT+, people who require information in different formats, and people who are homeless.

There was a liaison officer within the local authority who was working with members of the Gypsy, Roma and Traveller communities, and we saw there were plans in place to include the liaison officer within wider strategic planning to look at improving links with members of these communities. Staff told us by increasing visibility within the Gypsy, Roma and Traveller community they would be able to provide improved outcomes for people by having a better understanding of their specific needs.

There was a hotel in the area which was providing temporary accommodation for people seeking asylum and partners told us work was ongoing to create links with people who were residing there. Staff told us they had worked with people seeking asylum and had worked alongside representatives from the Refugee service to support people during their Care Act assessment. There was a multi-agency forum in place which met quarterly to discuss issues facing people who were placed by the Home Office in the hotel and local authority funding had been provided to Voluntary, Community and Faith Sector Enterprises (VCFSE) to support people seeking asylum. Staff told us there were plans to position a wellbeing officer from the local authority in the hotel to promote independence, although this was not in place at the time of our assessment. The local authority had a resettlement officer who worked within the hotel for the purpose of supporting people with access to services and empowerment.

The local authority used the Joint Strategic Needs Assessment (JSNA) and information from partners to identify seldom heard groups within the community and wider inequalities. The local authority was working with partners to reduce health inequalities through measures such as Halton Health Hub at Runcorn Shopping City which was supporting people to have health appointments in a more accessible way in response to feedback from people which stated they were often unable to attend appointments during standard business hours. Partners told us there was shared data on health inequalities through the Health and Wellbeing Board and there was joint problem solving to identify solutions such as through the Halton Health Hub and a mobile cancer screening clinic to improve early screening attendance rates.

The Health and Wellbeing Board as part of the wider Cheshire and Mersey Integrated Care System had been identified as a Marmot Community working with the Institute for Health Equity to address differences in health outcomes for people across Halton. There were Beacon Indicators in place to enable the local authority to monitor progress towards this. The Beacon Indicators were a set of locally agreed data measurements covering each of the Marmot themes which when reviewed annually would demonstrate if there had been reductions in inequalities. The life expectancy between people in Halton varied between 11 years for men and 9 years for women depending on where a person resided within the local authority. Partners told us there were plans to introduce neighbourhood teams to enable health and local authority teams to work more closely with communities and understand their specific needs, but these were not in place at the time of our assessment

The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions. There were processes in place to ensure Equality Impact Assessments were undertaken when strategic policies were being designed or reviewed. The local authority had included two additional protected characteristics in its Equality Impact Assessments; carers and social-economic disadvantage, to ensure vulnerable groups specific to the area were considered in strategic planning.

Local authority staff involved in carrying out Care Act duties had a good understanding of cultural diversity within the area and how to engage with people appropriately. Staff and leaders told us reverse mentoring had been set up to ensure cultural competence at all levels within the local authority and we heard a great example of how this was working in practice and the impact it was having. Leaders told us they were using evidenced based practice from other local authorities to learn how to embed and improve EDI in Halton as well as supporting within wider Northwest networks to improve awareness of EDI across the region. Staff also told us staff network groups had been established to develop and share understanding of LGBTQ+, Disability and Neurodiversity, Race and Religion although it was noted staff participation was low in some groups.

Inclusion and accessibility arrangements

There were appropriate inclusion and accessibility arrangements in place to enable people to engage with the local authority in ways that worked for them. The local authority had undertaken assessment of their website to ensure it was accessible and issues which had been identified were being addressed. The local authority had also translated their website into non-English languages to ensure it was accessible to people who spoke other languages. A partner told us they had provided deaf awareness training to local authority staff, so they were better able to understand the inclusion requirements of people who are deaf or have hearing impairments. The partner also told us there was good access to British Sign Language interpreters to support people accessing local authority services.

Staff told us they worked with people who don't speak English as a first language and used interpreters to support communication as well as providing paperwork such as support plans to people in their own language. Staff had access to telephone interpretation and in person translation to ensure people could engage with the local authority. Staff in specialist teams told us they had training in Makaton and talking mats to engage with people who can’t use words to communicate.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

We may not always review all quality statements during every assessment.

Care provision, integration and continuity

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

The local authority commitment

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Key findings for this quality statement

Understanding local needs for care and support

The local authority worked with local people and stakeholders to use available data, for example the Joint Strategic Needs Assessment (JNSA), to understand the care and support needs of people and communities. The JNSA provided an overview of health and social care needs of the people in Halton and underpinned the One Halton Health and Wellbeing Strategy 2022-2027 and commissioning plans for the local authority. The local authority monitored demographic changes to understand the changing needs of their community and anticipated future demands on services.

The local authority, in addition to data analysis, gathered insight through community engagement with partners, residents, carers, and people who use services to gather qualitative evidence about lived experiences. People's voice was incorporated into planning and service evaluation to provide a broader understanding beyond statistical indicators. For example, the local authority had undertaken the 'Big Conversation', a public consultation, which had enabled people to say what mattered the most to them to inform the local authority's service planning.

The local authority used information from partner organisations such as the NHS, Public Health teams and Voluntary, Community and Faith Sector Enterprises (VSFSE) to further understand emerging and ongoing needs. Data on hospital admissions, GP registrations, long term health conditions and safeguarding alerts were monitored as part of the local authority's broader care planning process. The One Halton Health and Well-being Strategy 2022 - 2027 outlined priorities to ensure services were more accessible, efficient, and responsive to the community. The local authority worked as partners of One Halton to align some services with health partners which enabled information sharing across services to address key challenges to improve health and well-being across Halton.

The Adult Social Care Vision was to improve the health and wellbeing of people so that people lived longer, healthier and happy lives. To evidence progress towards this, the local authority gathered and used information on social determinants of health such as housing, employment, education, and income. These wider factors were considered when assessing the circumstances which may influence the support needs of people and communities.

Market shaping and commissioning to meet local needs

People had access to local support options that were effective, affordable, and good quality to meet their care and support needs. There was limited choice of home care providers for people whose care was arranged by the local authority. This was because the local authority contracted with only one principal home care provider which operated across the borough although there was an additional provider sub-contracted. The local authority had recognised the limited choice and capacity risks with this arrangement, and they were moving to a new multi-provider framework which was coming into effect shortly after our assessment.

Staff told us people had the option to use direct payments to arrange their support with alternative home care providers if they wished to do so. However, this did not always support individual choice as some home care providers charged a rate that was above the direct payment rate, meaning that people had to 'top up' the fees to be able to use their provider of choice. Data indicated that people who used services in Halton who felt they have choice over services was 57.03% which was significantly worse than the England average of 70.28% (Adult Social Care Survey 2024). The local authority told us only a small number of people were paying to top up their direct payment to access a home care provider of their choice.

The local authority had a well-distributed geographical spread of residential and nursing home provision and sufficient capacity to meet current demand for non-specialist services. Staff told us people requiring more specialist care often had to seek residential care services outside the borough, particularly for people with mental health needs and more complex support requirements. Halton Borough Council was part of the Liverpool City Region Combined Authority which enabled them to access the Liverpool City region Flexible Purchasing System (FPS) to procure services for people with a range of needs and commission services from providers which were not available within Halton. This supported people who were placed out of borough to, in many cases, access placements which were within a 10 mile radius of Halton.

Commissioning strategies were aligned with the strategic objectives of partner agencies. The local authority had worked with partners to better understand market challenges to influence long-term planning and improve service delivery. Partners told us they had a very good relationship with the local authority, and they felt the local authority was responsive and personable. A local Co-production Charter was developed with people with lived experience along with commissioned research to explore the needs of the local population through a series of workshops and engagement sessions and surveys alongside feedback from complaints, and compliments enabled to shape the future of services. The local authority had used this to inform their commissioning of the upcoming home care provider framework.

The local authority had used the Market Position Statement 2023-2025 to identify market shaping measures which would need to take place to ensure they could meet the future needs of their population. The Market Position Statement identified to meet future demand due to the projected increase in population aged over 65 in the next 10 years, the current capacity within home care and residential and nursing homes will need to expand but leaders told us limited planning had taken place around this. The local authority had anticipated the increase in home care demand and factored this into their decision making to implement a wider home care provider framework which was due to commence after our assessment.

The local authority had commissioned and in-house services such as shared lives, day services and supported employment services to provide people with a range of support options. The services supported people with a wide variety of needs including adults with learning disabilities, people with physical and sensory disabilities and people with dementia. The local authority recognised that some of the commissioned models of care and support were not in line with best practice, such as building based day services, and were looking to make changes to provision where appropriate to ensure they were proportionate to a person's level of need. While some day services were based in micro-enterprises such as a brewery and a hair salon and some people had been supported to move into paid employment, we also heard about people who had been long-term attendees at the day centres.

The local authority had a transformation project in progress to improve support for adults with learning disabilities, aiming to enhance independence and optimise service efficiency. The local authority had identified key priority areas which were Supported living, Day Services, Respite Care, Residential and Nursing Care. To shape the future delivery of services, the local authority engaged with people who used services and their families to gather their insights. The local authority had commissioned research on provisions for people with a learning disability which was nearing completion at the time of our assessment. The local authority aimed to use the research to inform decision making on developing a more efficient and responsive service model.

The local authority had used their internal data from their housing panel to identify a rise in referrals for supported living provision where people can have their 'own front door'. Staff told us the local authority had identified their current housing stock for supported living was outdated and there were properties due to be decommissioned as the local authority updated their provision. The local authority was exploring options to build more single tenancy properties and had included this in their future housing strategy. While this was in progress and to support independence within existing provision, technology pilot programs were introduced, testing a blended model of care which integrated digital solutions, including computer tablets and sensors, to enhance flexibility and independence. The local authority highlighted in their Market Position Statement they wanted to explore the use of Individual Service Funds (ISF) to enable people to have more choice and control over their support.

The local authority had conducted research into the approaches taken by other local authorities to develop their Adult Social Care Commissioning Strategy for Care and Support 2023-2026. One focus of the strategy was on developing the support available from Voluntary, Community, and Faith Sector Enterprises (VCSFE) through grant funding. The local authority invested in a range of VSCFE, but partners told us they felt financial challenges had limited the growth of the sector. Partners told us they had noted improvements in recent months, expressing their input was valued in discussions about future service delivery. Partners told us felt their voices were heard and welcomed in board meetings, recognising their role as key stakeholders aligned with the local authority's strategic goals.

The local authority demonstrated work with stakeholders to review and expand integrated immediate care services within the community to reduce the reliance on long term services. There were examples of commissioning to support a preventative approach including the use of block-booked residential care home beds to support short term health needs to prevent hospital admissions. In addition, there was also a commissioned ‘step up- step down’ service working in partnership with stakeholders to facilitate hospital discharges and prevent hospital admissions to enable people greater opportunities to regain a level of independence. Partners told us this was an effective integrated team who worked together to respond to people who were unwell at home and give clinical support to prevent hospital admission.

Ensuring sufficient capacity in local services to meet demand

There was sufficient capacity to meet demand for people who required home care, and the local authority told us people did not have to wait for services to start. The local authority had good availability within extra care provision, where older adults can live independently with onsite support. Vacancy levels for non-specialist residential and nursing homes fluctuated based on demand however, generally had remained stable, with sufficient capacity to meet current needs. The local authority told us people could have some waits for residential and nursing home placements; however, these could be for a variety of reasons such as not being ready for discharge from hospital, or waiting for a placement of their choice, rather than lack of capacity.

There was some need for people to use services or support in places outside of their local area due to lack of local provision. Local authority data told us that as of October 2024, 141 people were placed in care homes outside of Halton. The local authority told us the reasons for such placements were due to the lack of specialist care home support within Halton, people's own choice and the timeliness of transfers such as to progress a person's discharge from hospital. Staff told us they had a focus on supporting individuals to return to their communities, when this was a person's choice, and their needs could be met within the area. Staff gave an example of a person who had been placed in an out-of-borough care home but was able to return to the local area when a nearby care home recruited additional staff to enable them to meet their needs. Staff told us there was an emphasis to keep the person within their community, however there were times the person's needs outweighed this.

The local authority had recognised the importance of unpaid carers and partners told us there was a good relationship with the unpaid carers network. Feedback from unpaid carers was actively sought by the local authority through consultation events on the theme of 'what carers feel is working or not in Halton'. This feedback was then incorporated into the One Halton Carers strategy 2024-2027.

We had mixed feedback about whether there was sufficient capacity for unpaid carers to have access to replacement care for the person they care for, in both planned and unplanned situations. Unpaid carers told us mixed feedback as some told us they had not heard of respite opportunities; however, others told us they had regular access to short breaks to enable them to continue in their caring role. The local authority had commissioned a respite service which was delivered within people's homes to enable carers to take a break where this was pre-booked. Data from the Survey of Adult Carers in England (SACE 2024) showed 15.00% of carers in Halton were accessing support services to take a break from caring for 1-24 hours, this was somewhat worse than the England average of 21.73%.

The local authority had identified through their consultation with unpaid carers there was no pre-bookable residential respite for older adults within the area, and they were evaluating their current respite provision and commissioning opportunities. The data for unpaid carers accessing support or services allowing them to take a break from caring for more than 24 hours was 20.00% which was similar to the England average of 16.14% (SACE 2024). There was provision of pre-bookable respite for people with a learning disability within the borough and staff told us this was reflected in people's care plans. Staff told us respite for unpaid carers of older adults provided within a residential home may mean the person moving to a care home out of the local authority area due to lack of availability in the borough when respite may be requested, which made it difficult for family and carers to visit.

The local authority had developed a data management system which provided information on the numbers of people who used support, broken down by service and primary support reasons which meant they knew what the market was providing, when and where people were receiving care, and they could track a person's journey across different care provisions over time. This data was used to identify people who were out of the borough and target the work of the specific teams to identify where people could move back to the area should they wish to.

Ensuring quality of local services

The local authority had clear arrangements to monitor the quality and impact of the care and support services being commissioned for people and it supported improvements where needed. The local authority had an established dedicated adult social care quality assurance team responsible for monitoring, reviewing and supporting commissioned care services. The quality assurance team played a crucial role in assessing the performance of commissioned services to ensure compliance with the established standards. Their responsibilities included evaluating provider performance against the expectations set out in contracts and service specifications in conjunction with the local authority's overall strategic priorities. Senior management within the local authority provided strategic oversight of the quality assurance process.

The quality assurance process for the local authority's internal care home provision was separate to their quality assurance framework for commissioned providers. There were improvement plans in place for all internal care home services as 1 was rated Good by CQC and 4 were rated Requires Improvement. At the time of our assessment, the Head of Service for Internal Care Homes was vacant. Given this was a critical role in the quality assurance process, an interim leadership arrangement was in place. The local authority had seconded additional staff into the Care Home division to ensure there was effective strategic oversight of quality. Partners told us work was ongoing and continuing to improve the quality of care within local authority owned care homes and they were seeing improvements through the reduction in quality-of-care concerns raised.

There were 41 registered adult social care services in Halton, including those managed by the local authority, at the time of our assessment, which were rated as 65.85% Good, 19.51% requires improvement and 2.44% inadequate by Care Quality Commission (CQC) with the remaining services unrated. National Data from the Adult Social Care Survey (2024) showed 79.13% of people who use services say those services have made them feel safe and secure which was lower than the England average (87.82%).

People told us they had concerns about the quality of care in care homes in Halton. The local authority was addressing safety and quality concerns in commissioned care provision and had undertaken comprehensive assessments through structured tools such as the Provider Assessment and Market Management Solution tool (PAMMS). PAMMS was a framework to assess the quality and compliance of care providers and partners told us they had undertaken these assessments and worked with the local authority collaboratively on any improvements which were required. The PAMMS process ensured the local authority were assured about the performance of providers through detailed analysis enabling identification of areas for improvement.

Where it was identified external providers required improvements to be made to the service, the local authority had put measures in place to continue monitoring and supporting the service. The local authority worked with a multi-disciplinary team through the Care Home Development Group which included key partners such as medication management teams, GPs, infection control teams, district nurses, and the local authority's care management team. The local authority was taking a collaborative approach to improving the quality of care however did place sanctions such as preventing new admissions to care homes when this was necessary. Partners told us they felt this work was showing improvements in the quality of care provided within care homes which they triangulated with information received from services working alongside providers.

The local authority quality assurance team carried out routine annual safe and well visits to commissioned services outside of core business hours which were unannounced. There was a focus on health and safety, observations of care and support, environmental factors and consultation with residents and staff. The local authority had 'keeping in touch' (KIT) days which were scheduled monthly with care home providers to establish and build relationships. Contract meetings were scheduled with Supported living and Domiciliary care providers on a quarterly basis. Providers told us they had strong relationships with the local authority and felt there was an open dialogue about any quality concerns to work together on improvements and an example was given of a recent issue with pharmacies where the local authority acted as an intermediary to resolve issues and ensure prescriptions were delivered in a timely manner.

The local authority's quality assurance framework included home care providers. Leaders told us work had been undertaken to ensure the quality assurance team had capacity to monitor the additional providers due to be added to the new provider framework. Through the quality assurance process, people who were using direct payments to purchase care with alternate care providers were given information on the quality of their chosen provider to enable them to make an informed decision about their care.

The local authority had processes in place should there be a service disruption, such as a provider failure to ensure the continuity of care, safety and wellbeing of all people using services. The local authority had a specific and comprehensive process for managing care home closures. A 'lessons learned' approach was undertaken upon reviewing the circumstances of failure to inform improvement measures and to prevent further recurrence.

Providers informed us the monthly 'information sharing group' meeting, facilitated by the local authority enabled external providers to come together to share trends, patterns and risks or emerging issues which may impact service delivery.

Ensuring local services are sustainable

We heard mixed feedback about how the local authority collaborated with care providers to ensure that the cost of care was transparent and fair. Partners told us the local authority had not yet confirmed funding rates for the new financial year at the time of our assessment. The rates were expected to be announced close to the start of the financial year which providers told us would create significant financial challenges as they would be unable to budget and forecast for the year ahead. The local authority told us they had undertaken consultation with providers and were expecting to notify providers about their funding rates shortly after our assessment.

In the past 12 months, no contracts had been handed back to the local authority by care providers across home care, supported living, or residential services. There was a stable and collaborative relationship between the local authority and the domiciliary care providers. Leaders told us a national care home provider had withdrawn from the market however, had waited for a purchaser rather than closing the homes which had enabled the care homes to remain open.

The local authority used performance and financial data to evaluate the current impact and value of care services and used this to target key areas of spend where improvements could be made to ensure the overall financial sustainability of care services within Halton. Leaders told us rather than cutting services to reduce costs, the focus was on remodelling to improve outcomes and reduce reliance and demand for services by increasing people's independence. For example, the provision of services for adults with learning disabilities had been identified as a high-cost area which was currently under review through the transformation programme to determine whether they could be provided in more efficient and effective ways while still providing good outcomes for people.

The transformation programme had commenced in 2023 and was due for initial completion in 2026. The local authority had carried out engagement seeking the views of people who used the services and their families to gain a better understanding of the service delivery. Additionally, this project focused on finding ways to sustain services more effectively and align them with the broader goals of the Adult Social Care Prevention Strategy 2023-2027. The key priorities included creating more employment opportunities for people with Learning Disabilities and increasing the focus on independence in service design.

The local authority had identified an increase in demand for services for older adults with projections indicating this will continue to rise over the next 10 years. Leaders were clear on the critical need to continue the work to prevent, reduce and delay care needs to manage future demands on services. The local authority had undertaken financial modelling to plan for the impact of meeting the potential future needs of their population.

The local authority understood its current and future social care workforce needs. It worked with care providers, including personal assistants and other agencies, to maintain and support capacity and capability as the high use of agency staff within home care and care homes presented significant challenges to the quality and consistency of care provided. The local authority's Adult Social Care Risk Assurance Framework 2024/25 identified recruitment and retention challenges, and an Adult social care workforce strategy was being developed.

Partners told us the local authority had been supportive of their efforts to recruit more staff and had assisted by advertising their vacancies on the local authority website for visibility. The local authority had made positive steps in recruiting a permanent workforce for their internal care homes, with just one having below 50% permanent staff at the time of our assessment and the other care homes nearly fully recruited. The local authority identified in their Market Sustainability Plan that a permanent workforce would provide better outcomes for people and better meet their needs and leaders were pleased with the progress they had made in the recruitment of permanent staff for their in-house services.

The local authority was working in partnership with the Liverpool City Region on a pilot programme, bringing together Direct Payment leads to explore ways to promote the role of personal assistants within adult social care. According to data shared by the local authority 645 people were currently receiving direct payments, however approximately half of these were using their direct payment to pay for a home care provider, rather than using the one offered by the local authority. The remaining people receiving a direct payment were using this to hire personal assistants. As part of the pilot actions were being taken to address this issue including the creation of job vacancies for those interested in pursuing a career as a personal assistant. The goal was to encourage more people to consider personal assistant as a viable and sustainable option for care thereby expanding the use of direct payments and more flexible in person centred way.

Partnerships and communities

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

The local authority commitment

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority worked collaboratively with partners to agree and align strategic priorities, plans and responsibilities for people in the area and to address shared concerns. The local authority had established the One Halton partnership where agencies agreed strategic plans and priorities which were laid out in the One Halton Health and Wellbeing Strategy for 2022-2027. One Halton was a partnership between the local authority, NHS organisations, GP Practices, Fire, Police and Voluntary organisations. Partners told us the One Halton Partnership was developed as a system-wide approach to address and reduce health inequalities within the area and there was a shared understanding of what the partnership was aiming to achieve. Partners told us One Halton was demonstrating small but incremental changes such as an increase in cancer screenings, which would potentially prevent, reduce or delay the future need for social and health care. A mid-point review of the One Halton Strategy was in planning stages at the time of our assessment to understand the impact the strategy had made on people's outcomes so far.

An example of collaborative work within the One Halton partnership had been the focus on falls prevention, specifically targeting older adults. Within this population, falls were of significant concern, leading to serious injuries, prolonged stays in hospitals or care settings, and reduced quality of life. The local authority had analysed data and worked closely with stakeholders including Public Health and healthcare providers to understand key issues. Prevention strategies had been developed to reduce key risk factors such as frailty, mobility and environmental hazards with initiatives to raise awareness and to educate older adults and their carers on prevention such as safe moving techniques and balance exercise programmes. The collaborative approach was delivered through the Intermediate Care and Frailty Service (HICaFS) where older adults received assessments and interventions designed to reduce the risk of falls. The One Halton partnership had focused on improving outcomes for older adults and ultimately reducing the future demand on healthcare and social care services.

The local authority had close links with educational establishments to support training of their workforce and had established The Research and Practice Development Care Partnership (RPDCP) which was a joint venture between the local authority, the University of Chester, Age UK Mid-Mersey, and the Caja Group. The local authority told us the partnership aimed to improve experiences of care by forging closer links between social care professionals and researchers. A recent piece of research had identified factors that were important in care services for older adults to maintain their wellbeing, such as the location of care in communities close to people where they could still access the same GP and community centres. The local authority was using these findings to inform their future planning of care provision, and this was being undertaken at the time of our assessment.

The local authority had worked closely with health partners to set up the Halton Health Hub. This was an outpatient clinic led by Warrington and Halton Teaching Hospitals NHS Foundation Trust, however, was developed jointly with the local authority and the local authority had accessed central government New Town funding to support this. Partners told us the local authority had been instrumental in joint planning for the Hub including public consultation to identify how people felt they would most benefit from the Hub. The Hub was supporting people to positive health outcomes for people to reduce their future need for social care. Partners told us there were plans for a joint health and education centre where local authority services will also be on site.

The local authority had integrated aspects of its care and support functions with partner agencies where this was best practice, and when it showed evidence of improved outcomes for people. The local authority worked closely with health partners to determine effective and appropriate ways to address shared issues such as people with no criteria to reside in hospital. The hospital discharge team and the mental health teams were both co-located with their health partners to ensure effective information sharing. Staff told us they worked closely with health partners to ensure positive outcomes for people, for example, through safe discharges from mental health hospitals.

Arrangements to support effective partnership working

When the local authority worked in partnerships with other agencies, there were clear arrangements for governance, accountability, monitoring, quality assurance and information sharing. Roles and responsibilities were clear. The One Halton Partnership had workstreams in place to agree strategic plans around specific identified priorities and senior responsible officers in place for these. Leaders told us there were close relationships between the local authority and partners which enabled information to be shared, and plans made appropriately around this.

The local authority used opportunities to pool budgets and jointly fund services with partners to achieve better outcomes. For example, pooled budgets had been used to set up Halton Integrated Care and Frailty Service (HICaFS) which was an integrated hospital discharge, reablement, intermediate care, and urgent community response service with a multi-disciplinary staff team working together to improve outcomes for people. There were joint funding arrangements in place to commission the Halton Integrated Community Equipment Service (HICES) through the BCF to enable professionals to access equipment to support people both on hospital discharge and at home.

The local authority was undertaking a pilot in a supported living provision which was funded by Cheshire and Merseyside Integrated Care Board (ICB) to trial blended support with technology being used alongside traditional care to support people to have greater independence and care tailored to their needs. The pilot had not been evaluated at the time of our assessment, but staff told us the early signs were showing positive outcomes for people.

Impact of partnership working

People told us the local authority had worked well with partners in a multi-agency way, and this had improved their outcomes. We reviewed people's care plans which evidenced multi-disciplinary partnership working to support people's wellbeing. The local authority monitored and evaluated the impact of its partnership working on the costs of social care and the outcomes for people. This informed ongoing development and continuous improvement. Partners told us they had positive working relationships with the local authority and there was two-way dialogue and appropriate challenge to ensure outcomes for people were being met.

Partners gave an example of where they had given the local authority feedback about a lack of understanding of sensory processing, and the local authority worked with partners to run workshops for families, professionals, and social care staff to increase their understanding of sensory processing. Partners also told us they had spoken with the local authority about people giving feedback about struggling to contact the local authority and not being able to use online services. The local authority had been responsive to this feedback and a Prevention and Wellbeing officer had commenced drop-in sessions at the partner's office to support people to access adult services if they needed this.

Working with voluntary and charity sector groups

The local authority worked collaboratively with Voluntary, Community and Faith Sector Enterprises (VCFSE) to understand and meet local social care needs. The local authority provided funding and other support opportunities to encourage growth and innovation within VCFSE. The local authority had provided funding to a range of VCFSE to enable them to provide services such as post-hospital discharge support and social support to reduce a person's isolation which were supporting people to remain healthy and independent. A partner told us they had a positive relationship with the Prevention and Wellbeing Service at the local authority and were supporting people who needed some assistance to live independently at home such as social prescribing and benefits advice which reduced people's need for local authority services.

However, partners told us they were having to reduce or remodel their offers due to reduced funding from the local authority, which was limiting the positive impacts they could provide for people and support them to prevent, reduce or delay their need for adult social care. We heard mixed views from partners on the impact of this, as one partner told us they had redesigned services to be more strengths-based to achieve the same outcomes for people with their reduced funding, and we heard an example of reducing long-term befriending services to focus on short-term interventions such as linking people with community assets. Some partners told us the local authority needed to be more creative in their approach to VCSFE and invest further in VCSFE to enable more people to be supported outside of commissioned adult social care services.

Other partners told us they felt the local authority was proactive in engagement with the voluntary sector and the local authority had a good understanding of the work and contribution from voluntary sector organisations. Staff told us some VCFSE had closed during covid and there were not as many as there used to be, which limited options for people to socialise outside of formal care services, but the community centres were providing good outcomes for people.

Theme 3: How Halton Borough Council ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

We may not always review all quality statements during every assessment.

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place. I feel safe and am supported to understand and manage any risks.

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Key findings for this quality statement

Safety management

Safety was a priority for everyone. The local authority understood the risks to people across their care journeys; risks were identified and managed proactively; the effectiveness of these processes in keeping people safe was routinely monitored. The views of people who use services, partners and staff were listened to and considered. For example, leaders told us the data around people feeling safe in a care home had dipped and the Safeguarding Adults Board challenged why this was, therefore a task and finish group was set up to identify solutions to ensure people felt safer. We saw documents that evidenced people's care plans identified risks to the person and the wider public and staff had identified measures to manage risk while ensuring a person-centred approach. The local authority used data to have oversight of waiting lists and had adopted a waiting well approach to ensure people were given regular updates and risk re-assessed while they awaited a Care Act assessment.

Policies and processes about safety were aligned with other partners who were involved in people's care journeys. Multi-agency audits were undertaken by the Safeguarding Adults Board to provide assurance that risks to people in their care were identified and themes were addressed as a joint priority. Partners told us key priorities were reviewed regularly at partnership boards and the Health and Wellbeing Board to ensure risks were shared between partners and addressed.

Information sharing protocols supported safe, secure, and timely sharing of personal information in ways that protected people's rights and privacy. Partners told us that local authority staff had access to their computer recording system to ensure they could safely access a person's records to streamline their care without needing information to be shared between systems. Staff told us there was effective sharing of information within the hospital discharge services to ensure they were updated on people's needs. We reviewed documents that demonstrated safe and timely information sharing between services when a person moved into a residential home in another area to ensure a smooth transition.

Safety during transitions

Care and support was planned and organised with people, together with partners and communities in ways that improved their safety across their care journeys and ensured continuity in care. This included referrals, admissions, and discharge, and when people were moving between services.

The local authority had a pathway in place to support safe transitions from child to adult services. People approaching the age of 16 who had an Educational Healthcare Plan (EHCP) were referred to the dedicated transitions team who worked with young people from aged 16 to 25 with a named worker approach which meant people kept a consistent worker into adulthood. A person could also be referred to the transitions team at age 14 if it was identified a longer term involvement was required to facilitate a smooth transition to adult services. The transitions team worked with people who had learning disabilities, visual and/or hearing impairments and life limiting physical disabilities to ensure they had a care plan in place before their 18th birthday.

We heard mixed feedback about people who did not meet the criteria for the transitions team with people with mental health illnesses transitioning to adult services aged 18 when they were closed to Child and Adolescent Mental Health Services (CAMHS). The local authority's transitions protocol reflected that a young person should be assessed by the mental health team at 16 however we heard this was not happening in practice. Local authority leaders told us their mental health social workers could become involved prior to a person turning 18 and provided the example of people who had been subject to the Mental Health Act. Partners told us there needed to be greater focus on continuity of care for people transitioning to adult services when they were open to mental health services as the focus was on age criteria for services rather than need. Other partners told us families did not know how to access the transitions service when they were not automatically referred, and they did not feel information was readily available outside of the transitions team.

The local authority had social workers based on hospital sites to ensure safe and timely discharge from hospital. Partners and staff told us local authority staff were integral parts of the discharge process to work collaboratively with the hospital to co-ordinate a person's transition out of hospital. Partners told us this approach was mirrored in mental health acute hospitals where local authority staff were invited to initial multi-disciplinary meetings on a person's admission and contributed to discharge planning from this point. Staff told us they worked flexibly across the hospital sites in Warrington and Whiston to support discharge flow in both areas. Staff gave examples of working jointly with health partners to ensure a person's needs were clear and they had the appropriate support in place on discharge, such as requesting speech and language support to undertake mental capacity assessments.

Where there were identified delays to a person's discharge this was discussed jointly between the health trust and the local authority and partners told us there was joint ownership of any issues impacting on safe discharge. The local authority was working with partners to trial new processes for hospital discharges such as introducing board rounds in one hospital site to ensure services and teams were kept up to date on people's needs. Staff told us there were daily discussions between the hospital and Halton Intermediate Care and Frailty Service (HICaFS) to discuss reablement care as a first option for people to ensure they had the opportunity to regain their optimal independence.

The local authority had recently commenced use of the Trusted Assessor model to support admissions to care home placements. Partners told us this would enable the local authority to follow a best practice model which has been adopted by many local authorities nationally. The trusted assessor reviewed a person's discharge assessment to determine the most appropriate discharge location and then identified care home placements which could meet that person's needs. Staff told us this was in the early stages of implementation, and it was planned to be expanded to home care packages, but it was already providing benefits for people. Staff told us the trusted assessor was able to streamline processes for people by discussing a person's need with care homes and this meant a person, or their family, only had to discuss this with one professional rather than with each care home.

Specific consideration was given to protecting the safety and well-being of people who were using services which were located away from their local area, and when people move from one local authority area to another. The local authority had an Out of Borough Provider Validation process to quality assure and review services being used which were out of the local authority area. The local authority had reciprocal information sharing agreements in place with neighbouring authorities to ensure any concerns about care in care homes outside the area were shared with the placing authority. Staff told us they would complete annual reviews for people when they were moved to a service out of the local authority area.

Contingency planning

The local authority had undertaken contingency planning to ensure preparedness for interruptions in the provision of care and support. The local authority knew how it would respond to different scenarios; plans and information sharing arrangements were set up in advance with partner agencies and neighbouring authorities to minimise the risks to people's safety and wellbeing. However, some unpaid carers told us they did not have an emergency plan in place should they be unable to continue in their caring role.

The local authority had clear business continuity plans in place for any disruptions which might impact local authority functioning. We reviewed an example of how this had been implemented with minimal disruption during a power cut at the local authority. The local authority had jointly devised service continuity plans with partners to provide guidance in case of any provider failure and minimise disruptions to a person's care.

Funding decisions or disputes with other agencies did not lead to delays in the provision of care and support. Staff told us they were aware of when a home care provider may close the provision due to a hospital admission and described good links with the provider to ensure a person had support in place when they were discharged from hospital.

Safeguarding

Score: 3

3 - Evidence shows a good standard

What people expect

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Key findings for this quality statement

Safeguarding systems, processes and practices

There were effective systems, processes, practices to make sure people were protected from abuse and neglect. The local authority had clear safeguarding polices in place and undertook regular case audits to ensure processes had been followed. The local authority had an Integrated Safeguarding Unit (IASU) who screened all safeguarding concerns to determine whether they met criteria for a section 42 enquiry. Partners told us they were able to contact the local authority and receive advice and guidance as to whether they should raise any safeguarding concerns.

Local authority processes stated concerns were to be screened within 24 hours of receipt and an initial risk assessment completed within 48 hours. Data provided by the local authority showed the median waiting time between receiving a concern and screening being completed was 0 days. Following the screening, if a section 42 enquiry was required, this would be completed by an appropriate member of staff from any of the social care teams.

The local authority worked with the Safeguarding Adults Board (SAB) and partners to deliver a co-ordinated approach to safeguarding adults in the area. The SAB did not have an independent chair, however following a North West ADASS Peer Review an independent scrutineer had been appointed which partners told us was helping the Board function better and provided increased internal challenge. Partners told us there was wide representation from different organisations on the board and the board membership had been widened to include more health partners and emergency service safeguarding leads which was leading to greater engagement and discussion. Leaders told us the Independent Scrutineer was due to provide their first report shortly after our assessment however there had already been useful feedback provided and improvements made, for example in using performance dashboards to monitor trends.

There were strong multi-agency safeguarding partnerships, and the roles and responsibilities for identifying and responding to concerns were clear. Information sharing arrangements were in place so that concerns were raised quickly and investigated without delay.

When safeguarding concerns related to people using a care service, the local authority had a pathway in place whereby the care provider would undertake an enquiry into the concern if it did not meet the threshold for a section 42 enquiry. Staff told us where providers led on investigating concerns, the local authority would review these to identify any emerging themes and identify any action which needed to be taken. Themes were also fed back to the Care Home Development group and multi-agency action plans devised if needed.

Staff involved in safeguarding work were suitably trained and supported to undertake safeguarding duties effectively. National data showed 53.92% of independent or local authority staff had completed safeguarding adults training which was similar to the England average of 48.70% (Adult Social Care Workforce Estimates 2023-2024). Staff told us they felt challenged due to a lack of experienced social workers within the IASU however told us they were a supportive team and worked together to manage risk with support from experienced managers and staff. The local authority undertook regular audits of safeguarding enquiries to ensure consistent practice across staff.

Responding to local safeguarding risks and issues

There was a clear understanding of the safeguarding risks and issues in the area. The local authority worked with safeguarding partners to reduce risks and to prevent abuse and neglect from occurring. The Safeguarding Adults Board (SAB) had identified their priorities for 2023-24 as quality assurance, co-production, and engagement, and learning and professional development. In their annual report 2023-24 the SAB reported they had undertaken thematic audits of cases under the themes of self-neglect, neglect and acts of omission in a person's home and concerns triaged by the Emergency Duty Team.

The local authority maintained strong links with a secure mental health rehabilitation service within the area and there were weekly meetings which took place between the centre's lead safeguarding practitioner and the local authority's Integrated Adult Safeguarding Unit (IASU) to ensure any themes on concerns were identified and to discuss any new concerns. There was also a wider multi-disciplinary team meeting which took place monthly between IASU, the Safeguarding Lead, advocacy, the Integrated Care Board (ICB) safeguarding lead and a linked officer from Cheshire Police. This enabled any themes or concerns to be discussed with a wider team of professionals.

Following an audit into a case involving self-neglect, the local authority had implemented a Multi-Agency Risk Assessment and Management policy (MARAM). The MARAM provided a framework for multi-agency working to address risk where an individual was not subject to a section 42 enquiry. Staff told us they felt the MARAM approach had been useful when working with several agencies to ensure risk management was co-ordinated and shared between services and gave us an example of working with a person with significant health needs and working under MARAM were able to co-ordinate responses to ensure a person's needs were met holistically.

Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice. The local authority had not been subject to a Safeguarding Adults Review (SAR) in the 2 years prior to our assessment despite several cases having been considered and rejected. To allay concerns about this, the Safeguarding Adult Board had introduced a new process whereby referrals for SARs were considered by a sub-group with sign off from the SAB Chair on their decision and oversight from the Independent Scrutineer. Partners told us the SAR referral criteria had been reviewed as it was not aligned with neighbouring authorities' which could cause uncertainty on when to refer. At the time of our assessment there were 7 cases going through the SAR consideration process, 2 of which were to be progressed to a SAR.

The SAB disseminated learning from SARs which had taken place across the region, arranging lunch and learn sessions for all partner agencies of the board and their staff to attend. Staff told us they had attended recent training sessions on learning from SARs including sessions about domestic violence and alcohol abuse.

Responding to concerns and undertaking Section 42 enquiries

There was clarity on what constituted a Section 42 safeguarding concern and when S42 safeguarding enquiries were required, and this was applied consistently. There was a clear rationale and outcome from initial enquiries, including those which did not progress to a Section 42 enquiry. The local authority had detailed guidance in place to support practitioners in determining when a safeguarding concern should be raised and when section 42 enquiries were required. The local authority also had guidance on whether a concern should be a provider-led response or referred for a section 42 enquiry.

The local authority told us between 1st March 2024 and 28th February 2025 they received 811 safeguarding concerns, all of which were triaged and 311 (41%) progressed to section 42 enquiries. The local authority had seen a reduction in safeguarding referrals received over the last 2 years according to national Safeguarding Adults Collection (SAC) data with 1095 concerns received in 2022-23 and 810 received in 2023-24. Leaders told us they were assured safeguarding concerns were being raised appropriately as data was triangulated with information from partners at the Safeguarding Adults Board (SAB) so they would be able to identify if partners were not raising concerns with the local authority.

There were clear standards and quality assurance arrangements in place for conducting Section 42 enquiries. The local authority reviewed data on safeguarding concerns received each week and monitored outcomes and any emerging themes and trends. Data on provider-led concerns was also reviewed by the IASU and Quality Assurance team to monitor trends in concerns originating from care providers. The quality assurance team were part of the quality subgroup at Halton SAB and discussed any themes with care quality with partners at the board. The local authority had a process for auditing safeguarding case files and in addition, thematic reviews were undertaken by the SAB.

The local authority had a backlog of Deprivation of Liberty Safeguards (DoLS) applications awaiting allocation to a Best Interest Assessor (BIA). Data provided by the local authority said there were 210 DoLS assessments awaiting completion in February 2025 which was a significant improvement from February 2024 when there were 394 applications outstanding. The local authority told us 118 of the waiting DoLS referrals were from hospital applications. Waiting lists for DoLS, including applications received from hospital settings, were prioritised within the local authority against the ADASS prioritisation tool and reviewed by a qualified BIA to ensure immediate risks were identified and addressed. The local authority was working with the North West ADASS DoLS group to discuss ways to streamline the process and reduce waiting lists.

We heard mixed feedback about whether relevant agencies were informed of the outcomes of safeguarding enquiries when it was necessary to the ongoing safety of the person concerned. Most partners told us they were informed of safeguarding enquiry progress and outcomes however, some told us they did not receive feedback and felt they had to chase the local authority to learn of outcomes.

Making safeguarding personal

Safeguarding enquiries were carried out sensitively and without delay, keeping the wishes and best interests of the person concerned at the centre. Data provided by the local authority told us all safeguarding enquiries were triaged within 24 hours of receipt and initial conversations with the person commenced at this point.

Staff told us there had been inconsistencies in how people's wishes were recorded in safeguarding enquiries particularly the voices of seldom heard groups, and there had been training completed with all staff to ensure consistency in their approach. Local authority processes highlighted the importance of consulting with the person and recording their wishes. Staff told us they kept the person at the centre of all safeguarding enquiries, ensuring their views were at the forefront including where a person would need additional support such as translators to make their views known.

People could participate in the safeguarding process as much as they wanted to, and people could access support from an advocate if they wished to do so. People were supported to understand their rights, including their human rights, rights under the Mental Capacity Act 2005 and their rights under the Equality Act 2010 and they were supported to make choices which balanced risks with positive choice and control in their lives. Partners told us told us staff had good links with advocacy services and knew when to refer a person for advocacy support. National data from the Safeguarding Adults Collection told us 81.48% people who lacked capacity were supported by an advocate, friend or family which was similar to the England average (83.38%).

Safeguarding plans and actions to reduce future risks for individual people were in place and they are acted on. The local authority provided data which told us in quarter 2 of 2024-25 97% of people whose section 42 enquiry was concluded had their desired outcomes met or partially met. They told us this was an improvement from Quarter 1 2024-25 where 90% of people had their desired outcomes met or partially met.

Theme 4: Leadership

This theme includes these quality statements:

- Governance, management and sustainability
- Learning, improvement and innovation

We may not always review all quality statements during every assessment.

Governance, management and sustainability

Score: 2

2 - Evidence shows some shortfalls

The local authority commitment

We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Key findings for this quality statement

Governance, accountability and risk management

There were clear and effective governance, management, and accountability arrangements at all levels within the local authority; these provided visibility and assurance on delivery of Care Act duties.

Approximately 2 years ago, the local authority had separated the previously joint adult social care and children's departments into separate directorates. Leaders told us this provided greater visibility, leadership capacity and accountability for adult services as the DASS reported directly to the Chief Executive rather than being accountable to the Director of Children's Services as per the previous structure. They were also a full member of the corporate leadership team.

There was accountability within the local authority for quality and sustainability and risks to delivery of Care Act duties. Partners told us there was regular oversight and quality assurance meetings held jointly with the local authority to share concerns and make decisions collaboratively. The projected increase in population of those aged 65+ was being discussed at a strategic level with partners and leaders were clear on the critical need to continue the work to prevent, reduce and delay care needs to manage future demands on services. The local authority had completed financial modelling to project the impact of their future population needs.

There was a stable adult social care leadership team with clear roles, responsibilities, and accountabilities. The statutory role of Director of Adult Social Services (DASS) was held by the Executive Director for Adult Services, a post which they had held for several years. The leadership team had extensive service within the local authority, and this enabled them to have strong relationships with staff and partners. Partners told us they knew who to contact in the local authority management team. Staff told us leaders were approachable and supportive.

Council members had oversight of data relating to local authority functions and had regular meetings with the Director of Adult Social Services (DASS) to discuss any concerns they had. They also received papers and information from senior management team meetings to review and to inform the scrutiny function.

The local authority used audits to monitor implementation of policy and the impact this was having on practice. Where any performance issues were identified, there were workplans devised to address these which were overseen by the senior management team. We reviewed workplans which evidenced achievable goals and progress being monitored regularly. The local authority acted upon the outcomes of case audits and staff told us about the Multi-Agency Risk Assessment and Management process which had been implemented following learning from a safeguarding case audit.

There were clear risk management and escalation arrangements. These included escalation internally and externally as required. There was awareness between senior leaders and partners of risks facing adult social care now and in the future. The local authority had a service level risk register which had identified risks and measures to manage these with escalation processes in place. The local authority demonstrated that they acted where risks were identified such as when they had identified an issue with waiting lists for Occupational Therapy and as part of their improvement plan had appointed a Principal Occupational Therapist to ensure best practice and risk management

There was a Transformation Programme in place, designed corporately, with elements covering adult social care and a specific adult social care delivery plan. We heard mixed feedback from leaders as to whether the plan was achievable within the planned timescales. The council's sustainability depended on changes being made within identified timescales, but leaders told us the transformation required further strategizing and engagement with people to ensure its impact was controlled and providing positive outcomes for people.

Senior leaders understood the local authority needed to change its operating model to ensure its sustainability with growing demand for adult social care, however we heard differing views from leaders on how this should be achieved. There was not a clear structure and process in place to implement the large-scale changes which were needed at pace to drive a sustainable, prevention, and strengths-based service and extend this beyond the current Transformation Programme.

There was consistent feedback from leaders who recognised while the current model was not thought to be sustainable, there needed to be system-wide change, co-produced with people, to deliver effective transformation and provide a greater focus on prevention and independence. Some positive changes had been made such as the introduction of the Prevention and Wellbeing Service (PWS), which were making an identifiable difference to promoting a strengths-based, community focus for residents. However, the transformation plan was, in its current format, focussed on working with people with a learning disability with limited wider learning or improvement and staff told us they were not aware of any wider changes as a result of the transformation work.

The local authority's political and executive leaders were well informed about the potential risks facing adult social care. There was a scrutiny process in place with elected members through the Health Policy and Performance Board (PPB). Leaders told us there had been additional oversight put into place over and above the scheme of delegation due to the financial pressures of the local authority and they felt this was a positive step to give greater review of decisions. However, leaders and partners told us the Health PPB agenda covered both health and adult social care which they felt did not enable sufficient time for adequate scrutiny and challenge, and they would prefer a separate adult social care meeting.

Strategic planning

The local authority used information about risks, performance, inequalities, and outcomes to inform its adult social strategy and plans. The local authority used data to inform its strategic change and development. The local authority had identified an increase in overdue annual reviews for people and had implemented a reviewing team to ensure people had a review of their care. The local authority was monitoring the data relating to this and had noted improvements in numbers of outstanding annual reviews and the team remained in place to continue their targeted work.

The local authority had monthly multi-agency meetings which included partners and advocacy to discuss shared data and used this to identify emerging trends and how resources should be allocated to address these. Partners told us they had shared data, and this led discussions about joint priorities. Key Performance Indicators were fed back to the Chief Executive to ensure business plans could be updated to address any changes needed to the service. Staff told us an example of how data demonstrated additional resource was required to support unpaid carers and following this, additional carers assessors were resourced and implemented.

The local authority had a Workforce Development Plan to address any impact of staffing on their duties. Leaders told us there was a strong 'grow your own' culture, which meant staff were supported to achieve qualifications and progress their careers within the local authority. Staff told us how they shared knowledge and experience through informal ways such as team meetings and practice sessions and that this was beneficial and strengthened relationships across teams.

Information security

The local authority had arrangements in place to maintain the security, availability, integrity and confidentiality of data, records and data management systems. Staff had access to secure email systems to support safe sharing of information with partners and there was an information governance team who oversaw the security and management of information. Where staff had access to multiple information systems, such as the emergency duty team who covered across two local authorities, staff told us of appropriate information security measures which were in place to protect people's data.

Learning, improvement and innovation

Score: 3

3 - Evidence shows a good standard

The local authority commitment

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Key findings for this quality statement

Continuous learning, improvement and professional development

There was an inclusive and positive culture of continuous learning and improvement. Local authority staff had ongoing access to learning and support so that Care Act duties were delivered safely and effectively. Staff were supported and encouraged to carry out training relevant to their roles to support practice. Staff told us about Social Work Matters events which were held every three months to share best practice, knowledge, updates on services available, and any relevant information. One staff member told us they had presented a case at the event to share their experience working with someone who did not speak English as a first langauge and how they used a translator and provided all documentation in the person's preferred language.

There was support for continuous professional development. Staff were supported to progress in their career. There were members of staff who had completed their Apprenticeship, Assessed and Supported Year in Employment (ASYE), and had been supported to progress to more senior roles.

There were some examples of co-production such as people who use services supporting with Interviews and reviewing policies and procedures. People told us they felt listened to and respected by the local authority; however, they told us change never really happened and improvements needed to be made to fully embed co-production as it was mostly used to consult with people rather than co-producing strategy. People who used services told us about their work interviewing people and their carers to gain feedback about supported living, one person told us they were completing a training course to be able to support the delivery of Oliver McGowan training, some people were also involved in making a video for The Social Care Institute for Excellence (SCIE) talking about their lives and the projects they had been involved in. Leaders identified there were opportunities to improve co-production further and ensure it was a part of routine service design.

The transformation programme was created as part of the Council's 3-year Reimagine Halton programme which began in April 2023, focusing on services for Adults with a Learning Disability, in particular Supported Living Services, Day Service Provision, Residential and Nursing Care Provision, Specialist Services and Respite Care Services. The focus of this work was to ensure a continued emphasis on meeting people's needs using a strengths and asset-based approach, whilst also reducing costs and delivering value for money. Staff told us the transformation programme had some good ideas, but they had yet to see any changes in practice.

The local authority commissioned the Institute of Public Care at Oxford Brooks University to carry out academic research, working in co-production with people who have a learning disability to gain their views and insight on what is needed in Halton. This work was still ongoing at the time of our assessment. Feedback from people regarding this work was positive.

The One Halton Carers Strategy 2024-2027 and delivery plan were co-produced with unpaid carers across Halton, the local authority told us they arranged a carers forum to gain insight into what it was like to be a carer. Feedback we received from unpaid carers regarding co-production was mixed with some unpaid carers not being aware of any co-production projects. Unpaid carers told us they were unsure whether their input would make any real changes.

The local authority gave examples of how they used evidence-based practice and shared learning to improve their services. An example of this was through their corporate Equality, Diversity and Inclusion (EDI) network in which adult social care were heavily involved. The local authority told us how they sought guidance from neighbouring local authorities to see what worked well and what should be improved when considering EDI. This helped the local authority identify areas they wanted to focus on when improving EDI for their staff and the people of Halton.

Leaders had taken part in a reverse mentoring scheme within the local authority in which leaders were mentored by staff who were neurodivergent to raise awareness on what it is like to work and live for those people. Leaders told us how they planned to use this learning to raise awareness to staff within the local authority which in turn would impact on their skills and knowledge in the community. The local authority was sharing their learning from the implementation of reverse mentoring with other local authorities within the region.

Learning from feedback

The local authority learned from people's feedback about their experiences of care and support, and feedback from staff and partners. This informed strategy, improvement activity and decision making at all levels. For example, the Halton Strategy for Adults with a Learning Disability was co-produced to identify 5 changes to help unlock an equal life for people with a learning disability. Additionally, there had been some recent research carried out by the University of Chester which studied the experiences of people using care and support services. The findings from this research supported improvements in relation to the home care offer. The new home care offer was not rolled out at the time of our assessment but was due to be rolled out soon to improve choice for people wanting to commission their home care through the local authority.

Leaders identified feedback from people who use services could be improved and they were looking at ways to improve the uptake of people's feedback via surveys etc to better gain the views of people using services and their unpaid carers. The local authority had undertaken consultation with people who use services to obtain feedback on their experiences.

The local authority used learning from complaints to improve practice. The Local Government Social Care Ombudsman (LGSCO) review report 2023-2024 stated they had received 5 complaints in respect to adult social care in Halton, of which, none of these were upheld. The Adult Social Care Annual Report 2023-2024 stated Halton had received 45 complaints, this was an increase on the previous year in which the local authority received 29 complaints. Leaders had oversight of compliments and complaints, and appropriate action was taken in a timely manner.

There were processes to ensure that learning happened when things went wrong, and from examples of good practice. Leaders encouraged reflection and collective problem-solving. Staff could speak with their team, their manager, and leaders openly and honestly and gained advice and support both formally in supervision and informally.

Adult Social Care

Care Quality Commission (CQC) Assessment

Improvement Plan

August 2025

Quality Statement 1: Assessing Needs (Score 2)

No.	Improvement Priority and Actions	Accountable Officer	Timeframe for Completion/ Key Dates	Progress	Monitoring Arrangements
1.1	Aim for people to only have to tell their story once • Overall ambition is to have a named work approach to reduce the need for people to tell their story more than once.	HoS – Care Management & PSW	Review – January 2026	Use of the team transfer process outlined in the Social Care Practice guidance to support approach. Work being progressed in Complex Care Widnes team in respect to Supported Living settings – named workers will be identified. This to be replicated across Complex Care Runcorn Team. Approach with care homes to be explored with Quality Assurance Team. Ongoing work in respect to recruitment and retention of staff.	Quarterly update to SMT
1.2	Re-assessment or review – Reduction in waits • Continue with the work already in place and being progressed which is addressing waiting lists/times, including the project regarding the use of AI which will support the reduction in waiting times in respect to re-assessment and reviews, but also initial assessments.	HoS – Care Management & PSW	March 2026	Care Reviews – Baseline position @ 28.2.25 :- • As at 28.2.25, there were 2,075 people in receipt of a long-term service. Of those individuals, during the last 12 months, 1,793 reviews had been completed and there were 282 reviews outstanding. Target as at end March 2026 = **TBC** NB. Need to ensure to take into account any reviews which have been identified as being needed within a 6 month period.	Quarterly performance updates to SMT

				Regular Performance meetings with Care Management need to be re-established. Progress in respect to AI developments are being shared and discussed at the Care Management Principal/Practice Manager meeting w/c 18.8.25 - Salesforce CRM and AI will be used in conjunction to support Adult and Children's Social Care workers in undertaking client reviews and assessments. Interviews with clients (subject to consent) will be recorded and automatically summarized, transcribed and inputted into the client's Eclipse case record (subject to the professional oversight of the social worker). The goal is to significantly reduce the SWs administration overhead, thereby improving productivity and allowing the SW more time to deploy their professional expertise.	
1.3	OT Assessments - Reduction in waits *(Link with 2.3)* • Continue with the work already in place and being progressed which is addressing waiting lists/times, including the project regarding the use of AI which will support the reduction in waiting times in respect to re-assessment and reviews, but also initial assessments.	Principal Occupational Therapist	March 2026	OT Assessments – Baseline position @ 28.2.25 :- • As at 28.2.25, there were 122 people waiting for an OT assessment. Target as at end March 2026 = **TBC** Regular Performance meetings with Care Management need to be re-established.	Quarterly performance updates to SMT

				Progress in respect to AI developments are being shared and discussed at the Care Management Principal/Practice Manager meeting w/c 18.8.25 - Salesforce CRM and AI will be used in conjunction to support Adult and Children's Social Care workers in undertaking client reviews and assessments. Interviews with clients (subject to consent) will be recorded and automatically summarized, transcribed and inputted into the client's Eclipse case record (subject to the professional oversight of the social worker). The goal is to significantly reduce the SWs administration overhead, thereby improving productivity and allowing the SW more time to deploy their professional expertise.	
1.4	Carers Assessments – Contingency Plans *(Link with 6.3)*	HoS – Care Management & PSW	March 2026	Contingency Plans – Baseline position @ 28.2.25 :- • As at 28.2.25, zero. Process now in place for completing contingency plans and is being implemented. Target as at end March 2026 = 25% of contingency plans to have been completed.	Quarterly performance updates to SMT
1.5	Carers Assessments – Waits on phone • Continue with the work already in place and being progressed	HoS – Care Management & PSW	Review - March 2026	The Contact Centre has an Adult Social Care line, which is a priority line and between January and	Quarterly performance updates to SMT, to include update from

	which is addressing waiting lists/times in respect to Carers Assessments.			December 2024, the average wait time was 12 mins and 22 seconds. In addition, we have direct email addresses for the Prevention & Wellbeing Service and Occupational Therapy which are monitored throughout the day as part of duty. We direct partners to these emails addresses as much as possible e.g. they can email the inbox directly, if they need a call back, rather than going via the contact centre. These email addresses are also given to people open to a worker for easier contact. It is anticipated that work on the Customer Care Journey project will improve wait times. In the process of automating a number of high volume low skill services such as missed bins, tip permits, fly tipping, pest control etc which will free up advisors to deal with the social care calls in a more timely manner. Are also introducing a Customer portal so customers can access services 24/7 and will be working over the next year to move more services to this portal. As part of Website Improvements (*Link to 2.4*), need to focus on content of ASC pages to ensure all information is on there and up to date. This will support the customer portal work.	Contact Centre on average wait times in respect to the ASC phone line.

				Carer Assessments – Baseline position @ 28.2.25 • Waiting List Size = **6** waiting for an assessment to be allocated to a worker. Target as at end March 2026 = **TBC**	
1.6	Financial Assessments – Reduction in waits • Continue with the work already in place and being progressed which is addressing waiting lists/times	Income, Assessment & Income Recovery Manager	March 2026	New process now in place; since the CQC Assessment, the I&A Team has continued to refine the referral and financial assessment processes to improve processing times. A standardised financial assessment referral form has been implemented within Eclipse for social work teams to use when identifying clients who require a financial assessment. This applies to clients with an existing service package as well as those considering a package of care. Stringent new procedural targets have been introduced for each stage of the financial assessment process, starting from the point a referral is received. For example initial contact to client by phone to arrange a telephone assessment appointment should be made within 2 working days of receipt of the financial assessment referral. Where targets are not met, reasons are documented to help identify areas for future improvement.	Quarterly performance updates to SMT – Performance updates will be based on the new procedural targets for the Service

				Financial Assessments - Baseline position @ 28.2.25:-
				
				• Waiting List Size = **55** waiting for a financial assessment to be fully completed.
				• Median waiting time *(from the commencement of service to financial assessment being completed for new cases)* - Over 12-month period 1.3.24 – 28.2.25.
				  ○ Combined Median = **30 days**
				  ○ Domiciliary Median = **15 days**
				  ○ Residential Median = **28 days**
				• Maximum waiting time *(from the commencement of service to financial assessment being completed for new cases)* - Over 12-month period 1.3.24 – 28.2.25
				  ○ Domiciliary Maximum = **298 days**
				  ○ Residential Maximum = **305 days**
				
				Target as at end March 2026 - The service has put into place a KPI to monitor the percentage of new assessments that are completed within 30 days. The aim is to complete 75% of all new	

				assessments within 30 days by the end of the year. (Q1/25: 74.25% were completed within 30 days) NB. The information requested by CQC as part of the Assessment process is not kept as standard by the service and has had to be produced manually, however from April 2026, the service should be in a position to generate this data in the required format.	

Quality Statement 2: Supporting People to Lead Healthier Lives **(Score 3)**

No.	Improvement Priority and Actions	Accountable Officer	Timeframe for Completion/ Key Dates	Progress	Monitoring Arrangements
2.1	Promoting preventative, strengths-based culture in Halton	Director of Adult Social Services	Review – March 2026	Strengths Based practice is now embedded and as part of our operational processes we routinely monitor this via case file audits, supervision, team meetings etc. We have developed a 'Train the Trainer' model for staff and people with lived experience to provide on-going training to new staff and refresher training for existing staff. We continue to engage across the Cheshire & Merseyside region Training Partnership, Research in Practice and Skills for Care to access strengths-based practice training opportunities, which are	Updates to SMT, when appropriate.

				cascaded through the teams via learning sets. This is also demonstrated from a strategic perspective in Halton's Health & Wellbeing Strategy, our Adult Social Care Commissioning and Prevention strategies. A new commissioning strategy/plan is due for completion by end of March 2026, whilst the Prevention strategy runs until March 2027.	
2.2	Carers - Access to preventative services • Range and access to preventative services to be reviewed and monitored as part of the implementation of the Carers Strategy via the Carers Strategy Group	Director – Commissioning & Prevention	Review – March 2027	One Halton Carers Strategy 2024-2027 in place. Continuing and improving access to preventative services forms part of the implementation of the Strategy's Delivery Plan. The Carers Strategy Group to capture ongoing actions against delivery plan to support reporting through to SMT. A range of activities are undertaken to support carers, for example:- • Carers Centre receive and distribute Carers Break Funding on behalf of the Council. • A number of small local community & voluntary organisations receive grant funding to facilitate activity to support carers.	Carers Strategy Group to provide quarterly updates to SMT

				• One off carer's breaks funding via a Direct Payment. • Home-Based Respite Care Service, which allows carers to have time away from their caring role, whilst maintaining a safe and consistent level of support to the person being cared for. • Accelerated Reform Funding received by Halton was passported over to Halton Carers Centre to develop a series of projects/interventions to explore ways to better support unpaid carers. • Halton Borough Council's Prevention and Wellbeing Service hold fortnightly drop-in sessions at the Halton Carers Centre, Runcorn on a Tuesday from 10am to 2pm.	
2.3	OT Assessments - Reduction in waits *(Link with 1.3)* • Continue with the work already in place and being progressed which is addressing waiting lists/times, including the project regarding the use of AI which will support the reduction in waiting times in respect to re-assessment and reviews, but also initial assessments.	Principal Occupational Therapist	March 2026	OT Assessments – Baseline position @ 28.2.25 :- • As at 28.2.25, there were 122 people waiting for an OT assessment. Target as at end March 2026 = **TBC** Regular Performance meetings with Care Management need to be re-established.	Quarterly performance updates to SMT

				Progress in respect to AI developments are being shared and discussed at the Care Management Principal/Practice Manager meeting w/c 18.8.25.	
2.4	Website Improvements	Director – Commissioning & Provision	Review – March 2026	Customer Care journey project being taken forward. To support work, need to review ASC pages to ensure that all necessary information is contained on there and that it is up to date. Initial work to commence at the next Care Management Principal Managers meeting on 16th September. Discussion to be held at the next ASC Improvement Group 17.9.25 with Corporate colleagues regarding developments, requirements, etc.	Quarterly updates to SMT
2.5	Direct Payments - Local Authority rates & Top Ups *(Link to 4.2)* • Review of the Direct Payments policy in respect to Top Ups will be required to ensure that the information contained reflects the position.	HoS – Care Management & PSW	September 2025	Review of the Direct Payments Policy and ASC Charging Policy to take place to ensure that it is clear in the policies as to how Top Ups are dealt with. Policy Team to support with the review.	Updated policies to be presented to SMT, when ready

Quality Statement 3: Equity in Experience and Outcomes **(Score 3)**

No.	Improvement Priority and Actions	Accountable Officer	Timeframe for Completion/ Key Dates	Progress	Monitoring Arrangements
3.1	Increase staff participation on staff network groups • As part of implementation of the SCWRES, undertake promotional activity to increase participation in the staff network groups.	Director – Care Management, Safeguarding & Quality	September 2025	Promotional activity being undertaken via the ASC EDI Group with the aim to increase participation from an ASC perspective into the Council's staff network groups, with work being fed into the overarching Corporate EDI group.	ASC EDI Group to update SMT with progress

Quality Statement 4: Care Provision, Integration and Continuity **(Score 2)**

No.	Improvement Priority and Actions	Accountable Officer	Timeframe for completion/ key dates	Progress	Monitoring Arrangements
4.1	Limited Choice of Home Care providers	Director – Commissioning & Provision	Complete	New multi-provider framework is now in place (operational since 28.4.25) and there are now 4 main contracted home care providers, with a further 8 providers on a framework.	Monitoring will take place as part of normal contracting arrangements.
4.2	Direct Payments - Local Authority rates & Top Ups *(Link to 2.4)* • Review of the Direct Payments policy in respect to Top Ups will be required to ensure that the information contained reflects the position.	HoS – Care Management & PSW	September 2025	Review of the Direct Payments Policy and ASC Charging Policy to take place to ensure that it is clear in the policies as to how Top Ups are dealt with. Policy Team to support with the review.	Updated policies to be presented to SMT, when ready

4.3	Specialist Care – Out of Borough • Establish Enhanced Dementia Working Group	Director of Adult Social Services	Review - September 2025	Enhanced Dementia Working Group now established. Work being progressed by HoS – ILS & Mental Health. Proposal for development of an enhanced dementia model has been drafted and is due to be considered by SMT and the Enhanced Dementia Working Group at it's next meeting planned for September 2025.	Update to SMT
4.4	Capacity within home care and care homes – Limited planning • Planning has taken place as evidenced in the MTFS, however further planning will take place as part of updating the Market Position Statement (MPS).	Director – Commissioning & Provision	March 2026	Work to commence on the new MPS in Q3/Q4 2025/26.	MPS to be presented to SMT, when ready
4.5	Investment in VSCFE *(Link to 5.1)* Work creatively with the sector. Reduction in funding • Ongoing opportunities to be explored to work with the VSCFE sector with regards to future opportunities and service redesign	Director – Commissioning & Provision	Review – March 2026	In 2024/25 11 voluntary and community sector organisations had contracting arrangements directly in place with Adult Social Care, in addition to another 6 local small community & voluntary organisations who received grant funding to facilitate activity to support carers.	Update to SMT
4.6	Carers – Access to breaks/respite (planned & unplanned): Pre-Bookable	HoS – Care Management & PSW	October 2025	We have in place the Bredon short stay residential respite service (LD specific), along with the Home-Based Respite Care Service, which is pre-bookable.	Update to SMT

				We also provide respite for people with physical disabilities and mental health needs. In 2024/25, 4,345 hours were delivered via the Home-Based Respite Care Service, which allows carers to have time away from their caring role, whilst maintaining a safe and consistent level of support to the person being cared for. Respite Policy in place. Short Term Task & Finish Group to be established to review the practical issues associated with implementation of the policy in order to support access to respite.	
4.7	QA Process for In-house care homes separate to QA Process for external care homes	HoS – ILS & Mental Health	Complete	QA Process for internal and external care homes, now fall under the QA Team	N/A
4.8	Work with care providers – cost of care being transparent & fair • Ongoing process via the annual fee setting process • Ongoing update of the Market Sustainability Plan	HoS – ILS & Mental Health	Annual Process	HoS – ILS & Mental Health to produce report for Executive Board in October 2025 to seek approval for ongoing consultation arrangements with providers as part of the annual fee setting process. This would support the ability to bring forward the fee setting process, so providers receive confirmation of fees earlier than they have done previously – aim would be to agree fees by February.	Update to SMT

				Market Sustainability Plan to be updated as required in line with national guidance.	

Quality Statement 5: Partnerships and Communities **(Score 2)**

No.	Improvement Priority and Actions	Accountable Officer	Timeframe for Completion/ Key Dates	Progress	Monitoring Arrangements
5.1	Investment in VSCFE *(Link to 4.5)* – Work creatively with the sector. Reduction in funding • Ongoing opportunities to be explored to work with the VSCFE sector with regards to future opportunities and service redesign	Director – Commissioning & Provision	Review – March 2026	In 2024/25 11 voluntary and community sector organisations had contracting arrangements directly in place with Adult Social Care, in addition to another 6 local small community & voluntary organisations who received grant funding to facilitate activity to support carers.	Update to SMT

Quality Statement 6: Safe Pathways, Systems and Transitions **(Score 3)**

No.	Improvement Priority and Actions	Accountable Officer	Timeframe for Completion/ Key Dates	Progress	Monitoring Arrangements
6.1	Transitioning to adult service when individuals open to mental health services – Criteria • Review and update policy	HoS – Care Management & PSW	September 2025	Principal Manager, Complex Care Widnes/Transition Team leading review work with support from the Policy Team. Work being undertaken with partners that is feeding into policy review.	Revised Policy to be presented to SMT when ready

6.2	Transition Service – Promotion of Service	HoS – Care Management & PSW	November 2025	Although information is available via the Local Offer, the Transition information needs to be promoted as part of ASC web pages and will need to link with the website development *(Link to 2.4).* As part of the review and update of the Transition policy (*Link to 6.1*), associated promotional activity will take place across ASC and the community.	Update to SMT
6.3	Carers Assessments – Contingency Plans *(Link to 1.4)* • Process now in place for completing contingency plans	HoS – Care Management & PSW	March 2026	Contingency Plans – Baseline position @ 28.2.25 :- • As at 28.2.25, zero. Process now in place for completing contingency plans and is being implemented. Target as at end March 2026 = 25% of contingency plans to have been completed.	Quarterly performance updates to SMT

Quality Statement 7: Safeguarding(Score 3)

No.	Improvement Priority and Actions	Accountable Officer	Timeframe for Completion/ Key Dates	Progress	Monitoring Arrangements
7.1	DoLS – Backlog of applications	HoS – ILS & Mental Health	March 2026	DoLS – Baseline position @ 28.2.25:-	Quarterly performance updates to SMT

	• Continue with the work already in place and being progressed which is addressing waiting lists/times			• Between 1st March 2024 and 28th February 2025, 917 people were referred for a DoLS assessment.
				  ○ As at 28.2.25:-
				  ○ 707 DoLS assessments have been completed.
				  ○ 210 DoLS assessments waiting to be completed:-
				  ▪ 92 awaiting completion for people in Care Homes; and
				  ▪ 118 are from hospital applications which are unlikely to be completed as they are generally discharged from hospital.
				
				Target as at end March 2026 = Waiting List: 150 DoLS assessments waiting to be completed.
				
				Work taking place with the acute trusts in respect to hospital applications.	

7.2	Safeguarding Enquiries – Outcome notification	HoS – ILS & Mental Health	Complete	Review taken place around feedback loop as part of processes and S.42	N/A

	• Process to be reviewed to ensure that agencies are informed of outcomes of safeguarding enquiries.			form has been updated to ensure feedback is given. As part of normal management audit processes, regular checks are undertaken to ensure this process is followed.	

Quality Statement 8: Governance, Management & Sustainability **(Score 2)**

No.	Improvement Priority and Actions	Accountable Officer	Timeframe for Completion/ Key Dates	Progress	Monitoring Arrangements
8.1	Transformation Programme • Strategy and engagement needed to ensure impact controlled and outcomes positive	Chief Executive	October 2025	Corporate review of Transformation programme is taking place, which will include the ASC transformation programme.	Updates to the Transformation Programme Board

8.2	Scrutiny Function – Not sufficient focus on ASC	Chair – Health and Social Care Policy & Performance Board	Council wide review - **TBC**	Agenda planning meetings are held with the Chair and Vice Chair in advance of agreeing the agenda for each of the Board meetings. These meetings are used to identify the priority items, both from a health and adult social care perspective, to go forward to the Board meetings for scrutiny. The Board receives an Information Briefing Bulletin in advance of each of the Board meetings. The Information Briefing is a way of helping to manage the size of the agendas of the Board meetings better and contains topics which would just be presented to the Board for information. This allows the focus of the meetings to be on those areas which require specific discussion, scrutiny and challenge. During 2024/25, the Board meetings over that period demonstrated a focus on Adult Social Care. 50% of the Policy Issues received by the Board during this period had a focus on Adult Social Care. In addition to the formal board meetings, each year the Board choose one scrutiny work topic, the outcome of which goes forward to Executive Board. This allows for a more in depth approach to scrutiny to be taken to a health or adult social care area where required.	PPB Annual report reviewed by Scrutiny Co-ordinators meeting Council wide review – update reports to Management Team

				In February 2025, work was undertaken to review the roles of the PPB in light of the new Corporate Plan and as such, it was recommended that the titles of the PPBs change to better reflect the work of the Boards. This included Health PPB. It was recommended that the title change to Health & Social Care. It was recognised that incorporating the words Social Care better reflects the scope of this Board`s work. These changes were approved by Executive Board on 17th April as part of the annual review of the Council's Constitution and went to full Council on 16th May for agreement. The Council has recognised that the approach to Scrutiny needs to be evolved to meet the prevailing environment. The Corporate Policy function are picking up a project. Commencing in September 2025, working with the LGA and the Centre for Governance & Scrutiny to baseline current activity and bring forward a Council-wide review.	

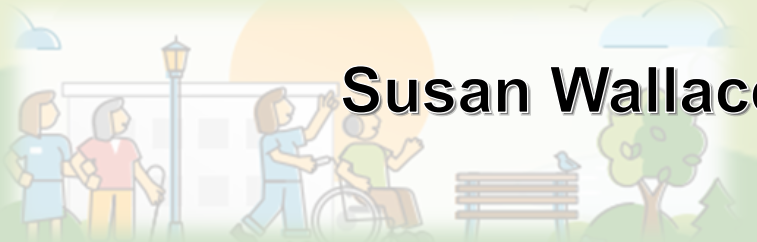
Quality Statement 9: Learning, Improvement and Innovation **(Score 3)**

No.	Improvement Priority and Actions	Accountable Officer	Timeframe for Completion/ Key Dates	Progress	Monitoring Arrangements
8.1	Co-production: Fully embed in service design and strategy development • Establish Co-production steering group	HoS – Commissioning	Review – March 2026	Advisory Group established and first meeting took place on 23.7.25. Work programme for the group to be developed.	Quarterly update reports to SMT
8.2	Improve uptake of people's feedback via surveys etc • Encourage use of the Communications & Engagement framework and associated operational process to promote activities and encourage people to participate in things like focus groups, provide comments on draft service development, policy or strategy work, gain feedback, questionnaires/surveys etc. • Collate and report on information gathered through engagement activities so that SMT may retain oversight of emerging trends and themes as part of our continuous improvement approach.	HoS – Commissioning	Review – March 2026	Work has been carried out to operationalise the Framework to support staff with promoting communication or engagement activity etc. Report went to SMT in April 2025 outlining the activity that had taken place during Quarter 4 2024/25, as a result of the Framework.	Quarterly update reports to SMT

Health & Social Care Policy and Performance Board 23rd September 2025

Adult Social Care CQC Assessment Report 2025

Susan Wallace Bonner. Director of Adult Social Services



Halton Borough Council Adult Social Care: CQC's Local Authority Assessment Outcome

The report published on 4 July 2025 rated the Council as

'Good'

James Bullion, CQC's chief inspector of adult social care and integrated care, said: *"At our assessment of Halton Borough Council's adult social care services, we found strong leaders who had a good understanding of their local population, and staff who were enthusiastic and passionate about providing good care and support to people living in Halton."*

What We Are Doing Well – The Headlines

- ✓ There is good support for adult social care at all levels.
- ✓ There is evidence to show clear and effective governance, management and accountability at all levels. Leaders are approachable and supportive.
- ✓ There is good communication and arrangements in place with partners.
- ✓ There is a strong, inclusive and positive culture of continuous learning and improvement .
- ✓ Staff are enthusiastic about their work and passionate about providing good care and support for people in Halton.
- ✓ Strong focus on prevention.
- ✓ There is a ‘grow your own’ approach with clear career pathways and development opportunities in place.
- ✓ The local authority used feedback from people’s experiences to identify and address areas for improvement.

Areas For Improvement

- Seamless transition between teams – people not having to repeat their story.
- Staff capacity – sufficient time to spend with people at assessment.
- Contingency planning - specifically with carers
- Promoting prevention as everyone's business – building understanding across partners.
- Access to information – accessible and easy to find information.
- Working with providers – negotiation of fees.
- Increase participation in EDI activities - such as the Staff Network Groups
- Planning for the future - capacity, demand and financial sustainability and the role of the CVS
- Feedback – Keeping partners informed, for example, around outcomes of referrals.
- Scrutiny of ASC – facilitating sufficient scrutiny of ASC
- Co production – embedding co-production
- Uptake of surveys – increase uptake of feedback surevys

Thank you for listening

Any Questions?

REPORT TO: Health & Social Care Policy and Performance Board

DATE: 23rd September 2025

REPORTING OFFICER: Executive Director, Adults

PORTFOLIO: Adult Social Care

SUBJECT: Adults Social Care Budget Position

WARD(S): Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of the report is to present a summary of the current budget position for Adult Social Care (ASC), recognising actions being taken to address immediate financial challenges and identify known budget pressures in the short to medium term.

2.0 RECOMMENDATION: That the Board:

I. **Note the financial position outlined in the report; and**
II. **Give due consideration to budget pressures highlighted within the report.**

3.0 SUPPORTING INFORMATION

3.1 Historically ASC have always achieved a balanced budget at year-end, in addition to saving in-year efficiencies, refer to Appendix 1 ASC Financial Position Timeline. Recently this has become more challenging as budgets have reduced, potential savings increased and the ASC landscape within which they operate has shifted in respect to increased levels of complexities of care being demanded, rapid hospital discharges and pressures within health budgets. The current financial performance of the ASC department is tabled below:

Division	Annual Budget £m	Variance To Date £m	Year-End Forecast Variance £m
ASC	24,522	(153)	(698)
Community Care	27,968	(876)	(2,627)
Internal Care Homes	7,932	(330)	(832)
Complex Care (Pool)	13,188	3	2
Total	**73,610**	**(1,356)**	**(4,155)**

3.2 ASC division is anticipated to overspend against planned budget by circa £700k. This will be the first year this division will not achieve a balanced budget The reasons for the overspend are two fold, firstly the problems of recruitment and retention

across the council as a whole are now impacting negatively on ASC's staffing budget. The cost of employing agency staff now outweighs savings realised from vacant posts and market supplements paid to new starters compound the problem. The second budget pressure is the underachievement of income for the community meals and telehealth care services.

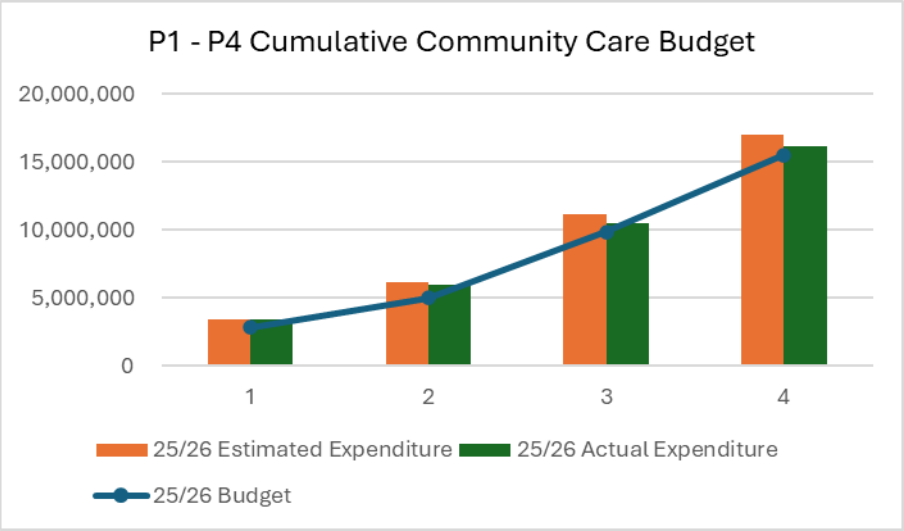
3.3 Community Care Services are experiencing significant and increasing pressures, driven by the following:

- Demand increases in both the volume and complexity of people's needs for ASC due to the increasing number of adults with complex physical and mental health needs, ageing population and also those in transition from childhood to adulthood.
- Increased pressure and demand on acute hospitals.
- The increase in the National Living Wage (NLW)
- The increase in National Insurance costs
- Availability and skills needs of the workforce.
- Stability of the market for ASC providers.

To mitigate some of the risk identified above a community care budget recovery working group has been established to identify way to reduce spend and bring it back in line with planned expenditure. Actions include:

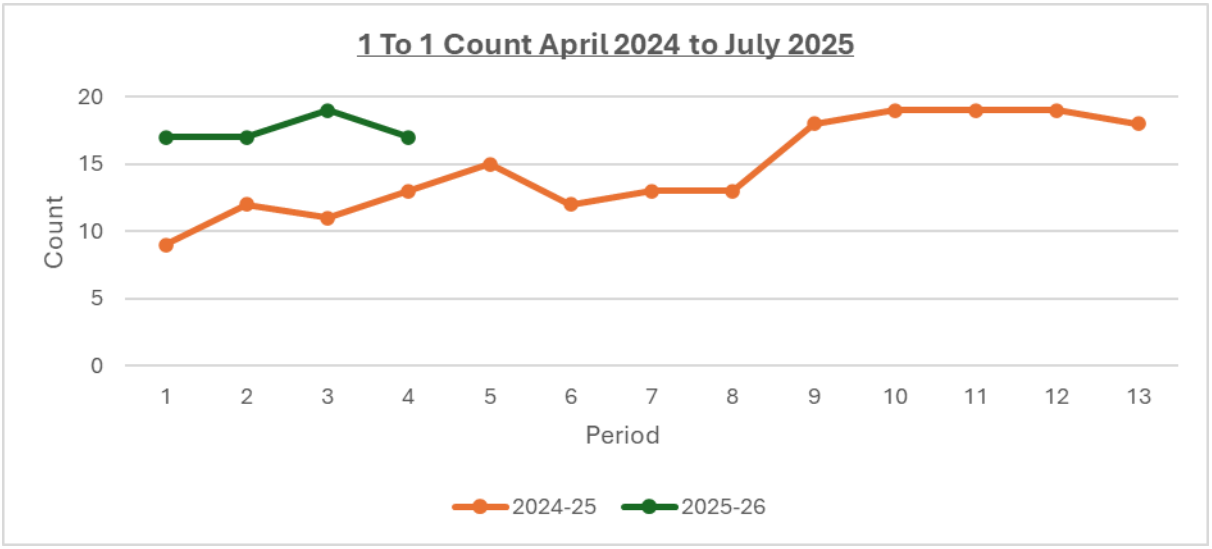
- Reduction of 1 to 1 packages of care if health's responsibility
- Review 15 minutes packages of domiciliary care to identify medicine prompts which are health's financial responsibility
- Ensure assessments carried out on discharge from hospital are complete and appropriate
- Maximise internal care home capacity in order to minimise externally commissioned nursing and residential beds

3.4 The recovery group meets every two weeks and consists of Councillor Ball. DASS, OD Care management, numerous care management colleagues and representation from finance. Monitoring and tracking cost reductions and cost avoidance is paramount to balance the budget and shape the care market for future years. The action plan has been quantified at para 5.1 below and at present actual spend against planned (forecast) spend appears to be on track, see below:

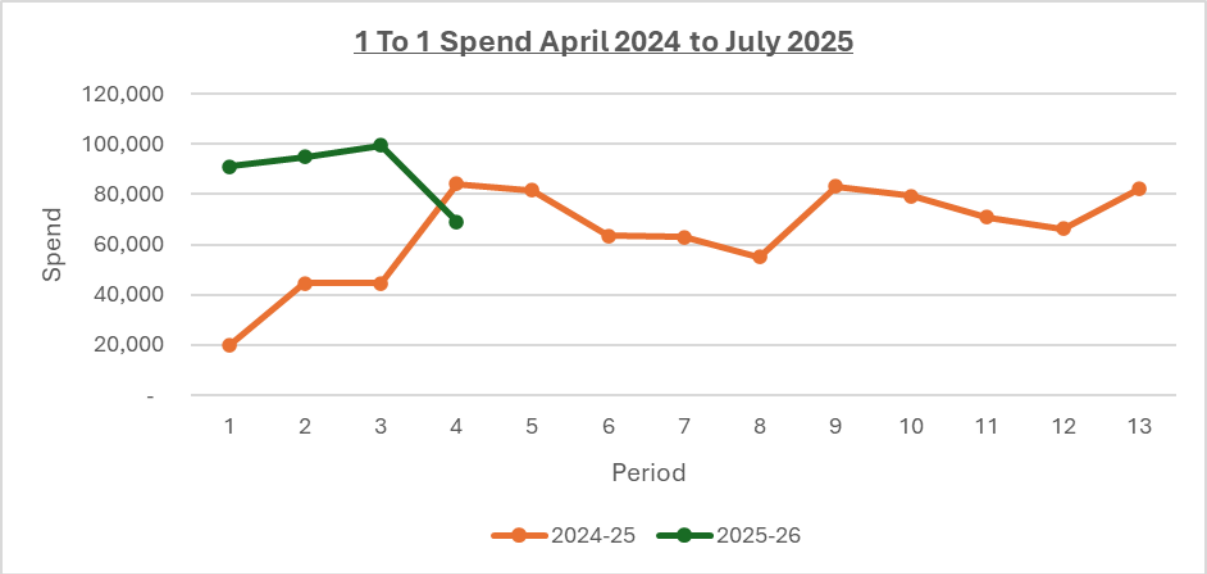


During 2024/25 payments for 1 to 1 support exerted pressure on this budget and still continue to do so. These are generally to mitigate the risk from falls particularly on discharge from hospital. The full year cost for 2024/25 was £837,882.

The graph below shows the count of service users receiving 1 to 1 care by period. Currently there are 17 compared to 13 at the same point last year, an increase of 30% although numbers have decreased from Period 3 to 4 as packages are being reviewed in line with the action plan.



This graph shows the spend on 1 to 1 care by period and clearly shows that the monthly spend has started to decrease as packages are being reviewed and alternative funding sourced.



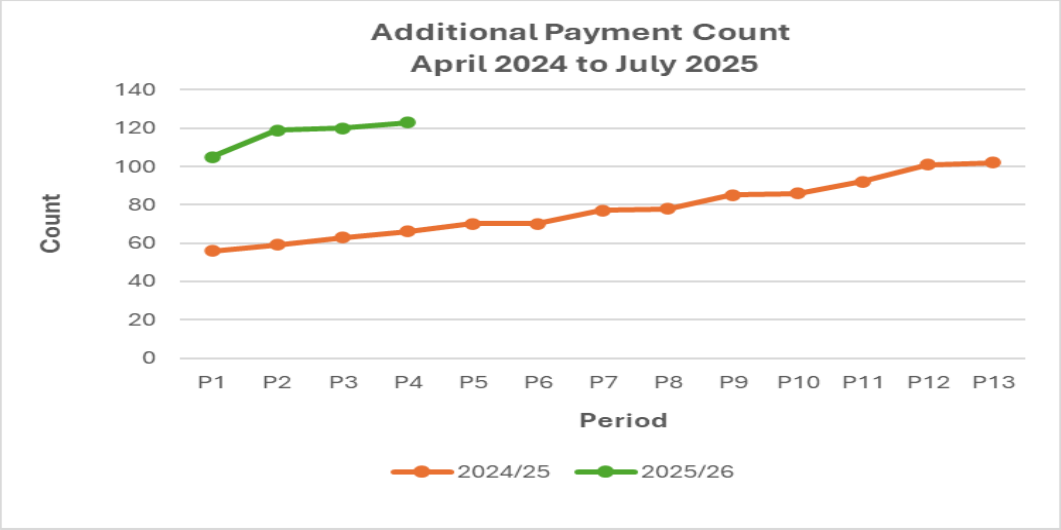
3.5 The care market is becoming increasingly fragile and this adds a further risk. These risks are illustrated by high staff turnover, suppliers leaving the market and increasingly slim margins for those that remain in the sector. In November 2022 Autumn Statement, the Market Sustainability and Improvement Fund (MSIF) was announced. The primary purpose of the fund is to support local authorities (LA's) to make tangible improvements to adult social care services by building capacity and improve market sustainability. Under section 5 of the Care Act 2014 LA's have a duty to promote the efficient and effective operation of the care market and support as a whole. Three vital target areas of improvement underpin this overarching objective, increasing fee rates to providers, increasing workforce capacity and retention and reducing social care waiting times.

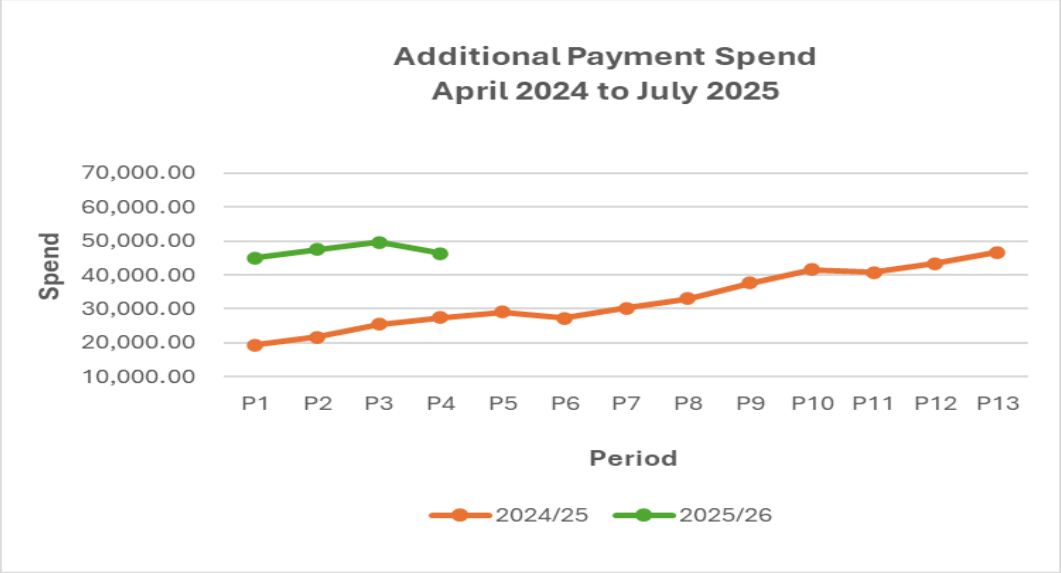
3.6 During 2023/24 and 2024/25 government provided additional ring fenced funding (Market Sustainability and Improvement Workforce Fund) with a particular focus on workforce pay and to support more workforce and capacity within the sector. In doing so this will ensure appropriate short term and intermediate care is available to reduce avoidable admissions and support discharge of patients when medically fit to leave. In accordance with grant conditions Halton's allocation was allocated to increasing workforce capacity in residential and nursing homes in the borough and to increasing provider fees early in the domiciliary care sector to facilitate avoidable admissions and support discharge of patients from hospitals.

3.7 Although fees to providers within the borough remain fairly competitive compared with other Mersey & Cheshire neighbours the number of top ups to residential and nursing homes rose sharply throughout 2024/25 both in and out of borough. A top up is where a care home charges an additional amount on top of the contracted bed rate. The cost of this for 2024/25 was £423,894.

The graphs below illustrate the count of service users with an additional payment by period and clearly shows a steady increase in numbers and costs for 24/25. The spend up to Period 4 2025/26 is £188,542.83. If numbers and costs remain the

same the forecast spend for the year will be approximately £605k.





3.8 On going financial pressures within the NHS are also having an impact on social care budgets, such as access to Continuing Health Care (CHC) and also costs incurred from services such as transport, medication support, occupational therapy which should all be funded from health. These services have been provided by ASC as it in was the best interest of the people using the services. Together with health ASC operated on a partnership give and take approach, however this culture has now changed in focus from a health perspective. Current responsibilities and changes in processes are under review however any changes to theses previously agreed “partnership agreements” will result in some relationship breakdown with health colleagues and possible challenges. This review is happening across the Cheshire & Merseyside region, not just in Halton.

3.9 Additional pressures from packages transitioning from children’s social care place further demand on the ASC budget. There were £114k of costs incurred on the Direct Payments budget alone in 24/25 relating to 7 young people turning 18. This

gives further evidence of the pressures ASC budgets face, not only from the increasing demands of the adult population, but also from those children who will eventually transfer and have a long term need for social care.

3.10 Until recently the Medium Term Financial Strategy (MTFS) has not always provided for ASC demographic growth on a recurrent basis. This has resulted in the community care budget being previously underfunded and unable to meet the demands of the services it provides on a balanced budget. However the budget was increased in 2025/26 by £2.382m to meet demographic growth pressures and by a further £2.433m to cover the expected overspend for 2024/25. Nevertheless, due to pressures already mentioned above, the actual outturn position last year before adjustments, was £4.4m overspent, therefore this budget started the new financial year facing a £1.967m funding gap, assuming annual commitments follow a similar pattern to previous years. Additionally the MTFS does not provide (on a recurrent basis) ASC for any financial burden resulting from children transitioning into ASC.

3.11 The Internal Care Homes are anticipated to be £0.832m over budget at year-end due primarily to unbudgeted agency staff costs. The recruitment of staff continues to be a pressure across the care homes and there remains a high number of staff vacancies across the care homes. A proactive rolling recruitment exercise is ongoing within the care homes and is supported by HR however due to pressures with recruitment and retention in the sector, heavy reliance is placed on overtime and expensive agency staff to support the care homes. In addition there are high levels of absenteeism in the homes adding to staffing issues. At the end of July 2025 total agency spend across the care homes reached £1.675m for the financial year. The cost of this has partially been offset by staff vacancies but remains the main driver for the overspend.

3.12 The Complex Care pool budget is on track to achieve a balanced budget.

4.0 POLICY IMPLICATIONS

4.1 The spending pressures outlined in the report will impact upon the financial performance of the ASC budget as a whole. Although corrective action is being taken to mitigate the financial liability, a balanced budget will be extremely difficult to achieve within existing resources.

5.0 FINANCIAL IMPLICATIONS

5.1 A financial recovery action plan and tracking monitoring system has been established with the aim of delivering a balanced community care budget at year-end. The plan incorporates the following:

Action	**Target** **£000**
Reduction (50%) in unnecessary or health related 1:1 care in care homes from 20 to 10 residents	650
Reduction or transfer to health (15%) of medication visits	208

Strengthen hospital discharge approach, ensuring patients are fit on discharge.	187
Increase occupancy rates in Internal Care Homes	290
Increase use of Oakmeadow respite facility	345
Increase flexibility of Disabled Facility Grant	947
TOTAL	**2,627**

5.2 **Conclusion**
The gross current year budget for Community Care Services is £53.38m (£27.97m net of income). The potential funding gap of £1.967m identified in para 3.9 is 3.7% of the current year's gross budget (7% of net budget) and accounts for 75% of the current overspend position.

5.3 The ASC budget accounts for over half of the total Council's budget and it is recognised that it will be required to contribute significant budget savings each year, in order to assist the Council with delivering a balanced budget as required by statute. However it must also be noted that a realistic ASC budget needs to be approved in order to maintain services at their current levels. Work is ongoing to identify different ways to provide services to meet the needs of residents within limited resources, by maximising the funding available and utilising it more flexibility. However the pressures identified in this report cannot all be provided for within current budget constraints. Funding for community care services must keep pace with growing demand and provider costs in order to avert market failure and the consequential impact on the lives of some of the most vulnerable residents in the Borough.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**
The ASC budget supports the delivery of services which contribute towards this 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**
As outlined in paragraph 6.1.

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 If the potential funding pressures identified within this report are not addressed in

the medium to long term, there may be a significant impact upon the delivery of Adult Social Care services within the Borough.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no specific implications arising from the report.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 There are no specific implications arising from the report.

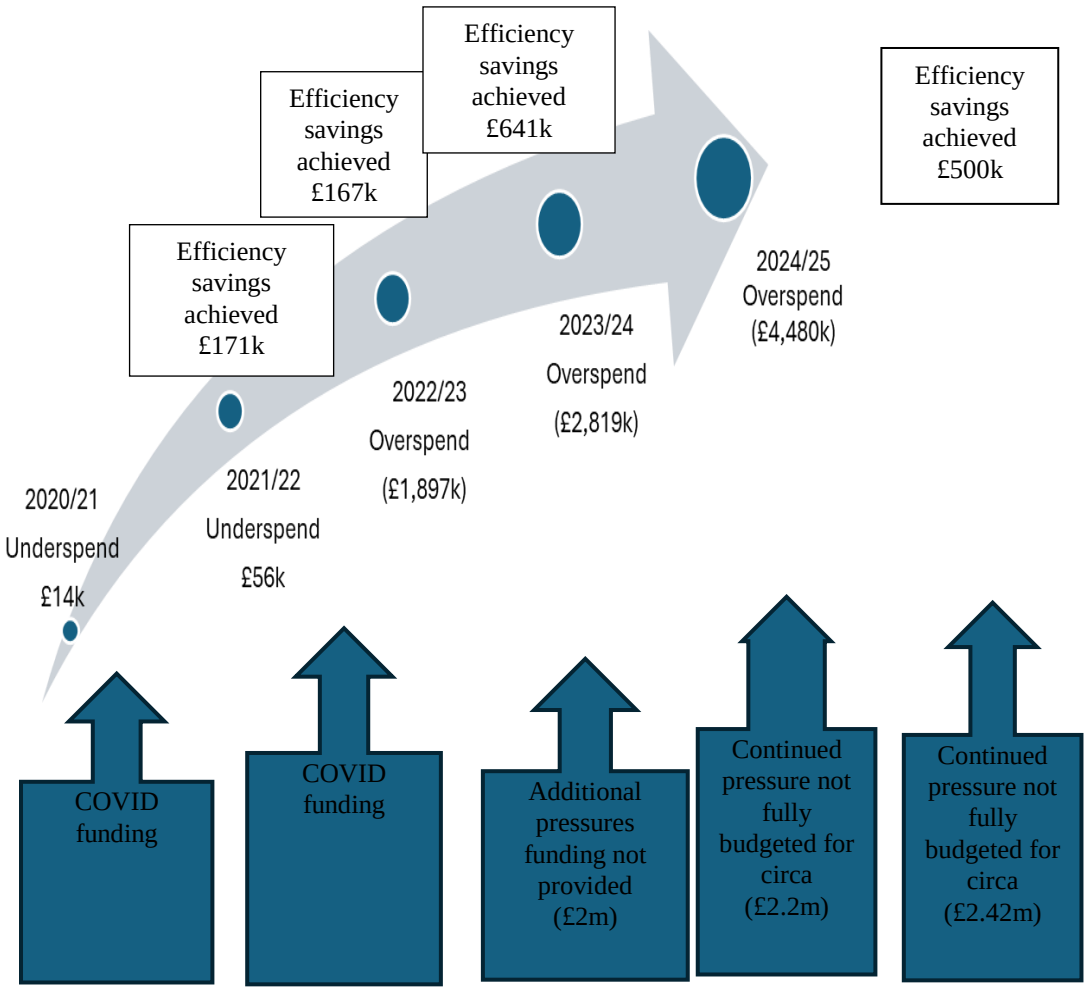
10.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

10.1 There are none within the meaning of the Act.

Appendix 1

ASC Financial Position Timeline

Year-End Position Trend



COVID funding ceased- expectations from providers in relation to increased funding- top ups (£600k) charged and requests for 1-1 support (£1.2m)

REPORT TO:	Health and Social Care Policy & Performance Board (HPPB)
DATE:	23rd September 2025
REPORTING OFFICER:	Executive Director, Adults
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Joint Health Scrutiny Arrangements – Cheshire & Merseyside: Stage 1 Delegation
WARD(S):	Borough wide

1.0 **PURPOSE OF THE REPORT**

1.1 The report is to introduce a proposal to delegate the Stage 1 consideration of substantiation variation to health services, where necessary, when Joint Health Scrutiny (JHS) arrangements may apply.

2.0 **RECOMMENDED: That**

1) the report be noted; and

2) the Board endorses the proposal for Stage 1 delegation as outlined and recommends Executive Board agreement, for onward approval by Council.

3.0 **SUPPORTING INFORMATION**

3.1 The protocol for establishment of JHS arrangements for Cheshire and Merseyside has been in place since 2014, with the latest review and update of the protocol being undertaken in 2024; presented and agreed at PPB in September 2024.

3.2 The statutory framework regarding health scrutiny authorises local authorities individually and collectively to:

- review and scrutinise any matter relating to the planning, provision and operation of the health service; and,
- consider consultations by a relevant NHS commissioning body or provider of NHS-funded services on any proposal for a substantial development or variation to the health service in the local authority's area.

3.3 In line with the protocol, prior to the establishment of any JHS arrangements, each local authority must first of all decide individually whether a proposal represents a substantial development/variation or not **(Stage 1).** The regulations then places a requirement on those local authorities that agree that a proposal is substantial to establish, in each instance, a joint overview and scrutiny committee for the purposes of considering it. It is then only the statutory JHS committee which can formally comment on the proposals if more than one authority agrees that the proposed change is substantial.

3.4 There have been a number of instances over the past 12 months where NHS Cheshire and Merseyside have approached Local Authorities with proposals to change health services and we have been asked to consider these proposals via health scrutiny arrangements.

Not just an issue within Halton, but across a number of other Local Authorities across Cheshire & Merseyside, on a number of occasions the timing of these proposals and the timescales we have been asked to respond to haven't aligned with formal Board meetings.

3.5 This issue has been raised and discussed at the Cheshire and Merseyside Health Scrutiny Officers Group and each Local Authority has been asked to consider delegating Stage 1 of the process (as described in paragraph 3.3). For some, this may be to named Members, but in Halton's case it is suggested that it should be via the Lead Officer of the PPB in consultation with the Chair and Vice Chair of the health scrutiny committee, when necessary.

3.6 There have been examples in the past where we have had to organise one off Special PPBs to consider whether changes were a substantial change/variation or not, to fit in with timings as outlined/required by health colleagues. Having a scheme of delegation in place would negate this need and only be initiated when timings do not allow for the proposals to be scheduled within the normal round of Board meetings.

4.0 POLICY IMPLICATIONS

4.1 The delegation arrangements are considered to be fit for purpose and will assist the Council in upholding the protocol.

5.0 FINANCIAL IMPLICATIONS

5.1 There are no financial implications arising directly from this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**
The arrangements are considered to support the protocol and will therefore better assist in upholding the priority.

6.2 **Building a Strong, Sustainable Local Economy**
No specific implications.

6.3 **Supporting Children, Young People and Families**
No specific implications

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**
No specific implications

6.5 **Working Towards a Greener Future**
No specific implications

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

No specific implications.

7.0 **RISK ANALYSIS**

7.1 There are no risks requiring control measures or a full risk assessment.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There are no specific implications arising from the report.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 There are no specific implications arising from the report.

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

10.1 There are none within the meaning of the Act.

REPORT TO:	Health and Social Care Policy & Performance Board
DATE:	23 September 2025
REPORTING OFFICER:	Debbie O'Connor – Head of Service – Care Management
PORTFOLIO:	Health and Social Care
SUBJECT:	Adults Directorate progress towards the Care 2030 vision
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To give an overview of the Adults Directorate's activity which directly impacts on the priority themes identified in the NW ADASS Care 2030 Strategy.

2.0 **RECOMMENDATION: That**

2.1 That SMT note the range and breadth of activity taking place which impacts on our journey towards 'Care 2030', and;

2.2 SMT approve the report to be further taken to the Health and Social Care Policy and Performance Board.

3.0 **SUPPORTING INFORMATION**

3.1 **Care 2030 Strategy**

3.1.1 The NW ADASS 'Care 20230 Strategy' was published in 2021, setting out a 10-year outlook for achieving change and creating a long term vision for Adult Social Care across the region. The Strategy recognised that demand for social care continues to grow and this is set against substantial financial challenges for local government. It suggested that current ways of working were unsustainable and in some cases no longer desirable.

3.1.2 It invited Local Authorities across the region to move away from reinforcing and protecting what we do and called for the sector to rethink, redesign and reorientate.
In order to do this, the Strategy gave three priority workstreams, with associated programme boards formed within the NW ADASS structure. These three priorities focus on:

- **Future Models** – “we will develop new ways of supporting people so that they can live the life they want in their community”
- **Future Markets** – “we will create a diverse and high-quality market for social care which is ethical, builds community wealth and offers greater choice”
- **Future Workforce** – “we will develop a high-quality and caring workforce so that people will be supported and cared for in the right way by brilliant and caring people”

3.1.3 A fourth programme board was formed within the organisation to look at **Sector Led Improvement,** asserting that: “we will take collective responsibility for the performance of the sector as a whole,” and working towards making best practice practicable and scalable.

3.1.4 Since publication of the Strategy, and sector recovery from the pandemic, NW ADASS have formed thematic working groups, bringing together service leads from across the region and aimed at exploring, creating and capturing innovative practice. These further feed in to the priority boards and from this a range of materials and resources have been produced for local implementation of different ways of working. Halton has been part of this and has achieved progress against each of the priority areas. The following section of this report outlines some key developments within Halton over the past two years. NB. This list of developments is by no means exhaustive.

3.2 **Halton’s progress towards Care 2030**

3.2.1 1. Future Models

One of the key elements of supporting people within their own community revolves around them having the right housing, which meets their current and future needs. Halton Borough Council, at the corporate level, has been working with consultants, arc4, to devise a borough-wide **Housing Strategy**. The work has involved looking at an extensive housing needs survey and analysis and the resulting draft strategy is current being scrutinised. The Housing Strategy has a strong focus on **specialist housing needs**, from supported living to older people’s accommodation.

3.2.2 The restructure of the Integrated Care Board (ICB) centres on the notion of ‘neighbourhoods’. The Council are working closely with the ICB ensure this **place-based focus** is achieved and that services within local communities are accessible and tailor to local needs. **Joint working** with the ICB extends past pooled budgets and active collaboration through the One Halton partnership, its respective

boards and strategy plans. Specific activity, working jointly with the ICB includes the continued focus on care homes, through the **Care Home Development Group**, emphasizing their place at the heart of our communities.

3.2.3 Work across the community involves engagement with a board spectrum of community services and intensive engagement with the voluntary sector. The Adults Directorate **strategic commissioning** with v**oluntary sector partners** reinforces its commitment to a diverse array of service access points across the community to meet different needs.

3.2.4 New ways of supporting people have been explored, and an extensive programme of training took place in 2023 with Helen Sanderson Associates, renowned for developing approaches to personalisation The training looked at **strengths-based working**, enabling the Adult Directorate to rethink its Care Act assessment paperwork and processes.

3.2.5 Further to this, Care Management teams have reconfigured to make their 'front-door' services more accessible and give greater choice and flexibility to the way people are supported. As the first port of call for residents with additional needs the **Prevention and Wellbeing Service** replaces the Initial Assessment Team. The re-focus has been implemented successful and a greater number of initial contacts have resulted in signposting and referral back into community based provision to meet their individual needs.

3.2.6 Emphasis on prevention has additionally been embedded into the directorate's practice through the development of a **Prevention Strategy**. The strategy is intended to help people manage their own health and wellbeing so that they can retain their independence for longer. It pinpoints a wide range of services and organisations that make up both a universal community support offer as well as more specialist services.

3.2.7 Coupled with the emphasis on prevention, an adult social care **Waiting Well** pathway has been devised to triage needs where services have waiting lists. This has meant that those who are most vulnerable can receive timely and responsive services.

3.2.8 In working more closely with people across the community the directorate has re-invigorated its approach to coproduction. Subsequent to the work undertaken to develop the **One Halton Coproduction Charter** in 2023, the Adults Directorate has working closely with people with lived experience from across the borough to gain their view and input into a range of projects. Notably, the Direct Payments team have worked with Care Management to form a **Personal Assistants (PA) Forum**, with steer from an expert by experience who uses PA support. Also, two workshop events took

place in February of this year to gain feed-in from experts by experience towards devising a new **Learning Disability Strategy** for the directorate. In July, experts by experience who've worked with us on other projects were invited to join the newly formed **Coproduction Advisory Group**, which with now take forward additional coproduction activity.

3.2.9 The Council-wide **Transformation programme** has a project team looking specifically at adults services. Recent activity has included participation through coproduction on work stream developments, including looking at **specialist and supported housing**. There has also been a series of pilots to introduce **digital technology** into care provision, and opportunities are now being rolled out further.

3.2.10 2. Future Markets

The directorate's **Market Position Statement** and **Commissioning Strategy** were both updated in 2023 and run to 2026. Between them, they recognise the pressure points, opportunities and future direction of travel for the borough in relation to future markets.
Substantial progress has been made in our commissioning of **Domiciliary Care** (also known as care at home) with a new framework tender process having taken place last year. The directorate now has additional care options available to residents and new contracted providers have received a thorough induction earlier this year and are being supported through the Quality Assurance team.

3.2.11 In further development of new and enhanced market options, the commissioning team have devised processes to make more effective use of the **Liverpool City Region Flexible Purchasing System**, particularly in relation to **supported living**. This has given opportunity for providers who are new to the borough to enter the market, offering greater choice and control to service users.

3.2.12 **Transition**, from children's to adults services, is overseen by a dedicated team within the care management structure of the Directorate. Having a clear process and pathway for achieving transition supports wider market stability as it forms part of the commissioning cycles of planning and evaluating future needs. The Transition Service works to a **Transition Protocol** document which establishes eligibility together with process and procedure for progressing cases into the team. These Protocols are currently being reviewed to ensure that they are meeting needs and have a strong fit with service provision.

3.2.13 The Directorate has a responsive Quality Assurance team who work with commissioned providers in a supportive, developmental and evaluation capacity. The team has a robust set of quality measures

which were updated in 2024 into a **Quality Assurance Framework** policy covering care homes, domiciliary care and supported living. This document sets out high quality standards and expectations, as well as giving clear guidance on how this is determined.

3.1.14 The **Halton Intermediate Care and Frailty Service (HICaFS)** was formulated shortly following the pandemic to look at how we manage urgent response services, hospital discharge and bedded and community intermediate care. As a joint health and social care service with a single point of access, the service has gone from strength to strength and embeds the ethos of **'Home First'** as the best place to retain or regain personal independence. Market impact can be demonstrated through 2023/24 figures, which showed that 67% of those people supported were subsequently discharged from the service as independent, whilst only 1% of individuals were admitted into a long-term care home.

3.1.15 A further example of effective systems working can be seen through the operations of the **Halton Safeguarding Adults Board**. The multi-agency approach has, amongst other achievements, successfully implemented the **Making Safeguarding Personal**, with 93% of people during 2023/4 having achieved or partly achieved their desired outcomes from the approach.

3.2.16 3. Future Workforce

Workforce pressures continue to be one of the most important considerations across the sector, and Halton is not immune to this. The Adults Directorate has been involved with regional initiatives to recruit and retain staff into the sector, including some prominent campaigns through NW ADASS.

3.2.17 On a local level the Directorate is currently in consultation with the national organisation Skills for Health towards devising a borough-wide **Adult Social Care Workforce Strategy**. This strategy will examine current challenges, strengths and opportunities to set out a comprehensive 5-year plan. It will be underpinned by the priorities in **Halton Corporate Plan 2024-2029** as well as aligned to specific Directorate requirements and quality standards. The Adult Social Care Workforce Strategy is due to be published this autumn.

3.2.18 Supporting our partners and providers with ongoing workforce needs, particularly during and following the pandemic, has been an ongoing core to the Directorate's strategic plans. The recent impact of the increase in **National Living Wage**, together with changes to the way **National Insurance** is paid, has seen the cost of care rising. Our annual **Fee Setting** consultation processes for 2025/26 resulted in increases across the board. In consideration of overall Council finances, this demonstrates our unwavering recognition to meeting workforce challenges and commitment to Adult Social Care

as a people-led sector.

3.2.19 Workforce learning and development standards are sector-led and contractual bound within the Directorate's commissioning process. To assure standards in safeguarding the **Halton Safeguarding Adults Board** continue to invest in an annual **training programme** open to partners and professionals across the borough.

3.2.20 Recruitment and retention into in-house services to the Adults Directorate remains a priority and **market enhancements** have been agreed for the retention of **qualified social workers**, to match the offer in the Children's Directorate. Our commitment to **Grow our Own** qualified workforce involves offering an extensive **Social Work Development Programme,** from pre-qualified to post-qualified development opportunities, including successful delivery of the **Assisted and Supported Year in Employment (ASYE)** programme and training and maintenance of sufficient capacity for the Council's **Approved Mental Health Professionals (AMHP)** duties. Alongside this the Directorate is exploring other **Advanced Apprenticeship** qualifications to aid the **progression and retention of talent**.

3.2.21 The Corporate **Values Framework** is well communicated across the Directorate and this reflect in the recent **Care Quality Commission (CQC)** rating of **Good**.

3.2.22 Directorate-wide communication and engagement is embedded into the **Adult Social Care Communications & Engagement Framework**, that looks at internal standards and expectations. This document was reviewed and updated in May of this year. In-house mechanisms used to achieve the framework include a quarterly **Adult Social Care Newsletter** and quarterly **Service Development Events**.

3.2.23 The Director of Care Management, Safeguarding and Quality Assurance, has been instrumental in taking forward some of the Council's **Equality, Diversity and Inclusion (EDI)** initiatives alongside corporate Human Resources. Alongside supporting staff EDI groups focussing on **Disability and Neurodiversity, LGBTQIA+ and Race Equality issues**, the Director has been pivotal in establishing a recent **Reverse Mentoring Scheme**, where senior leaders have learned from more junior members of staff. The Reverse Mentoring Scheme has resulted in some effective learning and enabled senior leaders to think in a more inclusive way.

3.2.24 The Directorate recognises the importance and value of the informal **Carers**. Support for unpaid carers help us to sustain community-based care for longer, and for those with care needs to remain as independent as possible. The Directorate received funding during

2024, through the Governments **Accelerated Reform Fund** issued to a regional consortium. Halton took the decision to direct this funding into the **Halton Carers Centre** to support and enhance their successful programmes of work. An increased emphasis on carers has been made on the Council's public facing webpages offering **Support for Carers** has seen the addition of a **Carers Information Booklet** in addition to some carers assessment and support videos aimed at breaking down barriers to carer contact.

3.2.26 The progress Halton has made towards the Care 2030 priorities and vision have been communicated across networks as part of sector-led improvement sharing. Halton will continue to work alongside NW ADASS to meet the objectives of transforming the sector.

4.0 POLICY IMPLICATIONS

4.1 The activities and initiatives in this report relate to a number of policy, procedure and strategy documents, including planned reviews. The service development team work with operational teams on a rolling programme to ensure the policy library is kept up-to-date.

5.0 FINANCIAL IMPLICATIONS

5.1 While finances are not the focus of this report, some of the activity cited ties to transformation and efficiency within the Council and services which are more closely aligned to known population need are generally set to save money in the long-term.

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

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

The report covers a range of Adult Social Care services, interventions and activity, all aimed at meeting this priority.

6.2 Building a Strong, Sustainable Local Economy

Workforce is identified as important consideration in achieving Adult Social Care outcomes. Adult Social Care is a key contributor to the economy.

6.3 Supporting Children, Young People and Families

The care and support provided through Adult Social Care services has a wider impact on family units as a whole.

6.4 Tackling Inequality and Helping Those Who Are Most In Need

The Directorate continues to forecast and plan towards identified needs, working closely with Public Health to understand and tackle health inequalities.

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

6.6 **Valuing and Appreciating Halton and Our Community**
Community presence and engagement is identified within the report as adding value to how the Directorate design and deliver services.

7.0 **RISK ANALYSIS**

7.1 Continued budget constraints may tighten the remit of the Directorate to statutory provision only. The early intervention and preventative activity currently undertaken play a key role in keeping people well for longer.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The Directorate continues to seek to engage with those who are seldom seen. The emphasis on community supports reaching people where they live.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 None identified.

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

‘None under the meaning of the Act.’

REPORT TO: Health & Social Care Policy and Performance Board

DATE: 23rd September 2025

REPORTING OFFICER: Executive Director, Adults

PORTFOLIO: Health and Wellbeing
Adult Social Care

SUBJECT: Performance Management Report - Quarter 1 2025/26

WARD(S): Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 This Report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Adult Social Care & Public Health in Quarter 1 of 2025/26. This includes a description of factors which are affecting the service.

2.0 RECOMMENDATION: That the Board:

i) Receive the Quarter 1 Priority Based report;
ii) Consider the progress and performance information and raise any questions or points for clarification; and
iii) Highlight any areas of interest or concern for reporting at future meetings of the Board

3.0 SUPPORTING INFORMATION

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health and social care priorities. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 1 of 2025/26.

3.2 The Board will note that Quarter 1 data in respect to Adult Social Care is not yet available for reporting. However key developments , emerging issues and finaicial statements that pertain to Adult Social Care have been included in the report.

4.0 POLICY IMPLICATIONS

4.1 There are no policy implications associated with this report.

5.0 FINANCIAL IMPLICATIONS

5.1 Financial statements, as at 31st May 2025, have been included within the priority based report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

The indicators presented in the thematic report relate specifically to the delivery of health outcomes in Halton.

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 indicators presented in the thematic report relate specifically to the delivery of health outcomes in Halton.

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 An Equality Impact Assessment (EIA) is not required for this report

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.

Health & Social Care Policy & Performance Board Priority Based Report

Reporting Period: Quarter 1 – Period 1st April 2025 – 30th June 2025

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the first quarter of 2025/26 for service areas within the remit of the Health & Social Care Policy and Performance Board. These areas include:

- Adult Social Care (including housing operational areas) *NB. Quarter 1 data is not yet available*
- Public Health

2.0 Key Developments

2.1 There have been a number of developments within the Adults & Public Health Directorates during the first quarter which include:

Adult Social Care

Vulnerable Adults Supported Accommodation
The supported living development at Crow Wood Lane with Halton Housing is being progressed. The scheme will deliver 3 accessible 2 bedroom bungalows and a 10 apartment 'own front door' provision. The development will be funded through Homes England and additional contribution from Halton Housing and Halton Borough Council, agreements have been drafted and ready for sign off and the specification agreed. Work started on site July 2025.

Public Health

We are seeing an increase in measles cases in our region with more of our local children and young people becoming ill. The reason we are seeing more cases of is because fewer people are having the MMR vaccine, which protects against measles as well as two other viruses called mumps and rubella. A recent outbreak occurred at Alder Hey. Children in hospital who are very poorly for another reason, are at higher risk of catching the virus. For this reason we have increased comms going out to parents and schools reminding families and carers of the importance of vaccination.

We have experienced periods of hotter weather this year, and public health have provided advice and support through comms using hot weather communications toolkit. The toolkit is intended to provide basic health information that can be communicated during hot spells so that the right messages reach the right people at the right time

One of the team led a Safeguarding Partnership Focus on Ketamine event in July. Over 120 practitioners attended from a range of organisations, with speakers from CGL, Birchwood Detox & Rehab, NW County Lines, Drug & Alcohol Youth Support Service, and St Helens Safeguarding. Over the next few months various festivals are taking place across the UK.

Our Health Protection team and Environmental Health team are working alongside Emergency Planning and wider health and safety partners from the local area to ensure the event runs safely again this year.

3.0 Emerging Issues

3.1 A number of emerging issues have been identified during the first quarter that will impact upon the work of the Adults & Public Health Directorates including:

Adult Social Care

Learning Disability Strategy
The strategy has been developed following a series of coproduction events with people with learning disabilities, family, carers and professionals. A draft strategy and action plan was presented to the working group in June and ALD Partnership Board in July. Comments requested by the end of August and the final strategy is due to be taken to the ALD Partnership Board in October.

Public Health

There have been a number of changes within the NHS culminating in the launch of the long awaited ten year plan for health, The plan is expected to drive three big shifts to health service,

- from hospital to community
- sickness to prevention
- and analogue to digital

New Neighbourhood Health Services will bring healthcare closer to the public, and the NHS App will become the digital front door to the NHS. The plan follows a number of reforms including changes to the structure of the NHS regional and local organisation. The details are not yet available but it is expected that the ICB will change and some bodies like Healthwatch will cease to exist in their current form and the risk is the loss of public voice. It's likely that there will be a number of job losses and there is risk of capacity within NHS. Neighbourhoods are a big theme within the new plans and we will continue to work with partners to develop these.

A new LCR Mayoral Regions Health Inequalities lead has been recruited and the public health team have reached out to understand how we can work together to improve health and reduce inequalities.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. During the development of Directorate Business Plans, services were required to undertake a risk assessment of all key service objectives with high risks included in the Directorate Risk Registers.

5.0 Progress against high priority equality actions

There have been no high priority equality actions identified in the quarter.

6.0 Performance Overview

The following information provides a synopsis of progress for both milestones and performance indicators across the key business areas that have been identified by the Directorates. It should be noted that given the significant and unrelenting downward financial pressures faced by the Council there is a requirement for Departments to make continuous in-year adjustments to the allocation of resources in order to ensure that the Council maintains a balanced budget. Whilst every effort continues to be made to minimise any negative impact of such arrangements upon service delivery they may inevitably result in a delay in the delivery of some of the objectives and targets contained within this report. The way in which the Red, Amber and Green, (RAG), symbols have been used to reflect progress to date is explained at the end of this report.

Adult Social Care

Key Objectives / Milestones

Information is not yet available.

Public Health

Key Objectives / Milestones

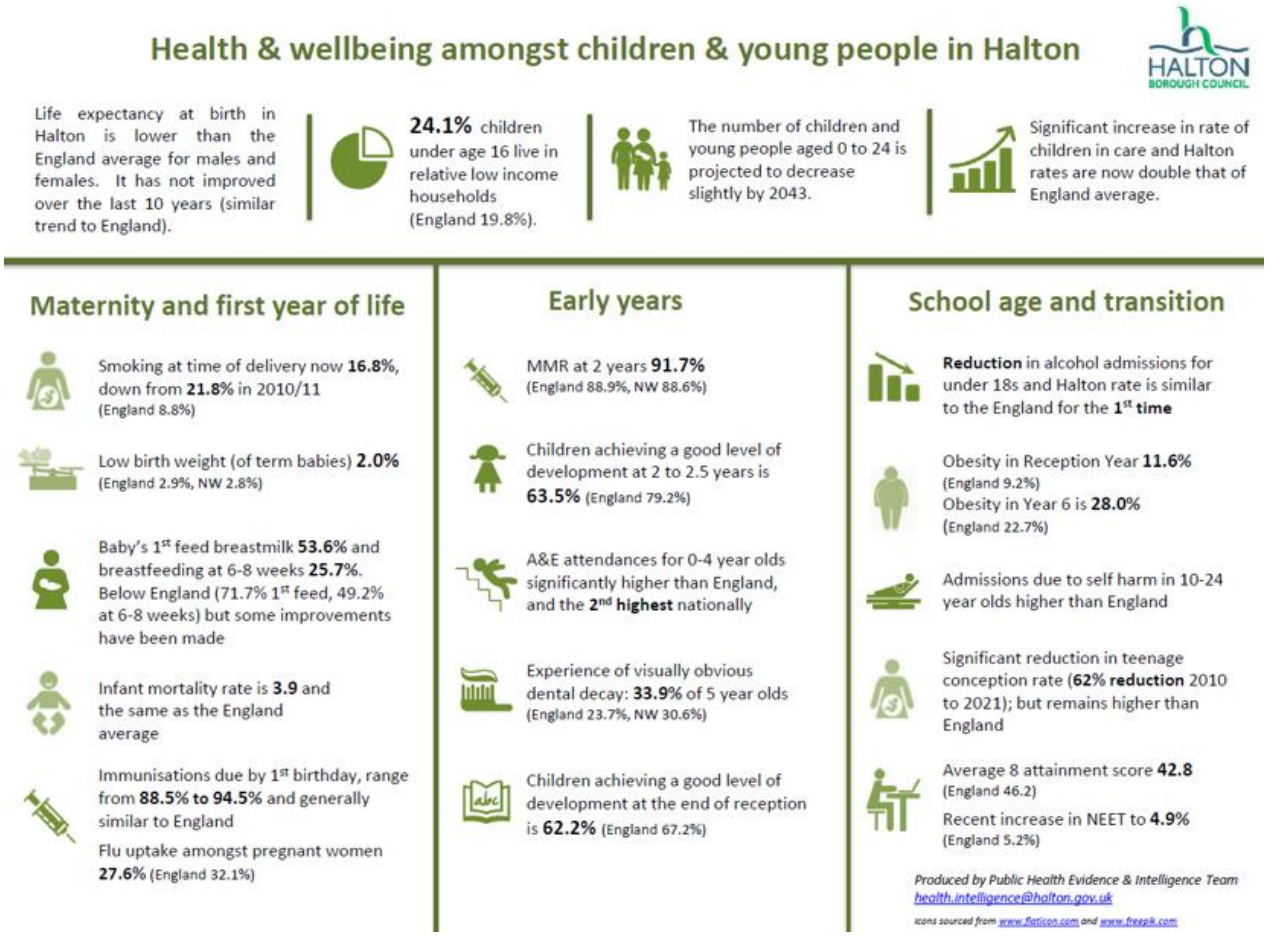
Ref	**Objective 1: Child Health**	
	Milestones	**Q1 Progress**
PH 01	Working with partner organisations to improve the development, health and wellbeing of children in Halton and to tackle the health inequalities affecting that population.	✓
Ref	**Objective 2: Adult Weight and Physical Activity**	
	Milestone	**Q1 Progress**
PH 02	Reduce levels of adult excess weight (overweight and obese) and adult physical inactivity	✓
Ref	**Objective 3: NHS Health Checks**	
	Milestone	**Q1 Progress**
PH 03	Ensure local delivery of the NHS Health Checks programme in line with the nationally set achievement targets and locally set target population groups.	✓
Ref	**Objective 4: Smoking**	
	Milestone	**Q1 Progress**
PH 04	Reduce smoking prevalence overall and amongst routine/manual and workless groups and reduce the gap between these two groups.	✓

Ref	Objective 5: Suicide Reduction	Q4 Progress
	Milestone	
PH 05	Work towards a reduction in suicide rate.	✓
Ref	**Objective 6: Older People**	
	Milestone	**Q4 Progress**
PH 06	Contribute to the reduction of falls of people aged 65 and over and reduction in levels of social isolation and loneliness.	✓
Ref	**Objective 7: Poverty**	
	Milestone	**Q4 Progress**
PH 07	To increase awareness of fuel poverty and drive change to tackle the issue through better understanding of services available across Halton (staff and clients).	✓
Ref	**Objective 8: Sexual Health**	
	Milestone	**Q4 Progress**
PH 08	To continue to provide an easily accessible and high quality local sexual health service, ensuring adequate access to GUM and contraceptive provision across the Borough, whilst reducing the rate of sexually transmitted infections and unwanted pregnancies.	✓
Ref	**Objective 9: Drugs and Alcohol**	
	Milestone	**Q4 Progress**
PH 09	Work in partnership to reduce drug and alcohol related hospital admissions.	✓

Supporting Commentary

Ref	Supporting Commentary
PH 01	Regular contract performance meetings take place every quarter with the 0-19 (+ SEND) (0-19 HCP) service. The 0-19 HCP service are supporting the development of the Family Hubs model, starting well strategy, leading on infant parent mental health and attachment, the Local Offer, and the SEND priority action plan. Bridgewater Community Health Care Trust (Bridgewater) continue to deliver the 0-19 HCP from four teams in four localities across Halton. Bridgewater are a key partner in the delivery of the Family hubs and starting well strategy, leading on infant parent mental health and attachment. Working in collaboration with all our partner agencies including Halton BABs, which launched on 19th November 2024 Halton BABS (Building Attachment & Bonds Service) - Halton Safeguarding Children Partnership The 0-19 HCP continues to offer a comprehensive health and wellbeing service to children and young people within the Borough. Some discrete elements of the service include, but not limited to, Health Visitor Service for 0 - 5 years, Family Nurse Partnership (First time pregnancy in teenagers), School Nursing Services for 5 - 19 years, SEND up to 25 years, support service users

to give children the 'best start in life' based on current evidence of 1001 Critical Days, Reception Age Hearing and Vision Screening, National Child Measurement Programme Services and Immunisation Services for children and young people aged 5 – 19 years (this element is commissioned separately by NHS England but forms an integral part of the service). The infographic below (using Q1 2024/25 performance data) gives an overview of the 0-19 HCP service and tracking the progress and impact of areas where the service is improving health outcomes for children and young people. These include maternity and first year of life, early years and school age and transition.



Source: 0-19 HCP produced by Public Health Evidence & Intelligence Team (October 2024)

Public Health report to direct award to Bridgewater using the Provider Selection Regime went to the Executive Board in October and was approved. This report was to seek executive board approval to proceed with a procurement process to grant a direct award to Bridgewater Community Healthcare NHS Foundation Trust (Bridgewater) for the delivery of 0-19 (+25 SEND) Healthy Child Programme (0-19 HCP) for the period 1st April 2025 – 31st March 2030, with the option of 2 x plus 1-year, pre-determined extension periods up to 31st March 2032.

The infant feeding offer continues to offer weekly drop-in support groups, in addition to home visits and telephone support in the postnatal period, plus antenatal workshops and engagement at community health visiting and midwifery clinics. HIT work closely with the Infant Feeding Specialist from Halton 0-19 team to offer joined-up universal and specialist services.

Women supported with breastfeeding	158
of whom were supported via home visits	47
Women supported with safe formula feeding via phone	85
Women attending breastfeeding support groups	31
Parents attending infant feeding drop-ins	59
Expectant parents attending infant feeding workshop	10
Parents attending Introducing Solid Foods workshops	68

	New settings joining Breastfeeding Welcome scheme | 19

HENRY Programme (preventing obesity for under 5s) facilitated jointly by HIT and 0-19 staff. Outcome data reports demonstrate consistent improvements in parenting confidence score and lifestyle scores by those completing courses. Plus **HIT Parent Workshops:**

Workshop	No. of courses	No. of completers
8-week HENRY **Right From the Start** courses completed	2	6
HENRY Parent workshops (one-off sessions)	6	20
HIT Fussy Eating workshop	1	12
HIT Sleep and Screens workshop	1	7
HIT Physical Activity and Sugar workshop	1	2

Healthy Schools and Healthy Early Years

Programme/event	Number of settings	Number of individuals
Schools engaged in Healthy Schools programme 2024-25	58 (88%)	-
HIT school workshops delivered in Q1	55	Over 1,400 pupils
Young Health Champions courses complete Q1	1	10 pupils
Schools represented at celebration event	28	110 pupils and staff
EY settings trained in Supervised Toothbrushing Q1	9	98 staff

Teen Lifestyle Programme 97 young people commenced on the Teen Lifestyle and Leisure Programme. This programme is for eligible 13-19 year olds, aligned with Core20Plus5 priorities. 66 of whom have completed or are currently fully engaged on the programme.

PH 02

Fresh start During **Quarter 1,640** referrals were made into the service. This is an **decrease** on the previous quarter. The service target is to get at least 70% of those referred to engage with the program. This would equate to **448** number of patients. Of those who was referred during **quarter 1,125** patients have so far recorded an initial contact, a further **46** have appointments booked, and **41 are awaiting action**. The Fresh Start service has a target to ensure 50% of those who have been referred onto the program achieve 12 weeks on the program and lose 5% of the starting weight. For **quarter 2** this number of patients should be **122** who started the service in **quarter 1**. **This quarter**, **104** patients completed 12 weeks which is **42%**

Exercise on prescription

During quarter 1, 343 referrals were made into the service. This is an increase of 3.5% on referrals in the previous quarter. The service target is to get at least 70% of those referred to engage with the program. This would equate to **240** number of patients. Of those who was referred during **quarter 1, 205** patients have so far recorded an initial consultation. This equals **59.8%** percentage of patients. This is an **increase** on the number of patients who started the service in the previous quarter.

The Exercise on Prescription service has a target to ensure 50% of those who have been referred onto the program achieve 12 weeks on the program and all should improve some form of functional outcome. Functional improvements could improve strength, balance, sit to stand, timed get up and go, quality of life improvement or wellbeing improvement. For **quarter 1** the number of patients should be **82**, who started the service in quarter **4.** This **quarter**, 84 patients completed 12 weeks which is **50.1%** percentage.

PH 03

Halton's invite target per quarter is to send 1900 invites. During Q1 2025/26 1813 invites where sent which is 95.4% of the target achieved. Based on the number of invited sent there is a national target of 75% uptake of patients invited should have had a health check completed. This would equal 1425 patients for us in Halton. During Q1 1003 health checks was completed, which is a 55.3% uptake. This is a drop on the previous quarter

<table>
<tr><td></td><td>however it should be noted that there has been significant sickness within the team during this quarter accounting for the drop in the number of health checks completed. From the number of health checks completed 582 people have been referred onto either primary care for clinical follow up or lifestyle services for behaviour change. This means that 58% of health checks completed have been referred on. This is an increase on the previous quarter.</td></tr>
<tr><td>PH 04</td><td>Quitting data from 01/04/2025 – 30/06/2025: Q1
<table>
<tr><td>Total of all referrals received in Q1</td><td>367</td></tr>
<tr><td>Total of all setting a quit date in Q1</td><td>225</td></tr>
<tr><td>Engagement Rate</td><td>61%</td></tr>
<tr><td>Total Quit</td><td>87</td></tr>
<tr><td>Quit Rate</td><td>Currently 39% *</td></tr>
<tr><td>* We are awaiting 4 week outcomes for 74 clients some of whom will have quit. Q1 is not complete data as 4 week outcomes for those that attend in June will not be available until July</td><td></td></tr>
<tr><td>Unemployed/Never Worked Set a Quit Date</td><td>26</td></tr>
<tr><td>Unemployed/Never worked Quit</td><td>6</td></tr>
<tr><td>Quit Rate</td><td>Currently 23% *</td></tr>
<tr><td>*Awaiting 4 week outcome for 11 clients. Q1 has incomplete data</td><td></td></tr>
<tr><td>Sick/Disabled/Unable to Return to Work Set a Quit Date</td><td>66</td></tr>
<tr><td>Sick/Disabled/Unable to Return to Work Quit</td><td>27</td></tr>
<tr><td>Quit Rate</td><td>Currently 41% *</td></tr>
<tr><td>*Awaiting 4 week outcome for 18 clients. Q1 has incomplete data.</td><td></td></tr>
<tr><td>Routine/Manual Set a Quit Date</td><td>30</td></tr>
<tr><td>Routine/Manual Quit</td><td>13</td></tr>
<tr><td>Quit Rate</td><td>Currently 43%*</td></tr>
<tr><td>*Awaiting 4 week outcomes for 10 clients. Q1 has incomplete data.</td><td></td></tr>
<tr><td>Home Carers (Unpaid) Set a Quit Date</td><td>9</td></tr>
<tr><td>Home Carers (Unpaid) Quit</td><td>3</td></tr>
<tr><td>Quit Rate</td><td>Currently 33%*</td></tr>
<tr><td>*Awaiting 4 week outcomes for 2 clients. Q1 has incomplete data.</td><td></td></tr>
</table>
Overall 131/225 clients setting a quit date in Quarter 1 (2025-2026) are from routine/manual and workless groups. This equates to 58% .

*So far 49/87 clients quitting in Quarter 1 (202-2026) are from routine/manual and workless groups. This equates to 56% .This will increase when full data for Quarter 1 is available.</td></tr>
<tr><td>PH 05</td><td>We continue to work closely with partners and Champs on the Zero Suicide Agenda and consistently drive Halton’s action plan to contribute to reduction in suicides. Work is underway to complete the latest suicide audit and once complete information will be used to refresh the local action plan. Work is underway by Champs to update the RTS system from Power BI dashboard to QES. The QES Suicide Surveillance system has been designed to support the real-time recording, reviewing and reporting of suspected suicides to better inform prevention, postvention and bereavement support. QES will eventually enable local areas to request real time information from key partners to understand whether the deceased was known to them enabling learning to take place in real time. Work is underway to create an easy read version of the Self harm booklets that have been developed for staff working with Children and Young People. Understanding men and boys mental health needs conference webinar was delivered to 120 people in June for men’s health week and 58</td></tr>
</table>

	have since watched the recording. Real Time Surveillance for Q1 2025/2026 is 4 in comparison to 3 for Q1 for 2023/2024 overall the number of RTS notifications is lower by 2 in comparison to this time last year however variation is small and could be naturally occurring.
PH 06	In Quarter 1, Sure Start to Later Life received 49 referrals and completed 75 reviews. Of those reviewed, 37% of clients reported feeling less lonely as a result of our intervention, and 58% said the service had a positive impact on their overall health and wellbeing. These outcomes are particularly encouraging given that the new model is still in early implementation, with staff undergoing intensive training in preparation for full rollout of our new Stronger for longer program. As we prepare to launch Stronger for Longer—our new preventative programme replacing Sure Start to Later Life (SSTLL)—we have already started to adopt elements of the new model within the current service. Sure Start will officially close on 4th August, and Stronger for Longer will bring with it a more structured and meaningful way of capturing outcomes for older adults, including improvements in health, wellbeing, mobility, social connectedness, and confidence accessing community support as a result of our 12 week support. Engagement with our community events has also remained strong. In Q1, 147 local residents attended our Get Together events aimed at reducing loneliness and isolation. Each event included a co-production session where attendees were invited to share their views and experiences to help shape the design of Stronger for Longer. These sessions have been instrumental in ensuring the new programme reflects the needs and priorities of the people it is intended to support. We are also in the process of developing a more robust system to identify individuals at greater risk of falling through our Exercise on Prescription (EoP) service. Currently, those at risk are sometimes referred into our specialist falls prevention class, but this is not always the most suitable or accurate intervention. Moving forward, we are working to ensure we have a robust way to capture data on those identified as higher risk of falls, regardless of which EoP class they attend. This will allow us to better track and evidence our contribution to falls prevention among adults over 65, beyond just attendance at a single class type.
PH 07	Available funding for emergency energy bill payments for both pre-paid meters and direct debit schemes as well as heating system repairs has been secured for a further 12 months. This support will be delivered alongside advice and wraparound support offered by Energy Projects Plus. This continues an offer that has been in place for 3 years for residents whilst keeping the same referral route for professionals to use. We'll be running sessions for front line professionals pre-winter and using available online platforms to connect available funding to professionals in a position to refer appropriate patients. Furthermore, the funding forms an essential part of our Winter Cold Homes pilot ensuring we can offer a full range of options to deal with the effects of living in fuel poverty as part of a patients care this Winter. Our commitment to working towards a proactive approach to offering available support for fuel poverty based on health conditions will be included in the new Halton wide housing strategy currently being finalised. This is alongside the priority to maximise the rollout of available government housing retrofit and improvement schemes.
PH 08	The sexual health service continues to be delivered by Axess and provides free contraception and sexual health services across the borough, including dedicated Young People's clinics. It has been agreed to utilise the 'plus one' and extend the contract duration with Warrington for an additional year until Autumn 2026. Work is ongoing at a local and regional level around Women's Health Hubs (WHH), where Halton have been identified as a priority area. The specifics of the funding allocation are still under discussion. The initial focus of developing WHH will be to increase access to LARC (IUD/IUS contraception and non-contraceptive) through enhanced training, inter-practice referrals and collaborative working between ICB, Local Authority, Primary Care, pharmacies and the sexual health service.
PH 09	A service review of the drug and alcohol treatment and recovery service, delivered by CGL, is currently ongoing. The contract for this has entered completed the first quarter of the first contract extension period.

	It is anticipated that the contract will be further extended by utilising the final one-year extension to take the contract until the end of March 2027. The North West Ambulance Service (NWAS) post funded by commissioners across the North West is continuing to provide strategic planning to ensure targeted and tailored support is provided following a non-fatal opiate overdose. All Halton residents treated by the services for opiate non-fatal overdose are automatically referred to the CGL. Data is provided by NWAS weekly for local monitoring of non-fatal overdoses. Locally CGL is working to increase access to Naloxone kits and training in the administration of the drug, which is used to counteract the effect of opioid drugs, for those who have overdosed. Harm reduction and safety advice is provided to service users, and information is shared with professionals and service users regarding particularly potent and harmful illicit substances that are being sold within the area. Health Check Officers completed **300** Audit C's in **Q1.** Lifestyle Advisors completed **71** Audit C's in **Q1** Stop Smoking Service completed **124** Audit C's in **Q1** so combined total for H.I.T delivering Audit C screenings in **Q1** is **495.**

Key Performance Indicators

Ref	Measure	Actual 2024/25	Target 2025/26	Quarter 1	Current Progress	Direction of Travel
PH01a	Healthy life expectancy at birth: females (years)	58.6 (2020-22)	58.8 (2019-21)	56.8 (2021-23)	✗	↓
PH01b	Healthy life expectancy at birth: males (years)	58.6 (2020-22)	58.8 (2019-21)	56.6 (2021-23)	✗	↓
PH02	A good level of child development (% of eligible children achieving a good level of development at the end of reception)	62.2% (2022/23)	62.5% (2023/24)	61.2% (2023/24)	✗	↓
PH03	Health Visitor new births visits (% of new births receiving a face to face visit by a Health Visitor within 14 days)	83.9% (2023/24)	90% (standing target)	90.1% (Q1-3 2024/25)	✓	↑
PH04	Prevalence of adult excess weight (% of adults estimated to be overweight or obese)	72.7% (2022/23)	72.0% (2023/24)	73.6% (2023/24)	✗	↓
PH05	Percentage of physically active adults	62.8% (2022/23)	62.8% (2023/24)	63.2% (2023/24)	✓	↑
PH06	Uptake of NHS Health Check	44% (2023/24)	60% (2024/25)	60% (Q1-4 2024/25)	✓	↑

	(% of NHS Health Checks offered which were taken up in the quarter)					
PH07	Smoking prevalence (% of adults who currently smoke)	13.3% (2022)	13.0% (2023)	14.6% (2023)	✗	↓
PH08	Deaths from suicide (directly standardised rate per 100,000 population)	9.3 (2020-22)	9.9 (2021-23)	13.2 (2021-23)	✗	↓
PH09	Self-harm hospital admissions (Emergency admissions, all ages, directly standardised rate per 100,000 population)	261.6 (2022/23)	259.2 (2023/24)	224.4 (2023/24)	✓	↑
PH10	Emergency admissions due to injuries resulting from falls in the over 65s (Directly Standardised Rate, per 100,000 population; PHOF definition)	2,206 (2022/23)	2,195 (2023/24)	2,144 (2023/24)	✓	↑
PH11	Social Isolation: percentage of adult social care users who have as much social contact as they would like (age 65+)	32.7% (2021/22)	40% (2022/23)	36.2% (2022/23)	✗	↑
PH12	Fuel poverty (low income, low energy efficiency methodology)	12.4% (2021)	12.0% (2023)	10.7% (2023)	✓	↑
PH13	New sexually transmitted infections (STI) diagnoses per 100,000 (excluding chlamydia under 25)	405 (2023)	399 (2024)	365 (2024)	✓	↑
PH14	Long acting reversible contraception (LARC) prescribed as a proportion of all contraceptives	49.2% (2023/24)	50% (2024/25)	50.9% (2024/25)	✓	↑
PH15	Admission episodes for alcohol-specific conditions	857 (2022/23)	848 (2023/24)	922 (2023/24)	✗	↓

	(Directly Standardised Rate per 100,000 population)					
PH16	Successful completion of drug treatment (non opiate)	19.1% (2023/24)	19.5% (2024/25)	26.9% (2024/25)	✓	↑

Supporting Commentary

Ref	Supporting Commentary
PH01a	2021-23 data showed a significant drop since 2020-22 of almost 2 years in healthy life expectancy. This will have been largely the result of the Covid-19 pandemic but also the cost of living crisis.
PH01b	2021-23 data showed a significant drop since 2020-22 of 2 years in healthy life expectancy. This will have been largely the result of the Covid-19 pandemic but also the cost of living crisis.
PH02	Despite the percentage rising in 2022/23, it decreased in 2023/24. Halton performs below the England average. Data is released annually.
PH03	The 2024/25 data has seen an increase from 2023/24 and has met the target of 90%.
PH04	Adult excess weight increased each year since 2020/21 and did not meet the target in 2023/24. Data is published annually by OHID.
PH05	Adult physical activity increased slightly in 2023/24 but is below the England average of 67.4%. Data is published annually by OHID.
PH06	Q1-4 2024/25 data has seen an increase in uptake from 2023/24 and has met the target.
PH07	Smoking levels increased in 2023 and did not meet the target. Data is published annually.
PH08	The suicide rate increased during 2021-23 and did not meet the target. However the rate is statistically similar to the England average. Data is published annually over a three year period.
PH09	Published 2023/24 data shows the rate of self-harm admissions has reduced since 2019/20 and met the target. Data is available annually.
PH10	There has been a reduction in falls injuries in 2023/24 and the rate has met the target. Halton's rate is now statistically similar to the England average. Data is available annually.
PH11	The proportion of adult social care users having as much social contact as they would like increased in 2022/23 but did not meet the target. Data is available annually.
PH12	Fuel poverty has improved in Halton since 2020 and is slightly below the England average. Data is published annually.
PH13	New STI rates decreased in 2024 and rates are consistently better than the England. Data is published annually.
PH14	Data 2024/25 shows a slight improvement on the 2023/24 annual figure and has met the target.
PH15	The alcohol-specific admissions rate has increased during 2023/24 (as it did across England as a whole) and has not met the target.
PH16	Data does fluctuate year on year but in 2022/23 and 2023/24, the Halton proportion of successful completions was worse than the England average. However, the figure increased in 2024/25 and met the target.

Appendix 1 – Financial Statements

COMMUNITY CARE

Revenue Budget as at 31st May 2025

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Residential & Nursing	20,674	1,340	1,395	(55)	(333)
Domicilary Care & Supported living	15,564	691	861	(170)	(1,343)
Direct Payments	15,513	3,430	3,644	(214)	(972)
Day Care	712	62	60	2	13
Total Expenditure	**52,463**	**5,523**	**5,960**	**(437)**	**(2,635)**
Income					
Residential & Nursing Income	-11,881	-729	-732	3	14
Community Care Income	-3,115	-230	-159	(71)	(210)
Direct Payments Income	-1,034	-77	-80	3	204
Income from other CCGs	-420	0	0	0	0
Market sustainability & Improvement Grant	-2,796	-466	-466	0	0
Adult Social Care Support Grant	-6,102	-1,017	-1,017	0	0
War Pension Disregard Grant	-54	0	0	0	0
				0	
Total Income	**-25,402**	**-2,519**	**-2,454**	**(65)**	**8**
Net Operational Expenditure	**27,061**	**3,004**	**3,506**	**(502)**	**(2,627)**

Comments on the above figures

The net spend position for the community care budget at the end of May 2025 is currently £0.502m over the available budget and the yearend shows net spend to be £2.627m over the annual budget. It is worth noting that there has been a change to the methodology of the forecast for these services. In previous years the forecast was derived from extrapolating the spend incurred on each periodic Master Service Return (MSR) to the end of the year. However this has proved to be increasingly unreliable.

In order to gain a more accurate forecast at the start of the financial year, intelligence gained from the previous year has been used as a basis. This was inflated by the anticipated demographic growth (4.9%) and therefore the associated increase in demand for services and also the uplift to providers (8%). The financial performance against monthly targets will be monitored closely and the forecast will be adjusted as necessary as we move through the year.

This forecast is as things stand at the moment assuming no material changes, apart from increased demand of 4.9% and the agreed fee increase of 8% with care providers. However there is a risk that the forecast could be significantly more as the ICB carry out a formal "turnaround" reviewing all NHS spend which may impact on the community care budget and could result in more challenges to social care funding requests.

To mitigate this financial risk a number of actions are being considered for implementation to reduce costs and help bring spend back in line with budget. These are detailed below:

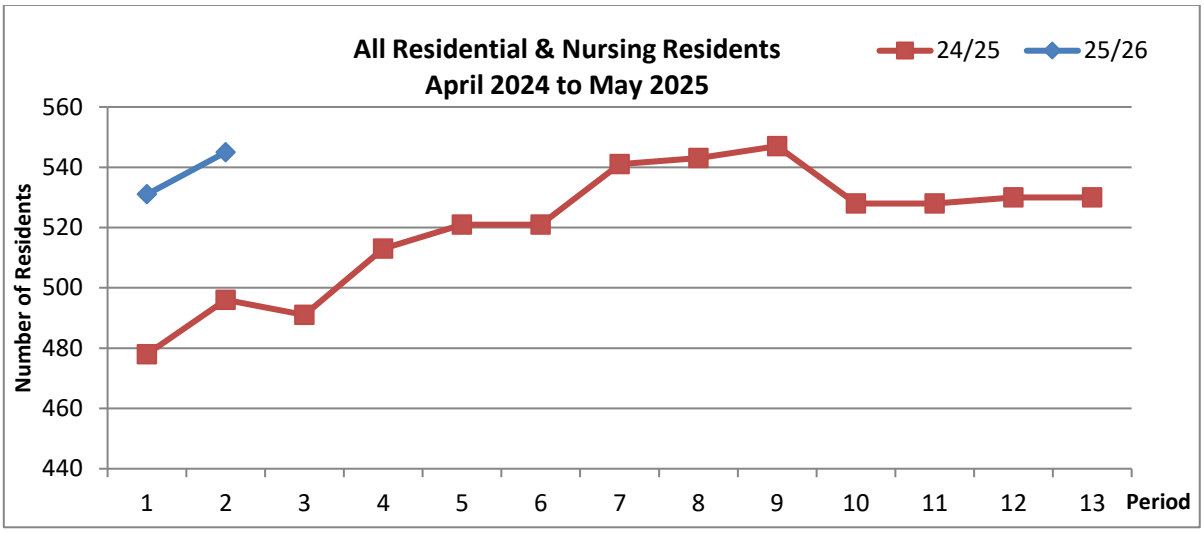
- Reduction of 1 to 1 packages of care if health's responsibility
- Review 15 minutes packages of domiciliary care to identify medicine prompts which are health's financial responsibility
- Ensure assessments carried out on discharge from hospital are complete and appropriate
- Maximise internal care home capacity

Further analysis of individual service budgets is provided below.

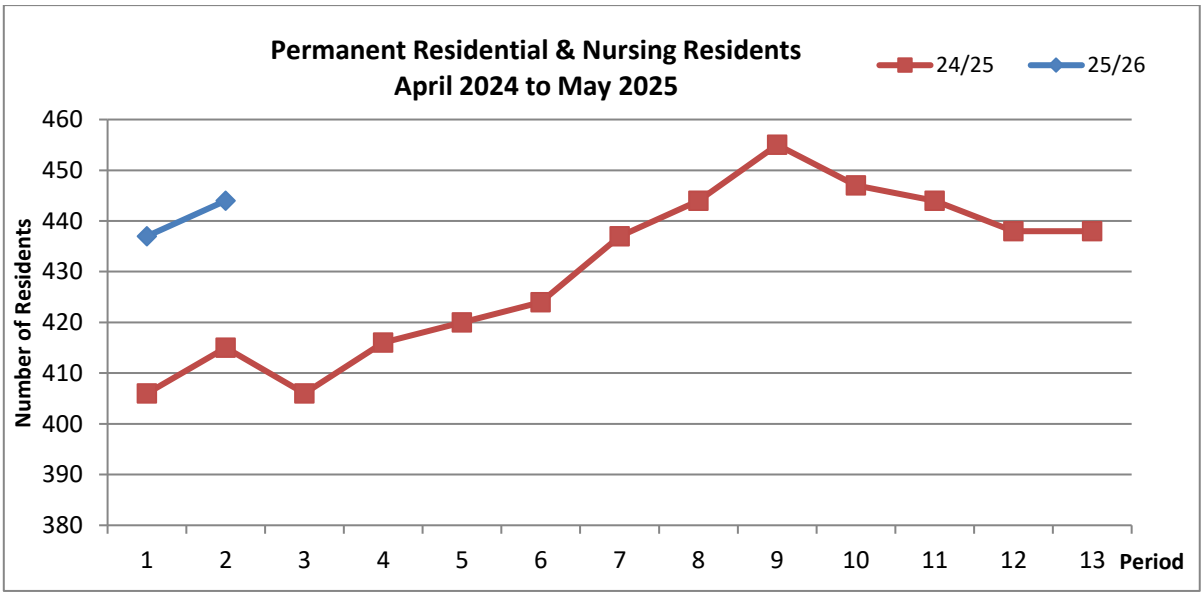
Residential & Nursing Care

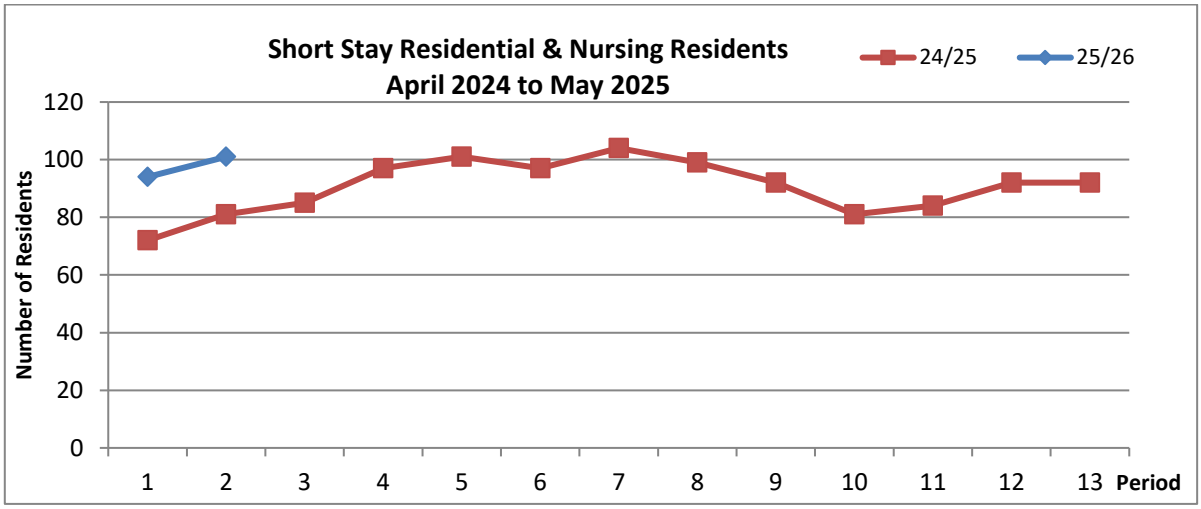
There are currently 545 residents in external residential/nursing care as at the end of May 2025 compared to 530 at the end of 2024/25, an increase of 2.8%. Compared to the 2024/25 average of 520 this is an increase of 4.8%. The average cost of a package of care is currently £940.85 compared to £850.24 at the end of 2024/25 an increase of 10.6%. Supplementary invoice payments so far amount to £86k.

The graph below illustrates the demand for all residential and nursing placements.



The above external care home data can be further split out to show short stay and permanent placements as in the graphs below.

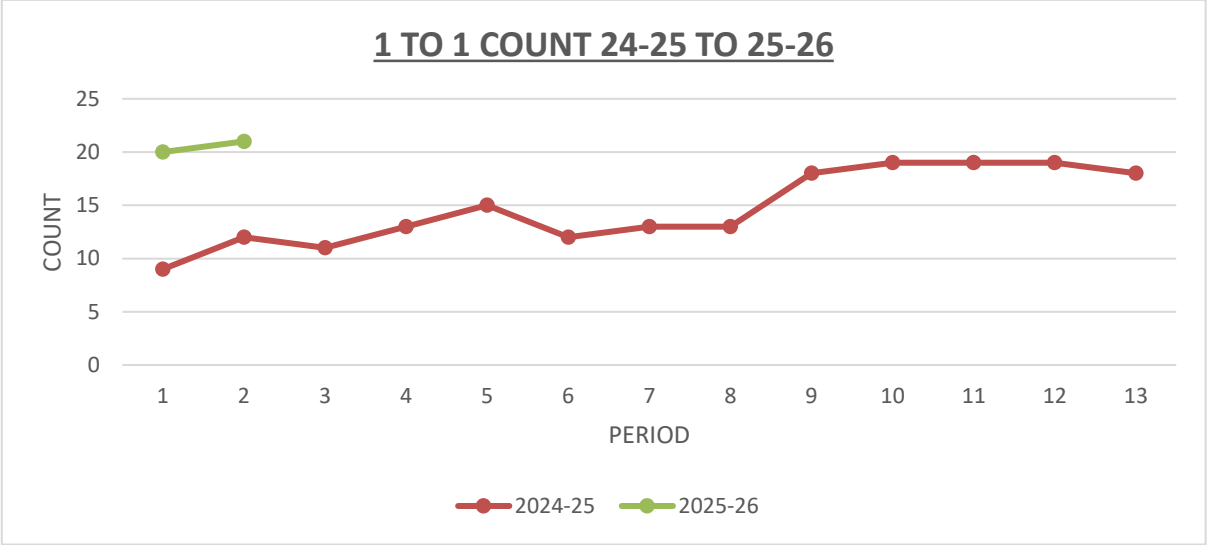




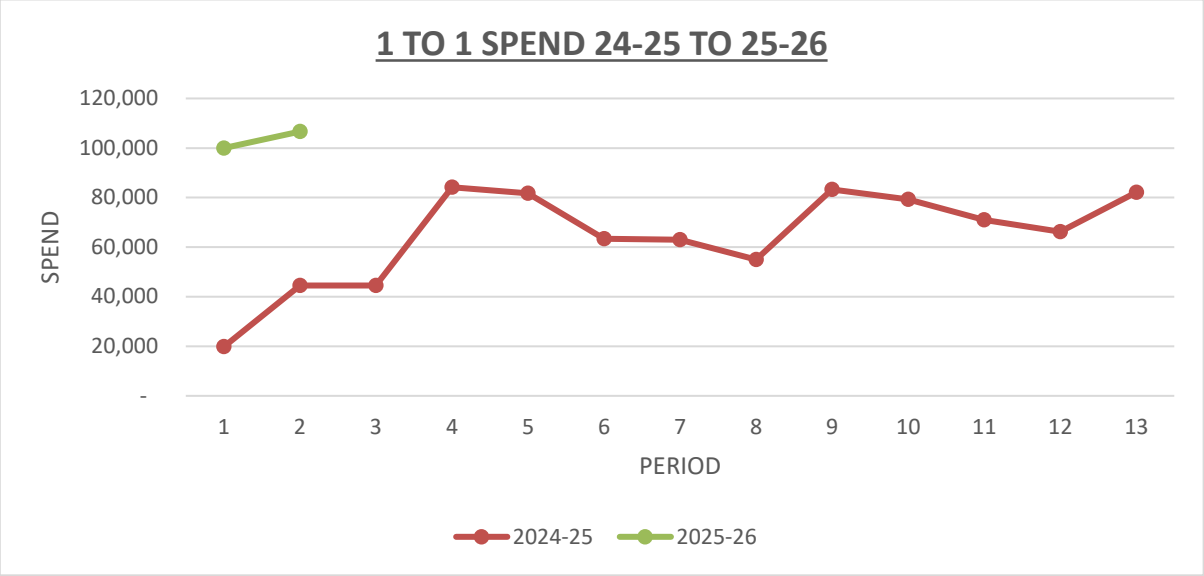
1 to 1 Support In Care Homes

Payments for 1 to 1 support continue to exert pressure on the budget, due to increasing demand. This is generally to mitigate the risk from falls particularly on discharge from hospital. The full year cost for 2024/25 was £837,882.

The graph below shows the count of service users receiving 1 to 1 care by period and clearly demonstrates an increase, particularly compared with the same period last year rising from 12 to 21. This is an increase of 75%.



The graph below shows the spend on 1 to 1 care by period. This shows that the monthly spend has increased 29% from £82k at the end of 2024/25 to £107k at the end of May. If the Council continue to pay 1 to 1 costs at the current rate this will amount to approximately £1.3m per annum.

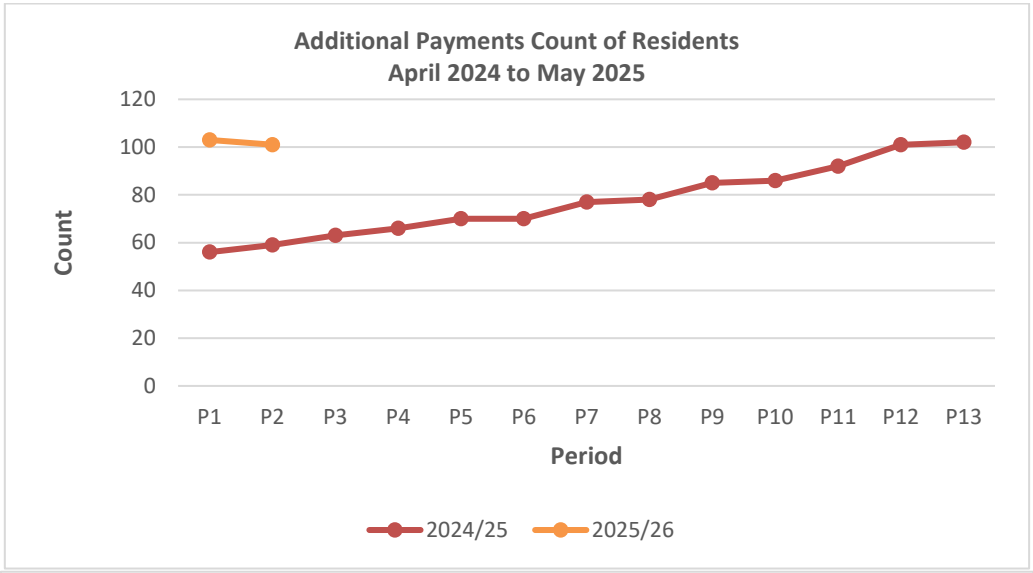


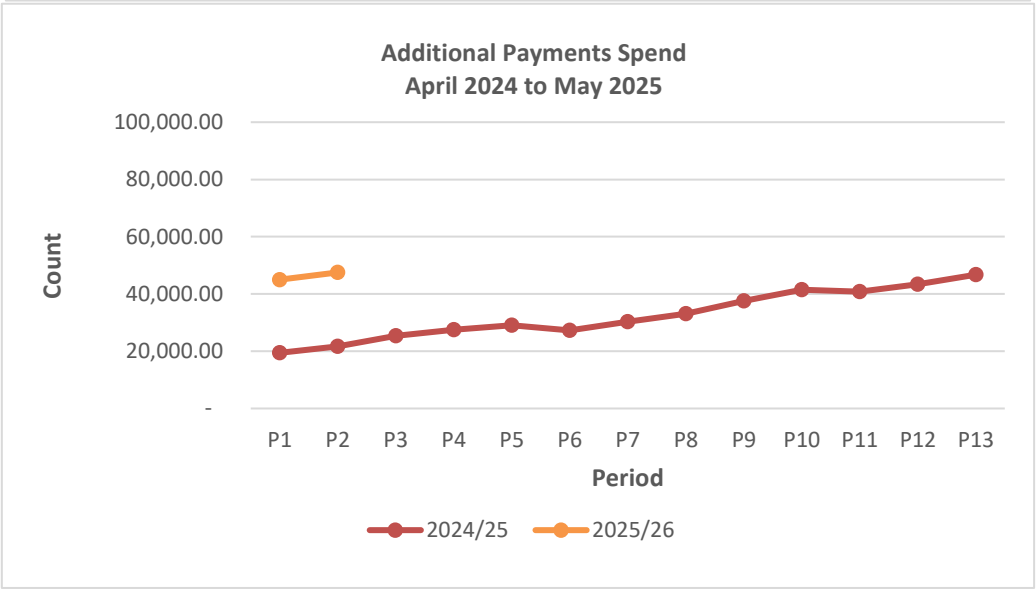
Additional Payments 2025/26

Additional payments to providers rose sharply throughout 2024/25, both in and out of the borough. These are where the care home charges an additional amount on top of the contracted bed rate. The cost of this for 2024/25 was £423,894.

The graph below illustrates the count of service users with an additional payment by period.

This clearly shows a steady increase in numbers and costs for 24/25. The spend up to Period 2 2025/26 is £92,526.32. If numbers and costs remain the same (101) the forecast spend for the year will be approximately £0.615m.





High Cost Packages

The number of permanent packages of care over £1k per week are tabled below:

Weekly Cost £	No of Permanent PoCs	
	P 1	P 2
1000-1999	60	61
2000-2999	23	28
3000-3999	6	6
4000-4999	9	8
5000-5999	5	5
6000-6999	2	2
7000-7999		
8000-8999	1	1
>10,000		
Total	106	111

Over £1,000 Out of Borough	76	80

Over Funded	£1,000	Joint	47	48

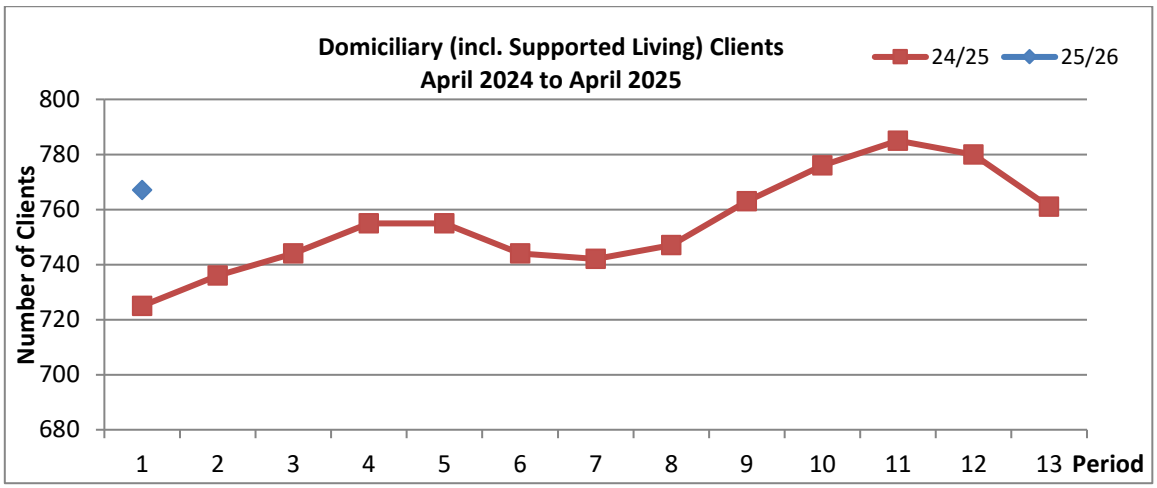
Since the beginning of the financial year the number of permanent packages over £1k has increased 4.7% from 106 to 111. Out of borough placements over £1k has increased 5.2% from 76 to 80.Joint funded packages of care over £1k has increased 2.1% from 47 to 48.

Domiciliary Care & Supported Living

Note only 1 period of data is available at the time of writing.

There are currently 767 service users receiving a package of care at home, compared to the average in 2024/25 of 754, an increase of 1.7%. However compared with April 2024 the increase is 5.8%.The average cost of a package of care is currently £452.39 compared with £450.64 in 2024/25.

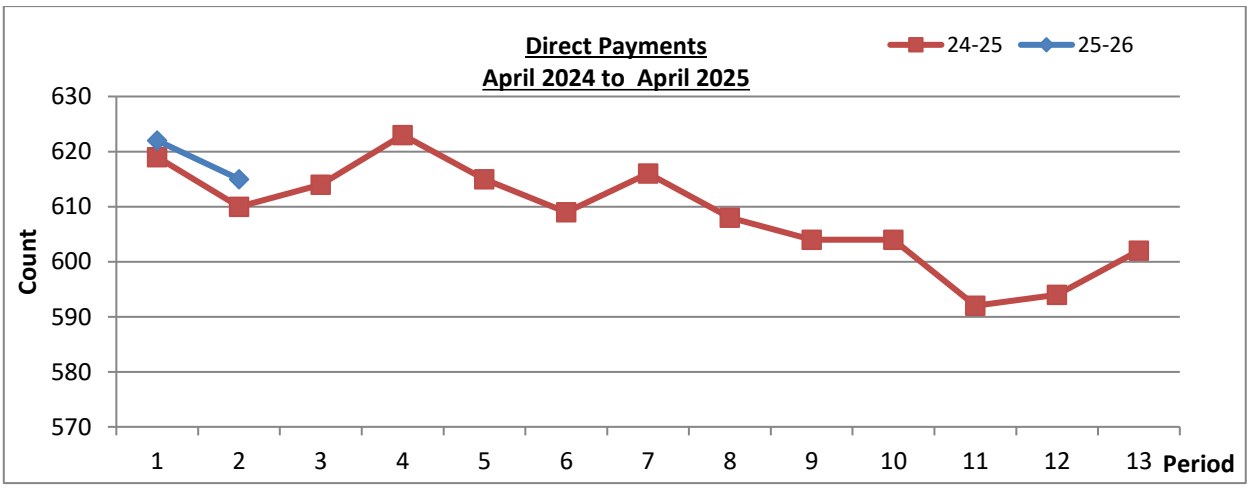
The graph below illustrates the demand for the service from April 2024 to April 2025.



Direct Payments

The average number of clients who received a Direct Payment (DP) in Period 2 was 615 compared with 622 in Period 1, a decrease of 1.1%. The average cost of a package of care has also decreased from £571.26 to £511.50, a reduction of 10.46%.

The graph below shows movement throughout the year.



The Community Care budget as a whole is very volatile by nature as it is demand driven, with many influential factors. It will continue to be closely monitored and scrutinised in year to quantify pressures on the financial performance. The Community Care budget recovery group continues to meet regularly to

identify savings and cost avoidance actions to try to mitigate some of the risk of overspend against this budget.

CARE HOMES DIVISION

Revenue Budget as at 31 May 2025

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Madeline Mckenna					
Employees	770	122	116	6	52
Agency - covering vacancies	0	0	10	(10)	(77)
Other Premises	90	14	5	9	15
Supplies & Services	26	3	6	(3)	(12)
Food Provison	51	4	9	(5)	(5)
Private Client and Out Of Borough Income	-127	-7	-5	(2)	(24)
Reimbursements & other Grant Income	-23	-2	-3	1	10
Total Madeline Mckenna Expenditure	**787**	**134**	**138**	**(4)**	**(41)**
Millbrow					
Employees	2,280	350	199	151	1,088
Agency - covering vacancies	0	0	178	(178)	(1,308)
Other Premises	117	16	19	(3)	(13)
Supplies & Services	72	11	16	(5)	(30)
Food Provison	81	7	13	(6)	(10)
Private Client and Out Of Borough Income	-13	-2	-5	3	11
Reimbursements & other Grant Income	-742	-62	-67	5	10
Total Millbrow Expenditure	**1,795**	**320**	**353**	**(33)**	**(252)**
St Luke's					
Employees	3,595	614	392	222	1,603
Agency - covering vacancies	0	0	252	(252)	(1,777)
Other Premises	156	19	29	(10)	(55)
Supplies & Services	67	10	13	(3)	(10)
Food Provison	128	21	26	(5)	(30)
Private Client and Out Of Borough Income	-152	-19	-15	(4)	0
Reimbursements & other Grant Income	-1,080	-83	-82	(1)	0
Total St Luke's Expenditure	**2,714**	**562**	**615**	**(53)**	**(269)**
St Patrick's					
Employees	2,031	338	365	(27)	700
Agency - covering vacancies	0	0	145	(145)	(927)
Other Premises	144	17	24	(7)	(20)
Supplies & Services	67	9	12	(3)	(10)
Food Provison	127	21	17	4	0
Private Client and Out Of Borough Income	-99	-8	-5	(3)	(10)
Reimbursements & other Grant Income	-684	-83	-48	(35)	(94)
Total St Patrick's Expenditure	**1,586**	**294**	**510**	**(216)**	**(361)**
Care Homes Divison Management					
Employees	322	54	30	24	129
Care Home Divison Management	**322**	**54**	**30**	**24**	**129**
Net Operational Expenditure	**7,204**	**1,364**	**1,646**	**(282)**	**(794)**
Recharges					
Premises Support	65	11	11	0	0
Transport Support	0	0	0	0	0
Central Support	663	111	111	0	0
Asset Rental Support	0	0	0	0	0
Recharge Income	0	0	0	0	0
Net Total Recharges	**728**	**122**	**122**	**0**	**0**
Net Departmental Expenditure	**7,932**	**1,486**	**1,768**	**(282)**	**(794)**

Comments on the above figures

Financial Position

The care home division is made up of the following cost centres, Divisional Management Care Homes, Madeline Mckenna, Millbrow, St Luke's and St Patrick's.

The spend for the first two months of the 2025/26 Financial Year to 31 May is £0.282M above profile, with an estimated spend above budget for the year of £0.794M. This primarily relates to unbudgeted agency staffing costs.

Comparison to Previous Year Outturn

The outturn position for financial year 2024/25 was £1.283M over budget. It should be noted that during the 2025/26 budget setting exercise the staffing budget allowance in respect of holiday cover for care staff was recalculated to reflect a more accurate number of staff cover days needed. This resulted in a permanent increase to the base staffing budget of £0.425m.

Supporting Information

Employee Related Expenditure

Employee related expenditure is over budget profile at the end of May 2025 by £0.064M, with the expected outturn at the end of financial year being £0.517m over budget. Projections take into account agency spending patterns over the previous 3 financial years, which consistently show increased spending patterns in the latter half of the financial year.

Recruitment of staff is a continued pressure across the care homes. There remains a high number of staff vacancies across the care homes. A proactive rolling recruitment exercise is ongoing within the care homes and is supported by HR.

Due to pressures with recruitment and retention in the sector, heavy reliance is being placed on overtime and expensive agency staff to support the care homes. At the end of May 2025 total agency spend across the care homes reached £0.585M, the cost of this has partially been offset by staff vacancies.

Premises Related Expenditure

Premises related expenditure is over budget profile at the end of May by £0.029M and is forecast as an estimated overspend at the end of the financial year 2025/26 of £0.073M

Repairs and maintenance continue to be a budget pressure across all the care homes. The recruitment of a facilities manager would help to reduce these costs. Budget for this post has been made available but the recruitment to this position has so far been unsuccessful.

Income

Income Targets include those for privately funded residents, out of borough placements, and reimbursements from the ICB in respect Of Continuing Health Care, Funded Nursing Care, and Joint Funded placements. Whilst most income targets are running generally to target, 2 Continuing Health Care residents sadly passed away early in the financial year. Income for this area is therefore currently reduced, and an under-achievement is currently projected.

Approved 2025/26 Savings

There are no approved savings for the care home division in financial year 2025/26.

Risks/Opportunities

The demand for agency staff within the care homes has been significantly high for several years.

Currently agency staff are being used for a variety of different reasons, to cover vacant posts, maternity leave and sickness absence.

The forecasts for agency staff are continuously reviewed to account for fluctuations in demand, however, the difficulty in the recruitment of new staff and the inability to retain existing staff has resulted in continued reliance on agency staff. The expectation is that the use for agency staff will be an ongoing issue.

BETTER CARE POOLED BUDGET

Revenue Budget as at 31 May 2025

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Intermediate Care Services	6,312	494	500	(6)	(31)
Oakmeadow	1,995	299	295	4	22
Community Home Care First	1,941	142	132	10	42
Joint Equipment Store	880	0	0	0	0
Contracts & SLA's	3,262	0	0	0	0
Inglenook	134	14	8	6	34
HICafs	3,720	98	121	(23)	(124)
Carers Breaks	445	27	20	7	47
Carers centre	365	0	0	0	0
Residential Care	7,236	906	906	0	0
Domiciliary Care & Supported Living	4,336	723	723	0	0
Pathway 3/Discharge Access	426	0	0	0	(2)
HBC Contracts	72	22	22	0	0
Healthy at Home	28	0	0	0	0
Capacity	30	0	-4	4	12
Total Expenditure	**31,182**	**2,725**	**2,723**	**2**	**0**
Income					
BCF	-15,032	-1,253	-1,253	0	0
CCG Contribution to Pool	-2,959	-246	-246	0	0
Oakmeadow Income	-2	0	0	0	0
Total Income	**-17,993**	**-1,499**	**-1,499**	**0**	**0**
Net Operational Expenditure	**13,189**	**1,227**	**1,225**	**2**	**0**

Comments on the above figures

The financial performance as at 31 May 2025 shows a balanced financial forecast for the Complex Care Pool as at period 2 of the financial year.

Intermediate Care Services are marginally over budget to date, with an over spend against budget of £0.031m expected at the end of the financial year. This is due to spend on agency staff covering vacancies within the hospital team.

Oakmeadow is currently under budget by £0.004m with an expected year end underperformance of £0.022m. This is due to a lower than anticipated expenditure on care staff, with current spend on casual and agency staff currently lower than at this point in 24/25.

The overspend on HICaFS is primarily due to the use of agency staff to cover vacancies. In the previous financial year, this overspend was offset by the underperformance on the Warrington and Bridgewater HICaFS contracts. At present no contract spend information is available, therefore contracts are currently forecast to spend to target, however, any underperformance on the contracts in this financial year will reduce the budget pressure on this service.

Community Home Care First is currently indicating a £0.042m underspend. This is a demand led budget and spend will fluctuate throughout the year. Current forecasting adopts a prudent approach, however, there remains a risk that these costs could increase throughout the year adding pressure to the budget.

Inglenook is expected to be £0.034m under budget by the end of the financial year. At present there are two clients using the service, however one client is funded by Continuing Health Care, which minimises the expenditure on this budget.

Carer's Breaks is showing a forecast outturn of £0. 047m under budget as demand for services is still lower than pre-pandemic levels.

Pathway 3 is currently forecast to be £0.002m over budget at the end of the financial year. Although currently this is only a small pressure, as this is a demand led budget it carries the risk that the spend will increase further, resulting in a more unfavourable position.

There is a slight underspend on the Capacity contract for improving residential care. This is due to majority of the contract costs being incurred during 24/25, leaving the a surplus of £0.012m in this financial year.

The forecast outturn for year end is currently showing a balanced budget. However, in accordance with the terms of the pool budget, should there be any unallocated funds at the end of the year, these will be shared equally with the ICB. The Halton Borough Council allocation will be used to contribute towards the pressures within community care.

ADULT SOCIAL CARE

Revenue Operational Budget as at 31 May 2025

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	18,077	3,038	2,778	260	1,302
Agency- Covering Vacancies	0	0	280	(280)	(1,567)
Premises	498	124	122	2	16
Supplies & Services	698	145	155	(10)	(52)
Aids & Adaptations	37	6	6	0	(4)
Transport	341	57	42	15	79
Food & Drink Provisions	228	38	24	14	78
Supported Accommodation and Services	1,408	235	184	51	269
Emergency Duty Team	157	0	0	0	(13)
Transfer To Reserves	295	0	0	0	0
Contracts & SLAs	1,050	189	189	0	0
					0
Housing Solutions Grant Funded Schemes					
Homelessness Prevention	548	196	193	3	0
Rough Sleepers Initiative	139	0	0	0	0
Total Expenditure	**23,476**	**4,028**	**3,973**	**55**	**108**
Income					
Fees & Charges	-1,044	-111	-62	(49)	(300)
Sales & Rents Income	-538	-175	-208	33	150
Reimbursements & Grant Income	-2,089	-96	-103	7	42
Capital Salaries	-117	0	0	0	0
Housing Schemes Income	-687	-687	-687	0	0
Total Income	**-4,475**	**-1,069**	**-1,060**	**(9)**	**(108)**
Net Operational Expenditure	**19,001**	**2,959**	**2,913**	**46**	**0**
Recharges					
Premises Support	789	132	132	0	0
Transport	792	132	142	-10	0
Central Support	4,039	673	673	0	0
Asset Rental Support	13	0	0	0	0
HBC Support Costs Income	-112	0	-19	19	0
Net Total Recharges	**5,521**	**937**	**928**	**9**	**0**
Net Departmental Expenditure	**24,522**	**3,896**	**3,841**	**55**	**0**

Comments on the above figures

The above information relates to Adult Social Care, excluding Community Care and Care Homes. Net Department Expenditure, is currently £0.055m under budget profile at the end of the second period of the financial year.

Current Expenditure projections indicate a balanced budget at the end of the financial year.

Employee Related Spend

The projected full-year cost is above the annual budget by £0.265m. The unbudgeted agency costs are in respect of covering vacant posts, particularly in terms of front-line Care Management and Mental Health

Team posts. Due to ongoing and increase in vacancies, there has been an increase in Agency staff use, with the continued use of these Agency staff members being forecasted until the end of the financial year. Agency expenditure across the division as a whole at the end of May 2025 stood at £0.280m, with a full-year spend of £1.567m projected.

Supplies and Services related spend

The projected £0.052m full-year spend above budget relates to an increased volume of caseload in respect of Deprivation Of Liberty Standards (DoLs) assessments. Spend to May 2025 was £0.018m with total spend for the financial year forecast at £0.215m, in line with the previous financial year's spend.

Transport related spend

Transport and transport recharge costs were substantially above budget in the previous financial year.

A review of costs, and apportionment of recharged costs between Children's and Adults Services is ongoing.

Housing Strategy related spend

.

Housing Strategy initiatives included in the report include the Rough Sleeping Initiative and the Homelessness Prevention Scheme. The Homelessness Prevention scheme is an amalgamation of the previous Flexible Homelessness Support and Homelessness Reduction schemes and is wholly grant funded. It is assumed that unspent funding is carried forward to the following financial year.

Income

Income for the Department as a whole is over budget profile by £0.009m with a projected under achieved target at the end of the financial year being £0.108m. The main areas making up the projected under achievement of target income are Community Meals and Telehealth care.

2025/26 Savings

Progress against 2025/26 approved savings for the Adult Social Care Directorate are included at Appendix A.

Progress Against Agreed Savings

2025/26 Adult Social Care Directorate Savings

Appendix A

Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
			25/26 Agreed Council 01 February 2023 £'000	25/26 Agreed Council 05 March 2025 £'000		
Housing Solutions	474	Remodel the current service based on good practice evidence from other areas.	125	0	U	Currently Under Review
Voluntary Sector Support	N/A	Review the support provided by Adult Social Care and all other Council Departments, to voluntary sector organisations. This would include assisting them to secure alternative funding in order to reduce their dependence upon Council funding. A target saving phased over two years has been estimated.	100	0	✓	Achieved
Community Wardens/Telecare Service		Community Wardens/Telecare Service – a review will be undertaken of the various options available for the future delivery of these services, with support from the Transformation Delivery Unit.	0	280	U	Currently Under Review
Care Management		Community Care – continuation of the work being undertaken to review care provided through the	0	1,000	✗	Unlikely to be achieved – currently forecast overspend position

Community Care Budget		Community Care budget, in order to reduce the current overspend and ongoing costs.				
Various		Review of Service Delivery Options – reviews will be undertaken of the various service delivery options available for a number of areas including; Day Services, Halton Supported Housing Network, In-House Care Homes, Reablement Service and Oak Meadow.	0	375	U	Currently Under Review
Total ASC Directorate			**225**	**1,655**		

PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT

Revenue Budget as at 31st May 2025

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	5,627	802	772	30	177
Other Premises	6	1	0	1	6
Supplies & Services	322	87	100	(13)	(78)
Contracts & SLA's	7,206	253	219	34	200
Transport	4	0	0	0	1
Other Agency	24	24	24	0	0
Total Expenditure	**13,189**	**1,167**	**1,115**	**52**	**306**
Income					
Fees & Charges	-122	-12	-11	(1)	(4)
Reimbursements & Grant Income	-154	-59	-59	0	0
Transfer from Reserves	-59	0	0	0	0
Government Grant Income	-12,435	-3,098	-3,098	0	0
Total Income	**-12,770**	**-3,169**	**-3,168**	**(1)**	**(4)**
Net Operational Expenditure	**419**	**-2,002**	**-2,053**	**51**	**302**
Recharges					
Premises Support	209	35	35	0	0
Transport Support	24	4	4	0	(3)
Central Support	1,897	316	316	0	0
Asset Rental Support	0	0	0	0	0
Recharge Income	-669	-112	-112	0	0
Net Total Recharges	**1,461**	**243**	**243**	**0**	**(3)**
Net Departmental Expenditure	**1,880**	**-1,759**	**-1,810**	**51**	**299**

Comments on the above figures

The current financial position shows the net spend for the department is £0.051m under the budget profile. The estimated department outturn position excluding the ring fenced public health grant for 2025/26 is £0.299m net spend under available budget.

Employee costs are expected to be £0.177m under budget profile. This is due to a number of vacancies and some reduced hours within the main Public Health department and the Health Improvement Team.

Budget pressures to be aware of are supplies and services which are currently forecasting a £0.078m overspend.

Contracts and SLA's are currently showing a forecasted £0.200m underspend against budget, however, there are a number of contracts which are due for renewal and in the current financial climate are likely to increase significantly. Also £0.059m has been used from Public Health grant reserves to balance the current year budget. This leaves a forecast balance of £1.283m in the Public Health grant reserve.

The department is proactive and work is currently being done to identify any areas were savings can be made as the use of reserves from previous years will not be available to balance future budgets.

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

Progress		Objective	*Performance Indicator*
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	*Indicates that the annual target is on course to be achieved.*
Amber		Indicates that it is uncertain or too early to say at this stage, whether the milestone/objective will be achieved within the appropriate timeframe.	*Indicates that it is uncertain or too early to say at this stage whether the annual target is on course to be achieved.*
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	*Indicates that the target will not be achieved unless there is an intervention or remedial action taken.*

Direction of Travel Indicator

Where possible performance measures will also identify a direction of travel using the following convention

Green		*Indicates that* **performance is better** *as compared to the same period last year.*
Amber		*Indicates that* **performance is the same** *as compared to the same period last year.*
Red		*Indicates that* **performance is worse** *as compared to the same period last year.*
N/A		*Indicates that the measure cannot be compared to the same period last year.*

REPORT TO: Health & Social Care Policy & Performance Board

DATE: 23 September 2025

REPORTING OFFICER: Finance Director

PORTFOLIO: Corporate Services

SUBJECT: Councilwide Spending as at 31 May 2025

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To report the Council's overall revenue spending position as at 31 May 2025, together with the latest 2025/26 year-end outturn forecast. In addition, details of the 2024/25 year-end outturn position are also provided for information.

2.0 RECOMMENDED: That;

(i) The Council's overall spending position as at 31 May 2025 outlined in the Appendix, be noted.

3.0 SUPPORTING INFORMATION

3.1 On 10 July 2025 the Executive Board received the report shown in the Appendix. This presented details of Councilwide revenue spending by each Department as at 31 May 2025 along with forecasts to year-end, and outlines the reasons for key variances between spending and budget.

3.2 Given the scale of the Council's current financial challenges, Executive Board requested that a copy of the report be shared with each Policy and Performance Board for information.

3.3 A Councilwide monitoring report is presented to Executive Board every two months and the attached report covers the period 1 April 2024 to 31 May 2025. Given it is early in the financial year, the report focused solely upon revenue spending by each Department, however, subsequent reports will also include spending against the capital programme.

3.4 Within the report, Appendix 1 provides a Councilwide summary of revenue spending, while Appendix 2 presents details relating to each Department. In addition to spending as at 31 May 2025, the latest year-end forecasts of variances between revenue spending and budget are provided.

3.5 The Executive Board also received on 12 June 2025 a report of the 2024/25 Councilwide outturn, which can be accessed via the following link;

https://members.halton.gov.uk/documents/s79891/202425%20Spending%20as%20at%2031%20March%202025.pdf
The final 2024/25 year-end outturn variances have been included in Appendix 1 below, by way of comparison to the current year's figures.

3.6 Appendix 3 indicates progress with implementation of previously approved budget savings for 2024/25 and 2025/26. Appendix 4 presents an update of the budget risk register.

4.0 POLICY IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

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

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

5.5 **Working Towards a Greener Future**

5.6 **Valuing and Appreciating Halton and Our Community**

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

6.0 RISK ANALYSIS

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

6.2 A budget risk register of significant financial risks is maintained and is included at Appendix 4 of the attached report.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 CLIMATE CHANGE IMPLICATIONS

8.1 None

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

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

APPENDIX

REPORT TO: Executive Board

DATE: 10 July 2025

REPORTING OFFICER: Director of Finance

PORTFOLIO: Corporate Services

SUBJECT: 2025/26 Spending as at 31 May 2025

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.2 To report the Council's overall revenue net spend position as at 31 May 2025 together with a 2025/26 forecast outturn position.

3.0 RECOMMENDED: That;

(ii) Executive Directors continue to implement the approved 2025/26 saving proposals as detailed in Appendix 3;

(iii) Executive Directors continue to identify areas where they can further reduce their directorate's spending or generate income, in order to reduce the council wide forecast outturn overspend position;

(iv) This report be shared with each Policy and Performance Board, in order to ensure they have a full appreciation of the councilwide financial position, in addition to their specific areas of responsibility.

3.0 SUPPORTING INFORMATION

Revenue Spending

3.1 Appendix 1 presents a summary of spending against the operational revenue budget up to 31 May 2025 and Appendix 2 provides detailed figures for each individual Department. In overall terms, net Council spending as at 31 May 2025 is £1.073m over budget. The outturn forecast for the year estimates that net spending will be over budget by £6.185m if no corrective action is taken.

3.2 The forecast position is of great concern and action to reduce net spend must be taken immediately. Without action being taken the Council will

not be in a position to provide a balanced budget by financial year-end and will further add to borrowings which will need to be taken through Exceptional Financial Support (EFS).

3.3 On 10 February 2025 Government issued a letter to the Council confirming it was minded to approve a capitalisation direction of a total not exceeding £52.8 million. The total is broken down by each financial year of the Council's request:

- £20.8 million in 2024-25.
- £32 million in 2025-26.

3.4 Consistent with those councils that have previously sought Exceptional Financial Support, in order for Government to provide a final capitalisation direction, the council is required to undergo an external assurance review which will include, but will not be limited to, an assessment of the council's financial position and governance arrangements. It is expected this review will be undertaken later in the summer although no date has been fixed as of yet.

3.5 Council approved the annual budget of £183.052m on 05 March 2025, in doing so they agreed to the use of EFS totalling £29.385m. If no action is taken to reduce the forecast outturn position of £6.185m it will increase the level of EFS required for the current year to £35.570m, above the provisionally approved limit.

3.6 The cost of EFS is significant over the long term for the Council, for every £1m borrowing undertaken it is estimated will cost the Council approximately £100k over each of the next 20 years. It is imperative that action is taken now to reduce the level of planned spend over the remainder of the year and that approved saving proposals are implemented with immediate effect

3.7 The figures reflect a prudent yet realistic view of spend and income levels through to the end of the year. Work will continue to progress on updating the financial position as more information is made available.

3.8 In setting the 2025/26 budget Council approved significant levels of growth to ensure the budget was more relevant to the planned level of spend. Budget growth of £33.555m (22%) was added to the 2025/26 budget to bring the approved net budget to £183.052m. That the Council is still forecasting an overspend against the 2025/26 budget is a huge concern.

3.9 There are continued demand pressures on the budget which are above growth levels provided in the 2025/26 budget, these are more notable against adults community care and home to school transport. Levels of demand covering children in care appear to be under control for the first two months of the year, although still too high for an authority the size of Halton. Further information is provided within the report on the main budgetary pressure areas.

3.10 In setting the 2025/26 budget, inflation of 2% was provided for the pay award. Based on the initial 3.2% pay offer to Trade Unions it is now clear that budgetary growth for the pay award is insufficient, it is currently forecast the additional cost of the 3.2% pay offer will add approximately £1m to the Council's running cost for the year. This additional cost is included within the reported forecast position for the year.

3.11 Another major factor in achieving a balanced budget position for the year is that all approved savings are fully achieved to the agreed levels. In total, savings of £7.225m were agreed for the current year, Appendix 3 provides detail on progress against the approved savings, it is clear significant work needs to be undertaken to ensure these are achieved. As per Appendix 3, savings have been RAG rated to inform on progress, high level summary of this is provided below.

Department	On-course to be achieved	Uncertain or too early to say	Highly likely or certain will not be achieved
	£'000	£'000	£'000
Adult Social Care	100	1,780	0
Finance	0	150	40
Legal	6	0	0
Children & Family Services	0	1,900	22
Education, Inclusion and Provision	0	300	0
Community and Greenspaces	282	0	0
Economy, Enterprise and Property	0	100	0
Planning & Transportation	0	0	100
Public Health	45	0	0
Corporate	0	2,400	0
Totals	**433**	**6,630**	**162**

3.12 The use and cost of agency staff continues to be one of the main contributing factors to the overspend position for the year. This is mostly evident within the Children & Families Department and the Council's in-house Care Homes. Initiatives and support from the Transformation Programme are ongoing to reduce reliance upon agency staff.

3.13 Analysis of agency spend for the year to date, together with comparative analysis of 2024/25 costs, is included in the table below.

	2025/26		2024/25
	As at 31 May 2025		As at 31 March 2025
	£'000		£'000
Adult Social Care	955		6,035
Chief Executives Delivery Unit	130		810
Children & Family Services	574		5,220
Community & Greenspace	71		447
Economy, Enterprise & Property	60		417
Education, Inclusion & Provision	54		295
Finance	3		114
Legal & Democratic Services	63		881
Planning & Transportation	2		210
Public Health & Public Protection	0		22
Total	**1,912**		**14,451**

Revenue - Operational Spending

3.14 Operational net spending for the first two months of the year is higher than the budget to date by £0.833m Based on current forecasts it is estimated net spend will be over budget for the year by £6.185m if no further corrective action is taken.

3.15 Within the overall budget forecast position for the period, the key budget pressure areas are as follows;

(i) **Children and Families Department**

The net departmental expenditure is estimated to be over budget profile at the end of financial year by £2.387m with the majority relating to social care services.

Growth budget of £12.1m and £3.9m of Children's Improvement Fund has been provided to the Children's and Families Department for financial year 2025/26. Unfortunately, this has not been sufficient to support the increasing costs across the service.

Although initial forecasts for financial year 2025/26 are showing a reduction in overspend of £6.047 compared to 2024/25 outturn, it's important to note that this is due to the increase in budget not the level of expenditure reducing in the service.

<u>Employee Expenditure</u>

Employee costs are forecast to be over budget profile by the end of financial year 2025/26 by £1.449m this is a similar level compared to the outturn for financial year 2024/25.

The level of agency has consistently reduced since October 2024 and is due to agency staff converting to Halton BC employees,

external recruitment and the employment of newly qualified social workers. The expectation is that agency will continue to reduce throughout the remainder of the year. Forecasts will be updated as and when changes are known.

Agency spend across the department remains high with spend totalling £0.574m.

One area of concern relates to the number of staff that remain in addition to the establishment (IATE). These are staff that are currently not allocated to an established role within their respective team. This figure currently stands at 9 across the service. Work should now be undertaken to reduce the level of staff that are in addition to the establishment if they do not form part of the redesign improvement plan.

Supplies and Services

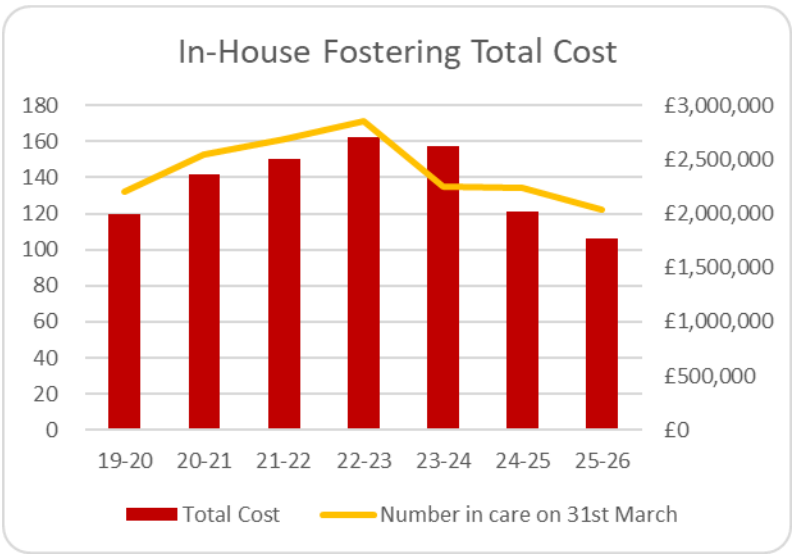
Supplies and services expenditure is forecast to be £1.057m over budget profile at the end of the financial year. Supplies and Services is diverse and covers a number of areas including nursery fees, consultancy, translation costs, equipment and support provided to young people.

A number of initiatives are being looked into to target specific areas of spend within supplies and services.

The creation of the Edge of Care and Family Time Teams should support the reduction of Supplies and Services expenditure. There is hope that particular tasks will no longer need to be outsourced which could result in the reduction in supplies and service.

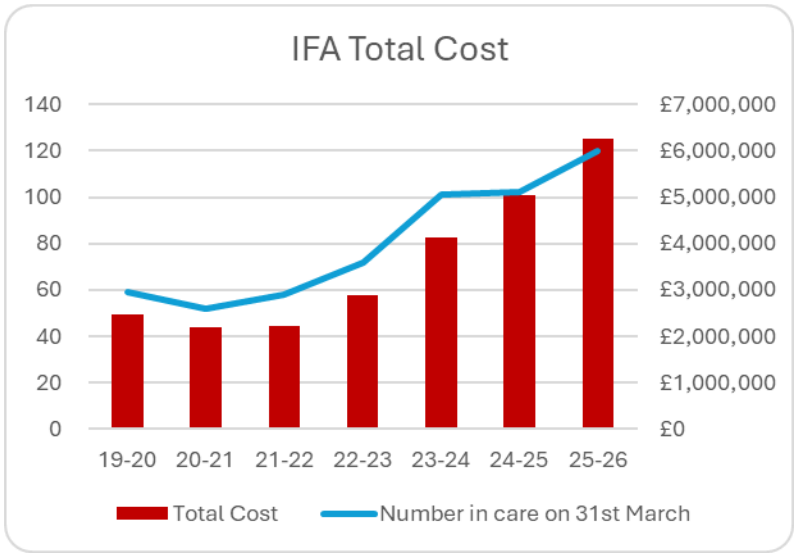
Fostering

Inhouse fostering placements is estimated to be £0.515m under budget profile for financial year 2025/26.



Work continues to recruit and retain Halton's In-house foster carers, along with training to develop carers enabling them to accommodate more specialist placements. This therefore means that costs could increase. However, the ability to accommodate young people within in-house provision provides a substantial saving in comparison to Independent Fostering Agency (IFA) or residential care.

Increasing numbers of children in care and insufficient in-house fostering provision has meant increased reliance on Independent Fostering Agencies (IFA). Higher numbers of children placed within IFA provision and increased IFA rates has resulted in an estimated forecast overspend for the end of 2025/26 as £0.785m.



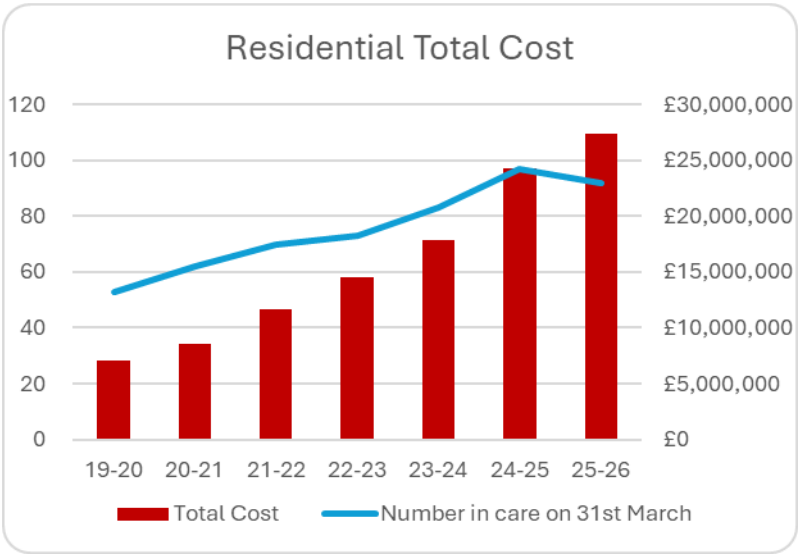
Residential Care

Out of Borough Residential Care continues to be a budget pressure for the Children and Families Department as the costs of residential care have continue to rise year on year. The numbers of young people in residential placements remains high and the cost of placements is rising significantly year-on year.

Residential care costs are forecast to be under budget profile by £0.038m, although this is a significant reduction of £5.994m overspend compared to financial 2024/25, it's important to note that residential care budgets have been increased by more than £10m.

The level of forecast expenditure for residential care is £1.8m higher than the outturn spend for 2024/25.

The graph below illustrates the rising costs of residential care, for consistency this does not include the costs of Unaccompanied Asylum-Seeking Children (UASC) as these costs were not included previous years.



(ii) **Adult Social Care Directorate**

Community Care

The net spend position for the community care budget at the end of May 2025 is currently £0.502m over the available budget and the year end forecast shows net spend to be £2.627m over the annual budget.

This forecast is as things stand at the moment assuming no material changes, apart from increased demand of 4.9% and the agreed fee increase of 8% with care providers. However there is a risk that the forecast could be significantly more as the ICB carry out a formal "turnaround" reviewing all NHS spend which may impact on the community care budget and could result in more challenges to social care funding requests.

To mitigate this financial risk a number of actions are being considered for implementation to reduce costs and help bring spend back in line with budget. These are detailed below:

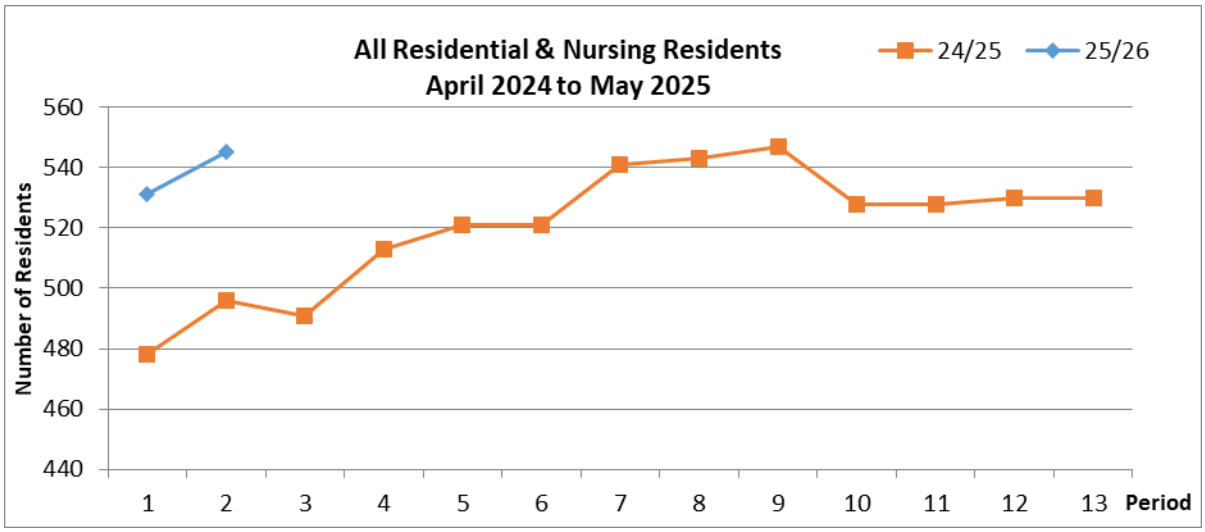
- Reduction of 1 to 1 packages of care if health's responsibility
- Review 15 minutes packages of domiciliary care to identify medicine prompts which are health's financial responsibility
- Ensure assessments carried out on discharge from hospital are complete and appropriate
- Maximise internal care home capacity

Residential & Nursing Care

There are currently 545 residents in external residential/nursing care as at the end of May 2025 compared to 530 at the end of 2024/25, an increase of 2.8%. Compared to the 2024/25 average of 520 this is an increase of 4.8%. The average cost of a package

of care is currently £940.85 compared to £850.24 at the end of 2024/25 an increase of 10.6%. Supplementary invoice payments so far amount to £86k.

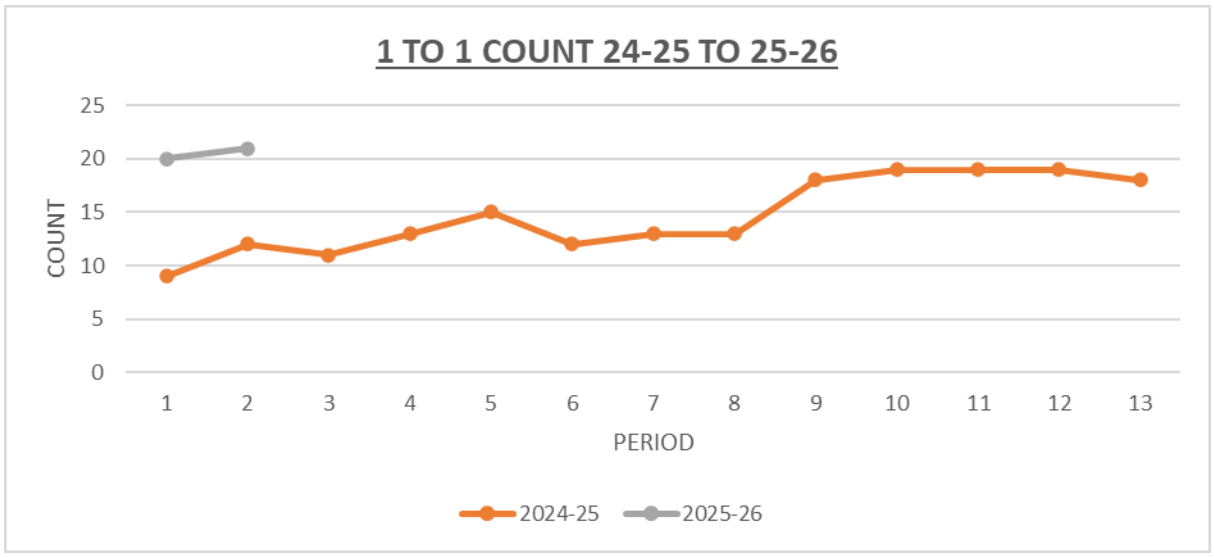
The graph below illustrates the demand for all residential and nursing placements.



1 to 1 Support In Care Homes

Payments for 1 to 1 support continue to exert pressure on the budget, due to increasing demand. This is generally to mitigate the risk from falls particularly on discharge from hospital. The full year cost for 2024/25 was £837,882.

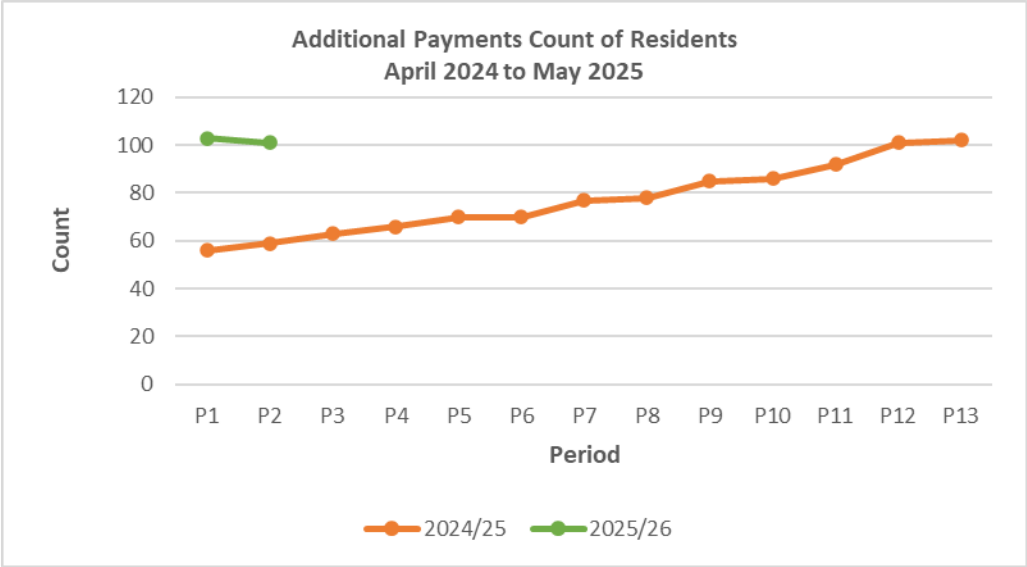
The graph below shows the count of service users receiving 1 to 1 care by period and clearly demonstrates an increase, particularly compared with the same period last year rising from 12 to 21. This is an increase of 75%.

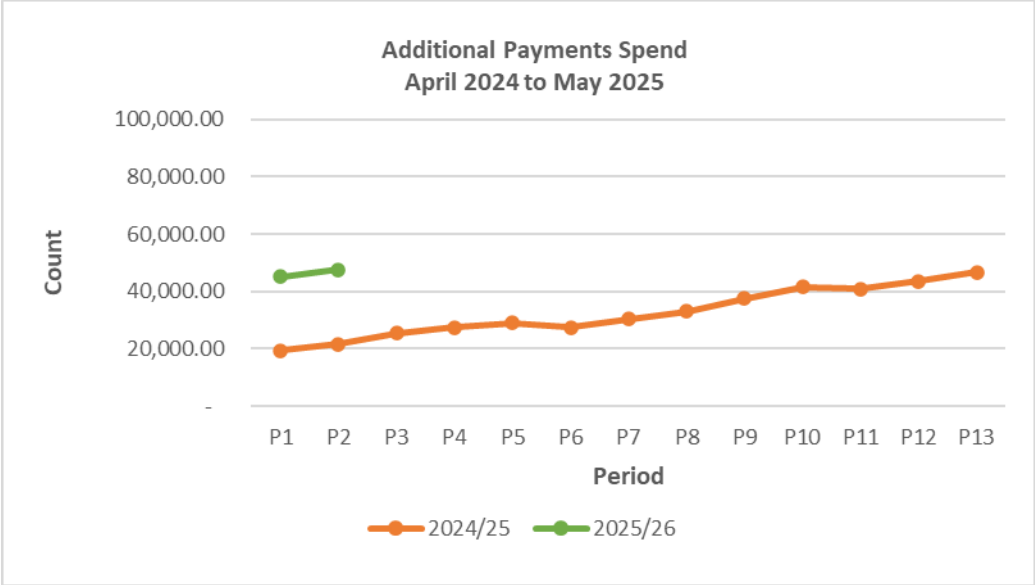


Additional Payments 2025/26

Additional payments to providers rose sharply throughout 2024/25, both in and out of the borough. These are where the care home charges an additional amount on top of the contracted bed rate. The cost of this for 2024/25 was £423,894.

The graph below illustrates the count of service users with an additional payment by period. This clearly shows a steady increase in numbers and costs for 24/25. The spend up to Period 2 2025/26 is £92,526.32. If numbers and costs remain the same (101) the forecast spend for the year will be approximately £0.615m.



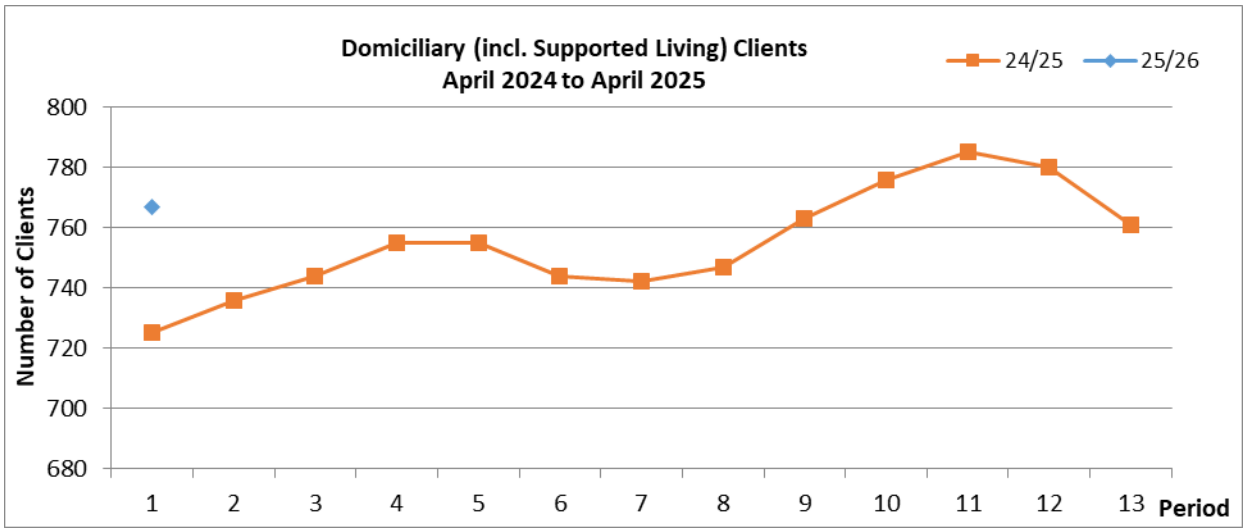


Domiciliary Care & Supported Living

There are currently 767 service users receiving a package of care at home, compared to the average in 2024/25 of 754, an increase

of 1.7%. However, compared with April 2024 the increase is 5.8%.The average cost of a package of care is currently £452.39 compared with £450.64 in 2024/25.

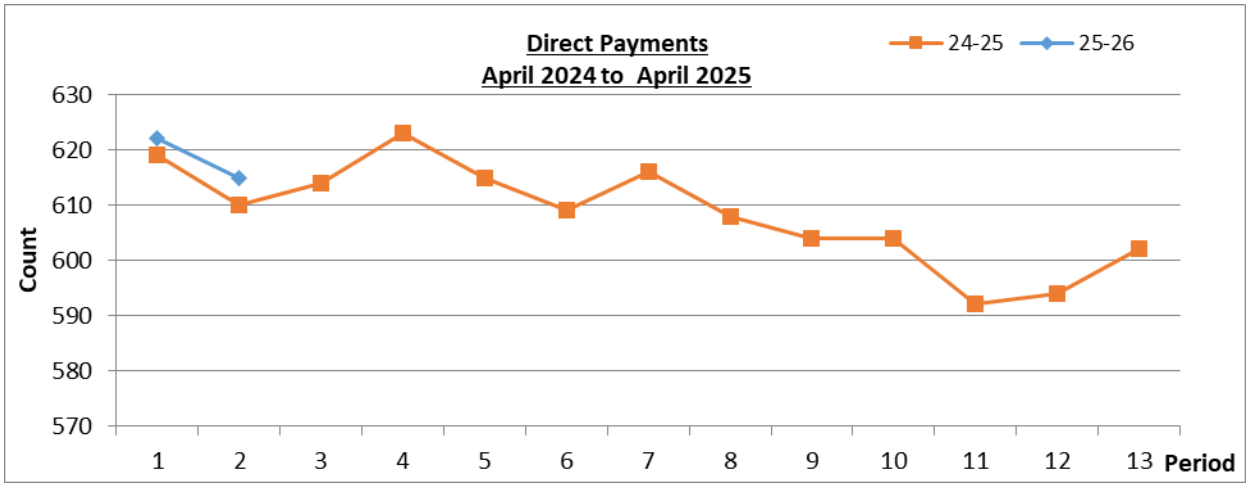
The graph below illustrates the demand for the service from April 2024 to April 2025.



Direct Payments

The average number of clients who received a Direct Payment (DP) in Period 2 was 615 compared with 622 in Period 1, a decrease of 1.1%. The average cost of a package of care has also decreased from £571.26 to £511.50, a reduction of 10.46%.

The graph below shows movement throughout the year.



Care Homes

Employee related expenditure is over budget profile at the end of May 2025 by £0.064M, with the expected outturn at the end of financial year being £0.517m over budget. Projections take into account agency spending patterns over the previous 3 financial

years, which consistently show increased spending patterns in the latter half of the financial year.

Recruitment of staff is a continued pressure across the care homes. There remains a high number of staff vacancies across the care homes. A proactive rolling recruitment exercise is ongoing within the care homes and is supported by HR.

Due to pressures with recruitment and retention in the sector, heavy reliance is being placed on overtime and expensive agency staff to support the care homes. At the end of May 2025 total agency spend across the care homes reached £0.585M, the cost of this has partially been offset by staff vacancies.

(iii) **Education, Inclusion and Provision**

Schools Transport is the main budget pressure for Education, Inclusion and Provision. The Council has a statutory responsibility to provide Special Educational Needs (SEN) pupils with transport. This is split into two main areas of SEN pupils attending In Borough and out of Borough Schools.

The table below illustrates the split between the two areas, and how each areas spend compares to the budget.

2025-26 as at May-25					
Area	Number of Users	Budget £000	Projected Spend £000	Variance £000	Average Cost per User
In Borough	484	1857	2066	(209)	£3,743.62
Out of Borough	145	1214	1612	(398)	£9,263.98
Total	**629**	**3071**	**3678**	**(607)**	

Note the above table excludes efficiency savings of £0.300m approved for the 2025/26 budget.

A Home to School transport consultation has been undertaken with stakeholders and partners with regard to implementing a new Home to School and College Travel and Transport Policy for Children and Young People with Special Educational Needs and Disabilities. The consultation has been completed and the results have been analysed and recommendations put to Executive Board for possible policy changes from the beginning of the new academic year. However, it is too early to say if the savings can be achieved.

The current records show 629 service users, the majority of which attend schools within the Borough. The Out of Borough overspend has decreased compared to the previous year's overspend of £0.799m due to £0.712m added to the budget in 2025/26 for growth. The demand for the School Transport service is increasing in line with the increasing number of pupils with SEN within the Borough. The graphs below show the number of SEN children using this service, it is anticipated that these figures will increase, based on historic information. The demand for the School Transport service continues to increase in line with the increasing number of pupils with SEN within the Borough.

(iv) **Corporate and Democracy**

The Corporate & Democracy budget is currently forecasting an underspend against budget of £1.860m at the end of the financial year, there are a number of reasons for this.

Included within the budget are council wide saving proposals of £2.4m, it is currently estimated that only £0.5m of these savings will be achieved by 31 March 2026. Further details of the agreed savings are included at Appendix 3.

The additional cost of the pay award over the approved budget is estimated to cost the Council an additional £1m in the current financial year. This estimate has been included within Corporate and Democracy until the pay award is agreed and implemented.

Contingency of £4.251m is included and assumed will not be called upon (for new spend) through to 31 March 2026. The high level of contingency was included within the budget to allow for the gradual reduction in agency costs, demand and general cost pressures.

Collection Fund

3.16 The council tax collection rate through to the end of May 2025 is 18.53% which is 0.05% lower than the collection rate at the same point last year.

Debt relating to previous years continues to be collected, and the Council utilises powers through charging orders and attachment to earnings/benefits to secure debts. £0.785m has so far been collected this year in relation to previous years' debt.

3.17 Business rate collection through to the end of May 2025 is 24.43% which is 1.22% lower than the collection rate at the same point last year.

£0.344m has so far been collected this year in relation to previous years' debt.

Review of Reserves

3.18 As at 31 May 2025 the Council's General Reserve is unchanged from the previous period at £5.149m, which represents 2.81% of the Council's 2025/26 net budget. This level of General Reserve is considered to be insufficient and provides little to cover unforeseen costs. Within the Medium Term Financial Strategy, growth to reserves will be included at a rate of £2m per year.

3.19 There is a regular review of earmarked reserves undertaken to determine whether they can be released in part or in full to assist with funding the Council's current financial challenges, recognising that this only provides one-year funding solutions.

Reserves Summary

3.20 A summary breakdown of the Council's reserves is presented in the table below, showing the balance of reserves as at 31 May 2025.

Summary of General and Earmarked Reserves	
Reserve	**Reserve Value £m**
Corporate:	
General Fund	5.149
Capital Reserve	0.499
Insurance Reserve	0.849
Specific Projects:	
Adult Social Care	0.710
Fleet Replacement	0.454
Highways Feasibility Costs	0.102
Local Development Framework	0.544
Community & Environment	0.546
Mersey Valley Golf Club	0.480
Mersey Gateway	34.351
CCLA Property Fund	0.263
Various Other	0.562
Grants:	
Building Schools for the Future	6.529
Public Health	1.504
Supporting Families Performance Payments	0.204
Children's & Education	1.225
Domestic Abuse	0.915
Enterprise & Employment	0.787
Food Waste Collection	0.237
Various Other	0.156
Total Earmarked Reserves	**56.066**

3.21 The above table shows the diminishing level of reserves available to assist with funding any future budget overspends and balancing future

budgets. Only the £5.149m of the General Fund could now be used for these purposes, as all remaining reserves are committed for specific purposes.

4.0 CONCLUSIONS

4.1 As at 31 May 2025, net revenue spend is forecast to be £6.185m over the budget to date despite significant levels of growth being included within the budget.

4.2 Urgent corrective should be taken as soon as possible across all Council services to identity spend reductions and ensure that agreed savings are fully implemented in a timely manner.

4.3 Departments should ensure that all spending continues to be limited to what is absolutely essential throughout the remainder of the year, to ensure that the forecast outturn overspend is minimised as far as possible and future spending is brought in line with budget.

5.0 POLICY AND OTHER IMPLICATIONS

5.1 None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

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

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

6.5 **Working Towards a Greener Future**

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

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

7.0 RISK ANALYSIS

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

7.2 A budget risk register of significant financial risks has been prepared and is included at Appendix 4.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 None

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

10.1 There are no background papers under the meaning of the Act

Summary of Revenue Spending to 31 May 2025 **APPENDIX 1**

Directorate / Department	2024/25 Outturn (overspend) £'000	2025/26 Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance (Overspend) £'000	**May 2025 Forecast Outturn (overspend) £'000**
Adult Social Care	(546)	24,522	3,896	3,841	55	0
Care Homes	(1,283)	7,932	1,486	1,768	(282)	(794)
Community Care	(2,651)	27,061	3,004	3,506	(502)	(2,627)
Complex Care Pool	0	13,189	1,227	1,225	2	0
Adults Directorate	**(4,480)**	**72,704**	**9,613**	**10,340**	**(727)**	**(3,421)**
Finance	(312)	5,430	1,413	1,404	9	(113)
Legal & Democratic Services	(1,144)	-170	-60	0	(60)	(482)
ICT & Support Services	282	197	1,285	1,253	32	70
Chief Executives Delivery Unit	(31)	1,110	342	347	(5)	(21)
Chief Executives Directorate	**(1,205)**	**6,567**	**2,980**	**3,004**	**(24)**	**(546)**
Children & Families	(8,434)	53,903	4,939	5,378	(439)	(2,387)
Education, Inclusion & Provision	(1,254)	12,095	1,115	1,307	(192)	(1,239)
Children's Directorate	**(9,688)**	**65,998**	**6,054**	**6,685**	**(631)**	**(3,626)**
Community & Greenspace	204	23,602	1,170	1,212	(42)	(134)
Economy, Enterprise & Property	175	2,602	236	268	(32)	55
Planning & Transportation	280	9,256	449	561	(112)	(672)
Environment & Regeneration Directorate	**659**	**35,460**	**1,855**	**2,041**	**(186)**	**(751)**
Corporate & Democracy	**(1,457)**	443	574	129	445	**1,860**
Public Health Directorate	**98**	1,880	-1,759	-1,810	51	**299**
Total Operational Net Spend	**(16,073)**	**183,052**	**18,808**	**19,890**	**(1,073)**	**(6,185)**

Adult Social Care

APPENDIX 2

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	18,077	3,038	2,778	260	1,302
Agency- Covering Vacancies	0	0	280	(280)	(1,567)
Premises	498	124	122	2	16
Supplies & Services	698	145	155	(10)	(52)
Aids & Adaptations	37	6	6	0	(4)
Transport	341	57	42	15	79
Food & Drink Provisions	228	38	24	14	78
Supported Accommodation and Services	1,408	235	184	51	269
Emergency Duty Team	157	0	0	0	(13)
Transfer To Reserves	295	0	0	0	0
Contracts & SLAs	1,050	189	189	0	0
					0
Housing Solutions Grant Funded Schemes					
Homelessness Prevention	548	196	193	3	0
Rough Sleepers Initiative	139	0	0	0	0
Total Expenditure	**23,476**	**4,028**	**3,973**	**55**	**108**
Income					
Fees & Charges	-1,044	-111	-62	(49)	(300)
Sales & Rents Income	-538	-175	-208	33	150
Reimbursements & Grant Income	-2,089	-96	-103	7	42
Capital Salaries	-117	0	0	0	0
Housing Schemes Income	-687	-687	-687	0	0
Total Income	**-4,475**	**-1,069**	**-1,060**	**(9)**	**(108)**
Net Operational Expenditure	**19,001**	**2,959**	**2,913**	**46**	**0**
Recharges					
Premises Support	789	132	132	0	0
Transport	792	132	142	-10	0
Central Support	4,039	673	673	0	0
Asset Rental Support	13	0	0	0	0
HBC Support Costs Income	-112	0	-19	19	0
Net Total Recharges	**5,521**	**937**	**928**	**9**	**0**
Net Departmental Expenditure	**24,522**	**3,896**	**3,841**	**55**	**0**

Care Homes

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Madeline Mckenna					
Employees	770	122	116	6	52
Agency - covering vacancies	0	0	10	(10)	(77)
Other Premises	90	14	5	9	15
Supplies & Services	26	3	6	(3)	(12)
Food Provison	51	4	9	(5)	(5)
Private Client and Out Of Borough Income	-127	-7	-5	(2)	(24)
Reimbursements & other Grant Income	-23	-2	-3	1	10
Total Madeline Mckenna Expenditure	**787**	**134**	**138**	**(4)**	**(41)**
Millbrow					
Employees	2,280	350	199	151	1,088
Agency - covering vacancies	0	0	178	(178)	(1,308)
Other Premises	117	16	19	(3)	(13)
Supplies & Services	72	11	16	(5)	(30)
Food Provison	81	7	13	(6)	(10)
Private Client and Out Of Borough Income	-13	-2	-5	3	11
Reimbursements & other Grant Income	-742	-62	-67	5	10
Total Millbrow Expenditure	**1,795**	**320**	**353**	**(33)**	**(252)**
St Luke's					
Employees	3,595	614	392	222	1,603
Agency - covering vacancies	0	0	252	(252)	(1,777)
Other Premises	156	19	29	(10)	(55)
Supplies & Services	67	10	13	(3)	(10)
Food Provison	128	21	26	(5)	(30)
Private Client and Out Of Borough Income	-152	-19	-15	(4)	0
Reimbursements & other Grant Income	-1,080	-83	-82	(1)	0
Total St Luke's Expenditure	**2,714**	**562**	**615**	**(53)**	**(269)**
St Patrick's					
Employees	2,031	338	365	(27)	700
Agency - covering vacancies	0	0	145	(145)	(927)
Other Premises	144	17	24	(7)	(20)
Supplies & Services	67	9	12	(3)	(10)
Food Provison	127	21	17	4	0
Private Client and Out Of Borough Income	-99	-8	-5	(3)	(10)
Reimbursements & other Grant Income	-684	-83	-48	(35)	(94)
Total St Patrick's Expenditure	**1,586**	**294**	**510**	**(216)**	**(361)**
Care Homes Divison Management					
Employees	322	54	30	24	129
Care Home Divison Management	**322**	**54**	**30**	**24**	**129**
Net Operational Expenditure	**7,204**	**1,364**	**1,646**	**(282)**	**(794)**
Recharges					
Premises Support	65	11	11	0	0
Transport Support	0	0	0	0	0
Central Support	663	111	111	0	0
Asset Rental Support	0	0	0	0	0
Recharge Income	0	0	0	0	0
Net Total Recharges	**728**	**122**	**122**	**0**	**0**
Net Departmental Expenditure	**7,932**	**1,486**	**1,768**	**(282)**	**(794)**

Community Care

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Residential & Nursing	20,674	1,340	1,395	(55)	(333)
Domicilary Care & Supported living	15,564	691	861	(170)	(1,343)
Direct Payments	15,513	3,430	3,644	(214)	(972)
Day Care	712	62	60	2	13
Total Expenditure	**52,463**	**5,523**	**5,960**	**(437)**	**(2,635)**
Income					
Residential & Nursing Income	-11,881	-729	-732	3	14
Community Care Income	-3,115	-230	-159	(71)	(210)
Direct Payments Income	-1,034	-77	-80	3	204
Income from other CCGs	-420	0	0	0	0
Market sustainability & Improvement Grant	-2,796	-466	-466	0	0
Adult Social Care Support Grant	-6,102	-1,017	-1,017	0	0
War Pension Disregard Grant	-54	0	0	0	0
				0	
Total Income	**-25,402**	**-2,519**	**-2,454**	**(65)**	**8**
Net Operational Expenditure	**27,061**	**3,004**	**3,506**	**(502)**	**(2,627)**

Complex Care Pool

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Intermediate Care Services	6,312	494	500	(6)	(31)
Oakmeadow	1,995	299	295	4	22
Community Home Care First	1,941	142	132	10	42
Joint Equipment Store	880	0	0	0	0
Contracts & SLA's	3,262	0	0	0	0
Inglenook	134	14	8	6	34
HICafs	3,720	98	121	(23)	(124)
Carers Breaks	445	27	20	7	47
Carers centre	365	0	0	0	0
Residential Care	7,236	906	906	0	0
Domiciliary Care & Supported Living	4,336	723	723	0	0
Pathway 3/Discharge Access	426	0	0	0	(2)
HBC Contracts	72	22	22	0	0
Healthy at Home	28	0	0	0	0
Capacity	30	0	-4	4	12
Total Expenditure	**31,182**	**2,725**	**2,723**	**2**	**0**
Income					
BCF	-15,032	-1,253	-1,253	0	0
CCG Contribution to Pool	-2,959	-246	-246	0	0
Oakmeadow Income	-2	0	0	0	0
Total Income	**-17,993**	**-1,499**	**-1,499**	**0**	**0**
Net Operational Expenditure	**13,189**	**1,227**	**1,225**	**2**	**0**

Finance Department

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	7,242	1,163	1,149	14	86
Insurances	1,042	546	521	25	169
Supplies & Services	1,103	58	71	(13)	(76)
Rent Allowances	31,500	4,275	4,275	0	0
Concessionary Travel	1,902	0	-45	45	91
LCR Levy	1,902	0	0	0	0
Bad Debt Provision	223	4	0	4	25
Non HRA Rent Rebates	70	12	3	9	57
Discretionary Social Fund	106	16	0	16	97
Discretionary Housing Payments	279	41	40	1	2
Household Support Fund Expenditure	420	420	420	0	0
Total Expenditure	**45,789**	**6,535**	**6,434**	**101**	**451**
Income					
Fees & Charges	-342	-123	-131	8	52
Burdens Grant	-58	-59	-63	4	24
Dedicated schools Grant	-150	0	0	0	0
Council Tax Liability Order	-670	-64	-55	(9)	(50)
Recovery of Legal Costs	-10	-2	0	(2)	(10)
Business Rates Admin Grant	-157	0	0	0	1
Schools SLAs	-319	-2	0	(2)	(10)
LCR Reimbursement	-1,902	0	0	0	0
HB Overpayment Debt Recovery	-300	-47	-35	(12)	(75)
Rent Allowances	-30,700	-4,262	-4,142	(120)	(684)
Non HRA Rent Rebate	-70	-14	-13	(1)	(5)
Discretionary Housing Payment Grant	-279	-93	-93	0	(2)
Housing Benefits Admin Grant	-453	-76	-76	0	0
Housing Benefits Award Accuracy	0	0	-22	22	22
Universal Credits	-5	-1	0	(1)	(5)
Household Support Fund Grant	-420	326	326	0	0
VEP Grant	0	0	0	0	5
CCG McMillan Reimbursement	-89	0	0	0	0
Reimbursements & Grant Income	-185	0	-21	21	173
Transfer from Reserves	-21	0	0	0	0
Total Income	**-36,130**	**-4,417**	**-4,325**	**(92)**	**(564)**
Net Operational Expenditure	**9,659**	**2,118**	**2,109**	**9**	**(113)**
Recharges					
Premises Support	493	82	82	0	0
Transport	0	0	0	0	0
Central Support	2,092	349	349	0	0
Asset Rental Support	0	0	0	0	0
HBC Support Costs Income	-6,814	-1,136	-1,136	0	0
Net Total Recharges	**-4,229**	**-705**	**-705**	**0**	**0**
Net Departmental Expenditure	**5,430**	**1,413**	**1,404**	**9**	**(113)**

Legal Services

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	1,836	244	261	(17)	(101)
Agency Related Expenditure	34	34	63	(29)	(174)
Supplies & Services	163	63	60	3	16
Civic Catering & Functions	21	1	1	0	5
Legal Expenses	422	2	5	(3)	(145)
Transport Related Expenditure	8	2	3	(1)	(1)
Other Expenditure	0	1	1	0	(1)
Total Expenditure	**2,484**	**347**	**394**	**-47**	**(401)**
Income					
Fees & Charges Income	-75	-10	-4	(6)	(40)
Reimbursement & Other Grants	0	0	0	0	2
School SLA's	-100	-4	0	(4)	(23)
Licence Income	-341	-37	-34	(3)	(20)
Total Income	**-516**	**-51**	**-38**	**(13)**	**(81)**
Net Operational Expenditure	**1,968**	**296**	**356**	**(60)**	**(482)**
Recharges					
Premises Support	62	10	10	0	0
Transport	0	0	0	0	0
Central Support	275	46	46	0	0
Asset Rental Support	0	0	0	0	0
HBC Support Costs Income	-2,475	-412	-412	0	0
Net Total Recharges	**-2,138**	**-356**	**-356**	**0**	**0**
Net Departmental Expenditure	**-170**	**-60**	**0**	**(60)**	**(482)**

ICT & Support Services Department

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	5,827	958	901	57	223
Supplies & Services	1,169	262	295	(33)	(199)
Capital Finance	100	19	6	13	73
Computer Repairs & Software	2,019	1,724	1,697	27	160
Communication Costs	133	25	41	(16)	(92)
Premises	139	55	56	(1)	(6)
Transport	3	0	0	0	1
Other	4	3	4	(1)	(6)
Total Expenditure	**9,394**	**3,046**	**3,000**	**46**	**154**
Income					
Fees & Charges	-849	-217	-217	0	2
Schools SLA Income	-659	-14	0	(14)	(86)
Total Income	**-1,508**	**-231**	**-217**	**(14)**	**(84)**
Net Operational Expenditure	**7,886**	**2,815**	**2,783**	**32**	**70**
Recharges					
Premises Support	373	62	62	0	0
Transport	22	4	4	0	0
Central Support	1,391	232	232	0	0
Asset Rental Support	1,494	0	0	0	0
HBC Support Costs Income	-10,969	-1,828	-1,828	0	0
Net Total Recharges	**-7,689**	**-1,530**	**-1,530**	**0**	**0**
Net Departmental Expenditure	**197**	**1,285**	**1,253**	**32**	**70**

Chief Executives Delivery Unit

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	3,522	558	548	10	65
Employees Training	99	42	38	4	21
Apprenticeship Levy	330	54	61	(7)	(41)
Supplies & Services	397	132	130	2	12
Total Expenditure	**4,348**	**786**	**777**	**9**	**57**
Income					
Fees & Charges	-226	-26	-24	(2)	(9)
Schools SLA Income	-577	-12	0	(12)	(69)
Total Income	**-803**	**-38**	**-24**	**(14)**	**(78)**
Net Operational Expenditure	**3,545**	**748**	**753**	**(5)**	**(21)**
Recharges					
Premises Support	157	26	26	0	0
Transport	0	0	0	0	0
Central Support	1,008	168	168	0	0
Asset Rental Support	53	9	9	0	0
HBC Support Costs Income	-3,653	-609	-609	0	0
Net Total Recharges	**-2,435**	**-406**	**-406**	**0**	**0**
Net Departmental Expenditure	**1,110**	**342**	**347**	**(5)**	**(21)**

Children & Families

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	19,364	2,808	3,029	(221)	(1,449)
Other Premises	392	92	97	(5)	(39)
Supplies & Services	1,592	0	94	(94)	(1,057)
Transport	367	49	19	30	180
Direct Payments	1,220	261	245	16	94
Commissioned services to Vol Orgs	224	168	168	0	0
Residential Care	27,517	2,130	2,238	(108)	38
Out of Borough Adoption	97	0	0	0	97
Out of Borough Fostering	5,469	248	399	(151)	(785)
In House Adoption	557	24	20	4	22
Special Guardianship Order	2,604	346	323	23	130
In House Foster Carer Placements	2,766	371	283	88	515
Lavender House Contract Costs	279	24	23	1	4
Home Support & Respite	494	67	63	4	25
Care Leavers	434	37	39	(2)	(10)
Family Support	81	10	7	3	15
Contracted services	3	1	1	0	(1)
Emergency Duty	184	0	0	0	0
Youth Offending Services	461	0	0	0	0
Transfer to Reserves	0	0	0	0	0
Total Expenditure	**64,105**	**6,636**	**7,048**	**(412)**	**(2,221)**
Income					
Fees & Charges	-33	-9	-7	(2)	(14)
Sales Income	0	0	0	0	0
Rents	-82	0	0	0	0
Reimbursement & other Grant Income	-486	-52	-27	(25)	(153)
Transfer from reserve	-15	0	0	0	1
Dedicated Schools Grant	-50	0	0	0	0
Government Grants	-13,477	-2,293	-2,293	0	0
Total Income	**-14,143**	**-2,354**	**-2,327**	**(27)**	**(166)**
Net Operational Expenditure	**49,962**	**4,282**	**4,721**	**(439)**	**(2,387)**
Recharges					
Premises Support	736	123	123	0	0
Transport	10	2	2	0	0
Central Support	3,331	555	555	0	0
Asset Rental Support	0	0	0	0	0
HBC Support Costs Income	-136	-23	-23	0	0
Net Total Recharges	**3,941**	**657**	**657**	**0**	**0**
Net Departmental Expenditure	**53,903**	**4,939**	**5,378**	**(439)**	**(2,387)**

Education, Inclusion & Provision

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	8,792	1,305	1,314	(9)	248
Agency - covering vacancies	0	0	29	(29)	(204)
Agency - in addition to establishment	43	24	24	0	6
Premises	15	1	0	1	3
Supplies & Services	3,012	300	309	(9)	(54)
Independent School Fees	10,155	3,004	3,004	0	0
Schools Contingency	400	2	2	0	0
Transport	43	3	6	(3)	(20)
Schools Transport	2,771	158	259	(101)	(907)
Early Years Payments including Pupil Premium	15,615	1,954	1,954	0	0
Commissioned Services	2,249	196	194	2	9
Inter Authority Special Needs	1,419	166	166	0	0
Grants to Voluntary Organisations	115	0	1	(1)	(66)
Capital Finance	4,604	712	712	0	1
Total Expenditure	**49,233**	**7,825**	**7,974**	**(149)**	**(984)**
Income					
Fees & Charges Income	-337	-126	-129	3	20
Government Grant Income	-6,534	-1,549	-1,549	0	0
Dedicated Schools Grant	-30,161	-5,027	-5,027	0	0
Inter Authority Income	-446	-94	-59	(35)	(211)
Reimbursements & Other Grant Income	-1,773	-298	-298	0	0
Schools SLA Income	-538	-12	-2	(10)	(59)
Government Grant Income	-491	-142	-142	0	0
Total Income	**-40,280**	**-7,248**	**-7,206**	**(42)**	**(250)**
Net Operational Expenditure	**8,953**	**577**	**768**	**(191)**	**(1,234)**
Recharges					
Premises Support	405	68	68	0	0
Transport Support	773	146	147	(1)	(5)
Central Support	1,947	324	324	0	0
Asset Rental Support	17	0	0	0	0
Recharge Income	0	0	0	0	0
Net Total Recharges	**3,142**	**538**	**539**	**(1)**	**(5)**
Net Departmental Expenditure	**12,095**	**1,115**	**1,307**	**(192)**	**(1,239)**

Community & Greenspaces

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	15,296	2,506	2,410	96	580
Agency - in addition to establishment	16	16	69	(53)	(237)
Premises	3,304	416	440	(24)	(139)
Supplies & Services	3,101	258	287	(29)	(176)
Transport	117	2	4	(2)	(10)
Other Agency Costs	240	63	81	(18)	(111)
Other Expenditure	172	0	0	0	6
Waste Disposal Contracts	7,121	0	0	0	(22)
Grants to Voluntary Organisations	41	9	7	2	16
Transfers to Reserves	97	0	0	0	0
Total Expenditure	**29,505**	**3,270**	**3,297**	**(27)**	**(93)**
Income					
Sales Income	-1,342	-268	-275	7	42
Fees & Charges Income	-6,019	-1,524	-1,510	(14)	(89)
Rental Income	-1,111	-174	-159	(15)	(85)
Government Grant Income	-3,861	-1,288	-1,288	0	0
Reimbursement & Other Grant Income	-801	-115	-115	0	0
SLA Income	-23	0	0	0	0
Internal Fees Income	-223	0	-18	18	155
Capital Salaries	-236	-6	0	(6)	(35)
Transfers From Reserves	-30	0	0	0	0
Total Income	**-13,646**	**-3,375**	**-3,365**	**(10)**	**(12)**
Net Operational Expenditure	**15,859**	**-105**	**-68**	**(37)**	**(105)**
Recharges					
Premises Support	1,657	276	276	0	0
Transport	2,433	424	429	(5)	(29)
Central Support	4,297	716	716	0	0
Asset Rental Support	199	0	0	0	0
HBC Support Costs Income	-843	-141	-141	0	0
Net Total Recharges	**7,743**	**1,275**	**1,280**	**(5)**	**(29)**
Net Departmental Expenditure	**23,602**	**1,170**	**1,212**	**(42)**	**(134)**

Economy, Enterprise & Property

	Annual Budget	Budget to Date	Actual Spend	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	4,124	773	710	63	376
Agency - covering vacancies	0	0	85	(85)	(270)
Repairs & Mainenance	1,690	133	150	(17)	(98)
Premises	173	136	136	0	(1)
Energy & Water Costs	1,080	93	87	6	37
NNDR	659	629	629	0	0
Rents	157	0	0	0	1
Economic Regeneration Activities	88	0	0	0	0
Security	603	4	3	1	3
Supplies & Services	383	63	62	1	8
Supplies & Services - Grant	576	97	97	0	0
Grants to Voluntary Organisations	72	11	12	(1)	(1)
Total Expenditure	**9,605**	**1,939**	**1,971**	**(32)**	**55**
Income					
Fees & Charges Income	-561	-103	-103	0	0
Rent - Commercial Properties	-883	-158	-158	0	0
Rent - Investment Properties	-38	-8	-8	0	0
Government Grant	-594	-55	-55	0	0
Reimbursements & Other Grant Income	-120	-241	-241	0	0
Schools SLA Income	-55	0	0	0	0
Recharges to Capital	-454	0	0	0	0
Transfer from Reserves	-602	-522	-522	0	0
Total Income	**-3,307**	**-1,087**	**-1,087**	**0**	**0**
Net Operational Expenditure	**6,298**	**852**	**884**	**(32)**	**55**
Recharges					
Premises Support	2,738	456	456	0	0
Transport	26	5	5	0	0
Central Support	2,878	480	480	0	0
Asset Rental Support	4	0	0	0	0
HBC Support Costs Income	-9,342	-1,557	-1,557	0	0
Net Total Recharges	**-3,696**	**-616**	**-616**	**0**	**0**
Net Departmental Expenditure	**2,602**	**236**	**268**	**(32)**	**55**

Planning & Transportation Department

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	5,975	967	947	20	125
Efficiency Savings	-100	-17	0	(17)	(100)
Premises	188	62	56	6	38
Hired & Contracted Services	380	3	15	(12)	(74)
Supplies & Services	117	41	65	(24)	(148)
Street Lighting	1,643	1	32	(31)	(191)
Highways Maintenance - Routine & Reactive	1,803	99	169	(70)	(425)
Highways Maintenance - Programmed Works	812	43	0	43	259
Fleet Transport	1,467	206	201	5	32
Bus Support - Halton Hopper Tickets	14	0	0	0	(3)
Bus Support	506	36	36	0	0
Agency Related Expenditure	8	1	1	0	3
Grants to Voluntary Organisations	31	31	31	0	0
NRA Levy	75	0	0	0	0
LCR Levy	1,553	0	0	0	0
Contribution to Reserves	359	0	0	0	0
Total Expenditure	**14,831**	**1,473**	**1,553**	**(80)**	**(484)**
Income					
Sales & Rents Income	-97	-16	-11	(5)	(27)
Planning Fees	-798	-198	-159	(39)	(232)
Building Control Fees	-251	-39	-33	(6)	(35)
Other Fees & Charges	-971	-193	-186	(7)	(40)
Reimbursements & Grant Income	-174	-36	-36	0	0
Government Grant Income	0	-4	-5	1	0
Halton Hopper Income	-15	-3	-2	(1)	(6)
Recharge to Capital	-210	0	0	0	0
LCR Levy Reimbursement	-1,553	0	0	0	0
Contribution from Reserves	-129	-129	-129	0	0
Total Income	**-4,198**	**-618**	**-561**	**(57)**	**(340)**
Net Operational Expenditure	**10,633**	**855**	**992**	**(137)**	**(824)**
Recharges					
Premises Support	739	123	123	0	0
Transport	808	118	120	(2)	(13)
Central Support	2,505	420	420	0	0
Asset Rental Support	918	0	0	0	0
HBC Support Costs Income	-6,347	-1,067	-1,094	27	165
Net Total Recharges	**-1,377**	**-406**	**-431**	**25**	**152**
Net Departmental Expenditure	**9,256**	**449**	**561**	**(112)**	**(672)**

Corporate & Democracy

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	369	61	80	(19)	(16)
Contracted Services	12	0	0	0	0
Supplies & Services	102	38	16	22	0
Premises Expenditure	24	8	8	0	0
Transport Costs	1	0	0	0	0
Members Allowances	994	166	171	(5)	0
Interest Payable - Treasury Management	4,258	710	676	34	200
Interest Payable - Other	215	36	36	0	0
Bank Charges	0	0	0	0	0
Audit Fees	0	0	0	0	0
Contingency	5,158	709	0	709	4,251
Capital Financing	3,346	584	584	0	0
Contribution to Reserves	300	300	263	37	0
Debt Management Expenses	20	3	3	0	0
Precepts & Levies	244	244	244	0	0
Pay Award over 2%	0	0	0	0	(1,000)
Efficiency Savings:					
Purchase of Additional Leave	-100	-17	0	(17)	(50)
Voluntary Severance Scheme	-200	-33	0	(33)	(100)
Apprenticeship First Model	-200	-33	0	(33)	(50)
Agency Staff Reduction	-1,700	-283	0	(283)	(1,700)
Review Existing Contracts	-200	-33	0	(33)	(100)
Total Expenditure	**12,643**	**2,460**	**2,081**	**379**	**1,435**
Income					
Interest Receivable - Treasury Management	-3,045	-507	-578	71	425
Interest Receivable - Other	-19	-3	-3	0	0
Other Fees & Charges	-146	-18	-13	(5)	0
Grants & Reimbursements	-334	-56	-56	0	0
Government Grant Income	-6,272	-1,045	-1,045	0	0
Transfer from Reserves	0	0	0	0	0
Total Income	**-9,816**	**-1,629**	**-1,695**	**66**	**425**
Net Operational Expenditure	**2,827**	**831**	**386**	**445**	**1,860**
Recharges					
Premises Support	22	4	4	0	0
Transport	0	0	0	0	0
Central Support	898	158	158	0	0
Asset Rental Support	0	0	0	0	0
HBC Support Costs Income	-3,304	-419	-419	0	0
Net Total Recharges	**-2,384**	**-257**	**-257**	**0**	**0**
Net Departmental Expenditure	**443**	**574**	**129**	**445**	**1,860**

Public Health

	Annual Budget £'000	Budget to Date £'000	Actual Spend £'000	Variance (Overspend) £'000	Forecast Outturn £'000
Expenditure					
Employees	5,627	802	772	30	177
Other Premises	6	1	0	1	6
Supplies & Services	322	87	100	(13)	(78)
Contracts & SLA's	7,206	253	219	34	200
Transport	4	0	0	0	1
Other Agency	24	24	24	0	0
Total Expenditure	**13,189**	**1,167**	**1,115**	**52**	**306**
Income					
Fees & Charges	-122	-12	-11	(1)	(4)
Reimbursements & Grant Income	-154	-59	-59	0	0
Transfer from Reserves	-59	0	0	0	0
Government Grant Income	-12,435	-3,098	-3,098	0	0
Total Income	**-12,770**	**-3,169**	**-3,168**	**(1)**	**(4)**
Net Operational Expenditure	**419**	**-2,002**	**-2,053**	**51**	**302**
Recharges					
Premises Support	209	35	35	0	0
Transport Support	24	4	4	0	(3)
Central Support	1,897	316	316	0	0
Asset Rental Support	0	0	0	0	0
Recharge Income	-669	-112	-112	0	0
Net Total Recharges	**1,461**	**243**	**243**	**0**	**(3)**
Net Departmental Expenditure	**1,880**	**-1,759**	**-1,810**	**51**	**299**

Progress Against Agreed Savings **Appendix 3**

Adult Social Care

Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
			25/26 Agreed Council 01 February 2023 £'000	25/26 Agreed Council 05 March 2025 £'000		
Housing Solutions	474	Remodel the current service based on good practice evidence from other areas.	125	0	U	Currently Under Review
Voluntary Sector Support	N/A	Review the support provided by Adult Social Care and all other Council Departments, to voluntary sector organisations. This would include assisting them to secure alternative funding in order to reduce their dependence upon Council funding. A target saving phased over two years has been estimated.	100	0	✓	Achieved
Community Wardens/Telecare Service		Community Wardens/Telecare Service – a review will be undertaken of the various options available for the future delivery of these services, with	0	280	U	Currently Under Review

		support from the Transformation Delivery Unit.				
Care Management Community Care Budget		Community Care – continuation of the work being undertaken to review care provided through the Community Care budget, in order to reduce the current overspend and ongoing costs.	0	1,000	U	Unlikely to be achieved – currently forecast overspend position
Various		Review of Service Delivery Options – reviews will be undertaken of the various service delivery options available for a number of areas including; Day Services, Halton Supported Housing Network, In-House Care Homes, Reablement Service and Oak Meadow.	0	375	U	Currently Under Review
Total ASC Directorate			**225**	**1,655**		

Finance

Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
			25/26 Agreed Council 01 February 2023 £'000	25/26 Agreed Council 05 March 2025 £'000		
Internal Audit	300	Restructure in light of potential retirements over the next two years within the Internal Audit Team.	50	0	U	It appears unlikely that the proposed £50k budget saving will be fully realised this year, if at all
Council Tax	84	Increase the charges applied when a court summons is issued by 30% (£23), to achieve full cost recovery over the three year period.	40	0	x	Increase in costs to be applied from 2026/27.
Debt Management		Debt Management – undertake a review of debt management policies and procedures, in order to implement a more robust approach to debt management and debt recovery, considering options such as seeking payment in advance wherever possible, to improve cashflow and reduce the risk of non-recovery.	0	100	U	Currently part of workstream being undertaken by the Transformation Programme.
Total Finance Department			**90**	**100**		

Legal and Democratic Services

Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
			25/26 Agreed Council 01 February 2023 £'000	25/26 Agreed Council 05 March 2025 £'000		
Members		Deputy Mayor – cease provision of the Deputy Mayor's allowance, whilst retaining a nominated Deputy Mayor.	0	6	✓	Achieved.
Total Legal and Democratic Services			**0**	**6**		

Children and Families Department

Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
			25/26 Agreed Council 01 February 2023 £'000	25/26 Agreed Council 05 March 2025 £'000		
Children's Centres	1,293	Review the operation of Windmill Hill Children's Centre, where there is the potential to save on premises and staffing costs.	22	0		With the implementation of the family hubs the review of Windmill Hill will no longer be viable. The centre is located in an area of deprivation and the role of the centre as a family hub is a priority in the Children's social care review and supporting families at an earlier level, improving access to services for the most vulnerable and ensure a positive start for all children. These fit with the council priorities
Children's Residential Care		Residential Placements – continuation of the work being undertaken to review residential placements, especially high cost placements, and identify opportunities to step-down placements or find alternatives, in order to reduce the current overspend and ongoing costs.	0	1,500		Residential placements were all reviewed in early 2024 with some reduction in costs established. As part of the longer term plan included in the sufficiency strategy, Halton has partnered with a not for profit organisation, Juno, who are awaiting registration from OFSTED - this approach is part of the LCR approach working with NFP organisations. in

						addition significant changes have been made to reduce the numbers of children coming into care. Mocking bird constellation is in place and evidenced support has resulted in appropriate transition so the need for residential is mitigated. A property has been identified for care leavers and further properties identified for additional semi-independent provisions. Juno will focus on their second home after July
Fostering		Independent Fostering Agencies and Out of Borough Fostering – continuation of the work being undertaken to review placements, to increase use of In-Borough foster carers wherever possible and thereby reduce costs, in order to reduce the current overspend and ongoing costs.	0	200	U	Recruitment campaign has been launched to attract in house foster carers so Council reliance on IFA's is reduced. Unfortunately there is a national shortage of foster carers and as a result the reliance on IFA's continues
Legal Costs		Court Costs – implementation of measures in conjunction with Legal Services, to reduce the backlog and ongoing number of Children's cases going to court, thereby reducing the timescales	0	200	U	Progress has been made on reducing the cost of court with success in reducing the number of applications, the reduction in timeliness of proceedings, further work is currently underway to reduce the number of C2 applications to court.

		involved and cost of court proceedings, in order to reduce the current overspend and ongoing costs.				PLO process is proving effective for some families in diverting away from legal proceedings and safely maintaining children with parents, further exploration is taking place on the use of in house psychologists to undertake assessments in the court arena to further reduce court costs
Total Children & Families Department			**22**	**1,900**		

Education, Inclusion and Provision Department

Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
			25/26 Agreed Council 01 February 2023 £'000	25/26 Agreed Council 05 March 2025 £'000		
Home to School Transport		Home to School Transport – undertake consultation with stakeholders and partners with regard to implementing a new Home to School and College Travel and Transport Policy for Children and Young People with Special Educational Needs and Disabilities.	0	300	U	The consultation with stakeholders and partners has taken place. The results have been analysed and recommendations put to Executive Board for possible policy changes from the beginning of the new academic year.
Total EIP Department			**0**	**300**		

Community and Greenspace Department

Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
			25/26 Agreed Council 01 February 2023 £'000	25/26 Agreed Council 05 March 2025 £'000		
Stadium & Catering Services – School Meals	12	Cease to deliver the school meals service, which has made significant losses of over £200,000 for a number of years and is forecast to make a similar loss by year-end. Work would be undertaken with schools over the next two years to support them to secure an alternative means of delivery, whether in-house or via an external provider.	12	0	✓	School meals service has ceased and is reflected in the 25/26 budget.
Green Waste		Green Waste – increase green waste charges from £43 to £50 per annum, to bring Halton onto a comparable basis with charges levied by neighbouring councils.	0	100	✓	Green waste charges have been increased to £50.

Service Area	Net Budget	Description of Saving Proposal	Savings Value		Current Progress	Comments
Area Forums		Area Forums – cease the funding for Area Forums.	0	170	✓	Area forum budgets have been removed in 25-26
Total Community & Greenspace Dept			**12**	**270**		

Economy, Enterprise and Property Department

Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
			25/26 Agreed Council 01 February 2023 £'000	25/26 Agreed Council 05 March 2025 £'000		
Asset Management		Accelerate the lease or sale of surplus land, non-operational buildings, surplus space within building, etc. to either generate lease rentals or capital receipts to help fund capital schemes and thereby reduce future capital financing costs.	0	100	U	It is currently too early to establish if this can be achieved. Although all options will be explored.
Total EEP Dept			**0**	**100**		

Policy, Planning and Transportation Department

Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
			24/25 £'000	25/26 £'000		
Highways		LED Advertising Screens – install LED advertising screens at appropriate locations within the Borough in order to generate advertising revenue. The estimated annual income is the Council's share of advertising revenue net of capital financing costs for the installations.	0	100		It is not anticipated that this income will be achieved this financial year as the LED screens are no closer to being installed.
Total PPT Dept			**0**	**100**		

Public Health Directorate Department

Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
			24/25 £'000	25/26 £'000		
Environmental Health		Pest Control – increase charges for pest control on the basis of benchmarking data, to bring Halton onto a comparable basis with charges levied by neighbouring councils.	0	45	✓	Charges Increased
Total Public Health Directorate			**0**	**45**		

Corporate and Democracy

Service Area	Net Budget £'000	Description of Saving Proposal	Savings Value		Current Progress	Comments
			24/25 £'000	25/26 £'000		
Chief Executives Delivery Unit		Purchase of Additional Leave – development of a voluntary scheme to enable staff to purchase additional annual leave.	0	100	U	Scheme being considered by Executive Board, uncertainty to timing and sign-up to the scheme.
Chief Executives Delivery Unit		Voluntary Severance Scheme – development of a policy whereby staff may be offered voluntary severance in appropriate circumstances, but without creating a significant pension strain liability.	0	200	U	Scheme to be designed and approved. Uncertainty to timing and sign-up to the scheme.
Chief Executives		Apprenticeships - implement an "Apprentice First" policy, with all	0	200	U	Scheme being developed, uncertainty to take up of the

Delivery Unit		appropriate vacant posts assessed initially to determine whether they might be suitable as an apprenticeship. This will build longer term resilience into the organisation's workforce and provide short term cost savings by drawing down funding from the apprenticeship levy. The scheme will be co-ordinated by the newly appointed Apprenticeship Officer, funded and supported by the Transformation Delivery Unit.				scheme.
Council Wide		Agency Staff Reduction – continuation of the work being co-ordinated by the Transformation Delivery Unit to reduce the reliance upon agency workers across the Council, in particular within Adults and Children's Social Care. Target net savings of £1.7m for 2025/26, £1.3m for 2026/27 and £1.1m for 2027/28.	0	1,700	U	There is evidence of reduced agency usage within the Children's directorate but targets have been built into directorate budget which duplicate what is included here. Uncertainty with regard to reductions across Adult Social Care. Highly unlikely the £1.7m saving will be achieved in the current financial year.
Council Wide		Review all existing contracts across the Council to re-consider their requirements and	0	200	U	Currently part of workstream being undertaken by the Transformation Programme.

		performance on the basis of outputs achieved.				
Total Corporate & Democracy			**0**	**2,400**		

Symbol	**Objective**
✓	Indicates that the objective is on course to be achieved within the appropriate timeframe.
U	Indicates that it is uncertain or too early to say at this stage whether the milestone/objective will be achieved within the appropriate timeframe.
✗	Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.

2025/26 Budget Risk Register as at 31 May 2025

Appendix 4

Risk No	Risk Identified	Impact	Likelihood	Risk Score	Risk Control Measures	Assessment of Residual Risk with Control Measures Implemented			Responsible Person	Timescale for Review	Progress Comments	Date Updated
						Impact	Likelihood	Risk Score				
1	**Pay costs** • Pay award • Staff Turnover Saving Target • Agency, casuals and overtime • National Living Wage	4	4	16	• Budget based upon individual staff members/vacancies • Budget monitoring • Contingency • Balances • Medium Term Forecast	3	3	9	ED/SB/ Directors	Monthly	2025/26 budget includes pay growth at forecast 2% pay award. Initial pay offer to trade unions was set at 3.2%, this will cost approximately a further £1m to the budget	31/5/25

	• Pension Costs				• Engage with Cheshire Pension Scheme and pension actuary • Market supplement paid in multiple service areas • Employer of Choice Initiative • Connect to Halton – Review of Scheme						Agency costs and usage remain high although some evidence of reduction in numbers within Children Social Care. Market Supplements paid to a number of service areas. Connect to Halton scheme went live September 2024, agency and casual appointments to be covered by the scheme.	
2	**Redundancy and Early Retirements**	3	3	9	• Benefits Tracking Process • Future savings to take into account cost of redundancy and early retirements. • Seek Government approval to use capital receipts to fund	2	3	6	ED/SB	Quarterly	Tracker created to monitor redundancy costs in current year. Look to capitalise redundancy costs where possible where evidence exists it creates a longer term saving.	31/05/25

					transformation costs. • Develop policy for voluntary severance scheme						£0.200m saving included in 25/26 budget for savings from voluntary severance scheme.	
3	**Savings not achieved**	4	3	12	• Budget monitoring • Contingency • Rigorous process in approving savings. • Review of savings at departmental and directorate level • Monthly budget monitoring • Medium Term Financial Forecast • RAG monitoring of savings included in bi-monthly monitoring reports. • Transformation saving targets reported monthly through Transformation Programme Board.	4	2	8	RR/ED/SB/Directors	Monthly	Savings for 2025/26 have been written into Directorate budgets. Budget savings monitored closely and if necessary offsetting savings sought. Transformation Programme Board meeting on monthly basis to discuss progress against programme.	31/05/25

4	**Price inflation**	3	3	9	• Prudent budget provision • Latest forecast information used eg. utilities • Budget monitoring • Contingency • Balances • CPI/RPI monitoring • MTFS	3	3	9	ED/SB	Monthly	CPI for May 2025 is 3.4% and RPI is 4.3%. Both running higher than inflation included in 2025.26 budget. Office of Budget Responsibility (OBR) forecast inflation to be 3.2% in 2025 and 2.1% through to 2027. Rates are higher than forecast that at 2025/26 budget setting and remain above Governments 2% target.	31/05/25
5	**Review of LG Finance** • Business rates retention – 100% Pilot and Review • Fair Funding	4	4	16	• MPs • SIGOMA / LG Futures • Liverpool City Region & Merseyside Treasurers	3	3	9	ED/SB/NS/MW/MG	Weekly/ Monthly	Business rate retention pilot continues through to March 2027. Government are	31/05/25

	Review • National Public Spending Plans • Social Care Green Paper				Group • Medium Term Financial Strategy • Member of business rate retention pilot region • Dialogue with DCLG • Responding to reviews and consultations						committed to providing more certainty on LG Finances through multi year settlements. Government issued the Fair Funding consultation on 20 June 2025, with a closing date of 15 August. Resetting the Business Rates Retention consultation was issued by Government in April 2025 with Halton submitting a response prior to the 02 June deadline.	
6	**Treasury Management** • Borrowing • Investment	2	3	6	• Treasury Management Strategy • Link Asset Services advice • Treasury Management	1	3	3	ED/SB/MG	Daily / Quarterly	BoE base rate reduced to 4.25%. Impact of Exceptional Financial Support request to be	31/05/25

					planning and monitoring • Attendance at Networking and Benchmarking Groups • Officer and Member Training						assessed with regards to timing of future borrowing.	
7	**Demand led budgets** • Children in Care • Out of borough fostering • Community Care • High Needs	4	4	16	• Budget monitoring • Contingency • Balances • Review service demand • Directorate recovery groups • Monthly budget monitoring • Children Improvement Plan Investment Funding	4	4	16	ED/SB/NS/MW	Monthly	Numbers of children in care and with protection plans reviewed on a weekly basis. Community care costs and numbers on increase, reviewed on a regular basis. Investment in Children Services following OFSTED inspection to be monitored with regard to control and reduction of future costs.	31/05/25
8	**Mersey Gateway Costs**	4	2	8	• Regular monitoring with Crossing Board	2	1	2	ED/SB/MG	Quarterly	Arrangements in place to monitor spend and	31/05/25

	• Costs • Toll Income • Funding • Accounting treatment				• Capital reserve • Government Grant • Liquidity Fund						availability of liquidity fund.	
9	**Council Tax Collection**	3	3	9	• Council tax monitoring on monthly basis • Review of Collection Rate • Collection Fund Balance • Provision for bad debts • Review recovery procedures • Benchmarking	3	2	6	ED/PG/SB/PD/BH/MG	Monthly	Collection rate to 31 May 2025 was 18.53% which is marginally lower than the rate of 18.58% at the same point last year. To 31 May 2025 £0.785m was collected in relation to old year debt.	31/05/25
10	**Business Rates Retention Scheme**	3	3	9	• Review and monitoring of latest business rates income to baseline and estimate for year. • Prudent allowance for losses in collection • Prudent provision set	3	1	3	ED/SB/LB/MG	Monthly	Collection rate to 31 May 2025 was 22.81% which is 1.22% lower than the rate at the same point last year. To 31 May 2025 £0.344m was	31/05/25

					aside for losses from valuation appeals • Regular monitoring of annual yield and baseline / budget position • Benchmarking Groups • Review recovery procedures						collected in relation to old year debt.	
11	**Income recovery** • Uncertainty to economy following cost of living and high inflation	3	3	9	• Corporate charging policy • Budget monitoring • Contingency • Balances • Income benchmarking	3	2	6	ED/MM/SB	Monthly	Income shortfalls identified and cause of increased concern in certain areas are being closely monitored. Additional posts created within Adult Social Care Directorate, responsible for improving the overall collection of social care debt.	31/05/25
13	**Capital Programme** • Costs • Funding	4	3	12	• Project Management • Regular monitoring • Detailed financial	3	2	6	Project Managers/ED /SB/LH	Quarterly	Capital receipts have been fully committed therefore new capital schemes need to bring	31/05/25

	• Key Major Projects • Clawback of Grant • Availability and timing of capital receipts • Cashflow • Contractors				analysis of new schemes to ensure they are affordable • Targets monitored to minimise clawback of grant. • Contractor due diligence • Dialogue with Government departments.						own funding.	
14	**Academy Schools** • Impact of transfer upon Council budget • Loss of income to Council Services	2	4	8	• Early identification of school decisions • DfE Regulations • Prudent consideration of financial transactions to facilitate transfer • Services continue to be offered to academies • Transfer Protocol	1	3	3	ED/SB/NS	Monthly	Consideration given in MTFS for loss of funding.	31/05/25
15	**Reserves** • Diminishing reserves, used to balance budget, fund overspend positions.	3	4	12	• Monitored on a bi-monthly basis, reported to Management Team and Exec Board • Benchmarking	3	3	9	ED/SB	Quarterly	Monitored and reported on a regular basis. Council reserves at historic low levels.	31/05/25

					• Financial Forecast • Programme to replenish reserves.						Reserves will need to be replenished within future budgets	
16	**Budget Balancing** • Council has struggled to achieve a balanced budget position for a number of years. • Forecast for current year is an overspend position of £19m. • Reserves insufficient to balance current year budget. • Council has been given approval in-principle for Exceptional Financial Support (day to day costs funded through capital borrowings) for 2024/25 and 2025/26.	4	4	16	• Current year budgets monitored on a regular basis. • Forward forecasting through to March 2029 reported on a prudent basis. • Regular conversations with DHLUC re Council's financial position. • LGA to undertake a financial assurance review. • Transformation programme in place. • Financial Recovery Plan required to better inform how the Council will achieve future sustainable budgets.	4	4	16	ED/SB	Ongoing	Council has received in-principle agreement to fund day to day costs through Exceptional Financial Support. EFS covers a total of £52.8m over two years, split: 24/25 - £20.8m 25/26 - £32.0m Council utilised £10m of EFS in 24/25, below the approved amount. Financial recovery plan to be put in place to limit Council exposure to EFS and repayment of borrowings to date.	31/05/25