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Health and Wellbeing Board

Wednesday, 8 October 2025 2.00 p.m.
DCBL Stadium, Widnes

Interim Chief Executive

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

The next meeting of the Committee is on Wednesday, 14 January 2026

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

Part I

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 9 July 2025 at DCBL Stadium, Widnes

Present: *Councillor Wright (Chair)*
Councillor Ball
Councillor T. McInerney
Councillor Woolfall
H. Back – Halton Housing
K. Butler, Democratic Services
S. Corcoran – Halton Housing
M. Hancock - Public Health
H. Herd – Warrington & Halton Hospitals
A. Leo, Integrated Commissioning Board
W. Longshaw, St. Helens & Knowsley Hospitals
D. Nolan, Adult Social Care
I. Onyia, Public Health
H. Patel, Citizens Advice Bureau
N. Renison - Halton Borough Council
J. Wallis - Bridgewater Community Healthcare
D. Wilson - Healthwatch Halton
S. Yeoman, Halton & St Helens VCA

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB1 APOLOGIES FOR ABSENCE

Apologies had been received from Lydia Hughes – Healthwatch Halton, Suketu Patel - Local Pharmaceutical Committee, Tim Phee - Mersey Care NHS Foundation Trust, Lucy Gardner - Warrington & Halton Teaching Hospitals and Lisa Windle – Halton Housing.

HWB2 MINUTES OF LAST MEETING

The Minutes of the meeting held on 12 March 2025, having been circulated, were signed as a correct record.

HWB3 PRODUCTION OF A BOROUGH WIDE HOUSING STRATEGY PROGRESS UPDATE

The Board received a report from the Executive Director – Environment and Regeneration, which provided a progress update on the new Housing Strategy for the

Borough.

Following the approval for production of a new Housing Strategy at the Council's Executive Board in April 2024, Board members were advised that Arc4, a housing research policy specialist, had been commissioned to support the production process of the Strategy. This had commenced in September 2024 and consisted of two stages, the first being a Housing Needs Assessment (HNA) which included a household survey of residents in Halton being undertaken.

The survey took place between November and December 2024 and was sent to 16,530 households. 1,620 useable responses were received (9.8% response rate). It covered 4 broad themes:

- Your home, neighbourhood and household;
- Housing history;
- Future housing requirements: whole household; and
- Future housing requirements: newly forming households.

The main purpose of the survey was to provide evidence to help assess housing need by type, size and tenure within different parts of the Borough.

The Housing Strategy was currently in the draft process (Stage 2) and once completed, an informal stakeholder engagement would be undertaken in June/July 2025, followed by a formal 6 week public consultation in July/August 2025; the final revisions and adoption was planned for September/October 2025.

After some discussions, the following additional information was noted:

- The public consultation would be promoted to all partners and residents of the Borough and would be made widely available both online and in a number of public places e.g. libraries and One Stop Shops;

- Concerns were raised about increasing needs to health services, however, it was confirmed that although the consultation would give an opportunity to raise such concerns, these would be addressed by the Local Plan. The Housing Strategy concentrated more on the demographic needs of the Borough e.g. the type of accommodation that was required to accommodate the needs of the ageing population and

people with learning disabilities. The Strategy was about the quality of the Borough's accommodation as well as the quantity and it was considered that good quality homes lead to good quality health outcomes; and

- It was reported that there were some concerns about the number of Houses of Multiple Occupation (HMO) in the Borough and it was confirmed that the private rental sector features heavily in the Strategy and how the sector would be monitored going forward.

RESOLVED: That the Board:

1) note the progress of the new Boroughwide Housing Strategy; and

2) promote participation in the stakeholder and formal public consultation process.

HWB4 PHARMACEUTICAL NEEDS ASSESSMENT

The Director of Public Health, presented a report which provided members of the Board with a briefing on the Pharmaceutical Needs Assessment (PNA) which included risks associated with it and proposed local governance arrangements.

Every Health and Wellbeing Board in England had a statutory responsibility to publish and keep an up-to-date statement of needs for pharmaceutical services of its local population. This was referred to as a Pharmaceutical Needs Assessment (PNA) and included dispensing services as well as public health and other services that pharmacies may be commissioned to provide.

The report set out the commissioning arrangements; proposed arrangements for producing Halton's next PNA; and the resources required.

The report also outlined the next steps which would be undertaken by a steering group. It was noted that once a final draft document had been completed, a 60 day statutory consultation would be undertaken and the results would be reported to the Board before its publication on 1 October 2025.

RESOLVED: That the Board:

1) note the contents of the report;

2) agreed that the Director of Public Health be the lead; and — Director of Public Health

3) agreed that the PNA be managed by a local steering group, led by Public Health.

HWB5 OVERVIEW OF PROPOSED REFORMS TO PERSONAL INDEPENDENCE PAYMENTS AND UNIVERSAL CREDIT

The Board received a report from the Director of Public Health which provided an overview of the UK Government's proposals for reform to Personal Independence Payment (PIP) and Universal Credit (UC). The proposed reforms were outlined in the Green Paper "Pathways to Work: Reforming Benefits and Support to Get Britain Working Again" which was published in March 2025.

PIP was a benefit payment for people under State Pension age and need help with daily activities or getting around because of a long-term illness or disability. PIP was made up of two components; a daily living and a mobility element and an applicant could be eligible for one or both. The report outlined the details of the PIP criteria and payments.

The benefit was not means tested and therefore an eligible individual could receive support regardless of their employment status, income or the amount of savings they had. As of January 2025, 3.7 million people in the UK were claiming PIP.

The report stated that from November 2026, new and existing claimants would need to score at least 4 points on at least one specific daily living activity, in addition to meeting the overall 8-point threshold. This would mean that some individuals who previously qualified for PIP might no longer be eligible.

UC was a working age benefit to support those on low income with living costs. Applicants may be employed or unemployed and currently there were 7.5 million people in the UK claiming UC with 3 million having no requirement to find work. Payments are paid on a monthly basis and consist of a standard allowance with some additional payments being paid based on individual circumstances.

The report outlined the proposed changes that were due to come into effect from April 2026, particularly regarding the health element for those with limited capability

for work. New claimants would receive a reduced health element, and the existing health element for current claimants would be frozen until 2029/30. However, some individuals with severe, lifelong conditions would see their payments increase with inflation.

The Board was advised that approximately 10,000 people in Halton claim PIP and approximately half this amount would not qualify under the proposed criteria. It was suggested that some work could be done at a local level as to what might be a reformed PIP system in the next few years.

Members were advised that since the publication of the report, Parliament had made further amendments and therefore an accompanying presentation was delivered to the Board to outline these changes. It was noted that the two main changes to note were:

- all proposed amendments to PIP had been put on hold pending the Timms Review of the system, which was expected in the Autumn; and

- the UC health element cut would no longer apply to existing claimants.

RESOLVED: That the Board note the report and accompanying presentation which outlined the most up-to-date proposed Welfare Reform changes and the impacts on Halton residents.

HWB6 OVERVIEW OF PUBLIC HEALTH INITIATIVES TACKLING THE CAUSES AND EFFECTS OF HEALTH INEQUALITIES IN HALTON

A report was presented to members of the Board which provided an update on Public Health projects which targeted health inequalities. The report highlighted the various approaches undertaken to address the issues which included:

- Healthy Advertising Policy – the policy was introduced to combat the impact exposure to unhealthy advertising had on residents and to tackle the rates of overweight and obesity in Halton. This policy was part of the proactive approach to promoting health improvement in communities. Halton was one of only 23 Boroughs nationally to have made such a commitment and was working with partners in each area to bring together a joint

evaluation on the impact of the policy;

- Winter Cold Homes Initiative – due to Halton's successful application to the NHS Cheshire and Merseyside Data and Access Governance Committee, Halton would be able to run a preventative scheme this Winter. Via a dashboard, patients health conditions would be assessed alongside areas of deprivation, to identify those most at risk of requiring hospital admission, due to the effects of fuel poverty. Halton was the first Public Health Department in the North West to be granted access to this dashboard. It would work closely with relevant partners to establish opportunities to change the ways of working with an aim to move towards a proactive prevention approach, opposed to intervention services; and

- Household Support Fund Schemes - in the recent Spending Review, the Government announced the replacement of the Household Support Fund with a new Crisis and Resilience Fund. Although details were not yet known, the Fund would cover multiple years opposed to short-term renewals of the current Fund. This would allow more opportunities for long-term collaboration in other areas.

RESOLVED: That the report be noted.

HWB7 HALTON'S VCFSE SECTOR AND IT'S ROLE IN WIDER DETERMINANTS

The Board received a presentation and accompanying report from the Chief Executive Officer of Halton and St. Helens Voluntary Community Action (VCA), which provided an overview on the work of the VCA and the local Voluntary, Community, Faith, and Social Enterprise (VCFSE) to address health inequalities and the wider determinants that negatively impact health outcomes for people.

There was an estimated 724 groups and organisations in Halton that provided support, services and community action and Halton's VCFSE sector provided a huge contribution to the economic and social wellbeing of the Borough. There were 1,861 paid staff in the sector and 17,671 volunteers who delivered 23.574 hours for local voluntary and social action. The workforce was worth £57.8 million to the Borough and the sector created £44.8 million gross value added.

The presentation outlined the top priorities of the VCFSE for the next 12 months which included funding, recruitment, organisational planning, maintaining reserves and working with others to deliver services.

Members were advised that the VCA ran a Community Lottery whereby charities, community organisations, social businesses and community groups could sign up, free of charge and get a slice of the ticket proceeds. 60% of the ticket proceeds from the Community Lottery go to charities, voluntary organisations and other not-for-profit groups with the remainder being put towards prizes and operating costs.

RESOLVED: That the report be noted.

HWB8 THE IMPACT OF ADVICE SERVICES ON TACKLING POVERTY AND THE WIDER DETERMINANTS OF HEALTH

The Board received a presentation and accompanying report which provided an overview of the volume and nature of enquiries local people were raising with the Citizens Advice Halton. The report outlined the emerging trends and what challenges they may pose for the wider health and wellbeing system.

The following key messages outlined in the presentation were noted:

- By May 2025, 50% of people getting debt advice from Citizens Advice were in a negative budget – this was up from 37% in January 2019;
- In January 2019 people had approximately £20 disposable income each month. By May 2025 this had dropped to minus £23 each month;
- The over 65s had on average £85 spare each month. All other age profiles had negative budgets;
- Owner occupiers had on average £56 spare each month. All other age profiles had negative budgets, ranging from minus £4 to minus £130 each month; and
- Personal Independent Payment enquiries had dropped from 130 each month to 75 each month. It was suggested that this reflected the Citizens Advice capacity as opposed to demand.

RESOLVED: That the report be noted.

HWB9 BETTER CARE FUND PLAN 2025-26

The Board received a report from the Executive Director of Adult Social Services, which provided an update on the Better Care Fund (BCF) Plan 2025-26, following its submission on 31st March 2025.

In January 2025, the Government published a BCF Policy framework for 2025-26 which set out the vision, funding, oversight and support arrangements. The aim was to reform to support the shift from sickness to prevention and to support people living independently and the shift from hospital to home.

The Board noted that in order to support the BCF Plan 2024-25, the current Joint Working Agreement was reviewed and updated to reflect recent changes in governance and processes. The new Joint Working Agreement runs for two years up to the end of March 2027 and this was approved by partners.

RESOLVED: That the Better Care Fund Plan 2024-25 be noted for information.

HWB10 BETTER CARE FUND 2024-25: YEAR END REPORT

The Board received a report from the Executive Director of Adult Social Services, which provided an update on the Better Care Fund 2024-25 Year-End return, following its submission on 29 May 2025.

The update provided the Board with information on the four national conditions which had been met, progress on the four national metrics, income and expenditure actual, year-end feedback and adult social care fee rates.

RESOLVED: The Better Care Fund Year-End return for 2024-25 be noted for information.

Meeting ended at 3.40 p.m.

REPORT TO: Halton Health and Wellbeing Board

DATE: 8th October 2025

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Stronger for Longer Service

WARD(S) All Wards

1.0 PURPOSE OF THE REPORT

1.1 To inform Health and Wellbeing Board members about the launch of a new service aimed at supporting adults in Halton over the age of 55 'Stronger for Longer'.

2.0 RECOMMENDED: That

1) **the report be noted; and**
2) **the Board agrees to engage with promotion of the new service and to look for opportunities for partnership working between organisations working with the older population in Halton.**

3.0 SUPPORTING INFORMATION

3.1 Stronger for Longer Service Development Process

For a number of years the Halton Borough Council (HBC) Public Health Ageing Well offer, has provided a range of in community services to support residents over 55 years of age to remain healthy, connected and independent in Halton. This includes Get Together social events, regular chats with the team afternoons and the 1:1 information and advice service know as Sure Start to Later Life.

Previously the 1:1 service was limited to the sharing of information and resources with the expectation that clients would act independently to access services. The team of Information Officers would carry out an in-person visits to a clients home, getting to know the client and their needs, providing information on local services. Clients would then be followed to review their progress. Although this was sufficient for some clients, it is clear that most of those referred to the service required a more intensive approach in order to support them to access the local community.

3.2 Following a full review of client feedback, service level data and local health priorities a new model of service delivery was required. The result of this development work is the Stronger for Longer Service.
Stronger for Longer will focus on closer collaboration with the clients over the age of 55 to break down barriers to accessing groups that will improve health and wellbeing. This change brings the service in line with the full holistic offer of the Health Improvement Team (HIT), integrating our service with the range of preventative services the team specialises in.

3.3 The Stronger for Longer Service is a structured 12 week programme with the intensity of support tailored to the individual in question. Once referred into the service a client will be visited in their home for an initial assessment. The assessment is broken down into four sections.

1. The team will get to know the client and make them comfortable with the service. Discuss their current routine, how often they access the community and attend social activities, getting to know what interests they could be supported in pursuing.

2. Assessment of the clients current support network, for example who they live with, do they use public transport, do they have the support of a carer.

3. Assessment of a clients health and wellbeing including taking blood pressure and checking for risks of falls. This is in line with the wider preventative aims of the HIT and clients will be supported to access the wider offer of the team.

4. Goal Setting. Together with the client, a handful of clear goals will be agreed to work towards over the following 12 weeks. A level of support needed to achieve these goals will also be agreed upon. This is broken down into 3 tiers.

   Tier 1: For those clients who only require some information and advice and would prefer to access these independently.
   Tier 2: For clients requiring more of a connection with the team, following up on availability of local services and making referrals on behalf of the client.
   Tier 3: For clients requiring in person support from the team. Accompanying clients to events in the community they are currently missing out on. For example, this could be to attend a HIT Weight Management class or a knit and natter group to pick up a new hobby and meet new friends in the community. The Stronger for Longer Team will provide 1:1 support to the client over the 12 week programme to attend classes with them, overcoming barriers to access and make

sure they are comfortable making new connections in the community.

3.4 Over the course of the programme a clients progress will be reviewed after 6 weeks and at the end of the 12 week course. Adjustments will be made to goals after 6 weeks if required with support tailored to a clients needs. On completing the course after 12 weeks a reassessment of the clients situation and the improvements that have been made to reduce their social isolation will take place.

3.5 The Stronger for Longer Service launched in early August 2025 and one of the first clients was Irene, a 64-year-old woman from Widnes. During the initial assessment, she shared that she hadn't been out socially in over two years and often couldn't find the motivation to get dressed in the mornings.

She was introduced to a range of local community activities and showed a particular interest in the Upton Get Together Group, held close to her home. With her consent, staff provided level 2 barrier breaking support and supported her to book and pay for the next session, which was taking place just a few days later.

She attended the event independently, armed with the knowledge that her Age Well worker would be there to greet her and integrate her in to the session. Irene engaged with others, enjoyed making conversation, taking part in activities and even got up to dance. She was delighted to win a raffle prize and told staff how much she was enjoying herself. By the end of the afternoon, she had made a connection with another attendee and arranged to go to an aqua exercise class together the following week. The two have since become close friends and are regularly enjoying attending the new leisure centre pool.

This simple but timely support led to meaningful change, helping her reconnect socially, improve her confidence, and take steps to become more physically active, all of which contribute positively to her health and wellbeing.

3.6 To promote the new service a launch event was held in July at the DCBL Stadium. At the event the new service model was outlined to attendees, with information on how local groups and individuals can refer into the service (including the criteria the service will apply to determine suitability for the program), and how services can work in partnership with the Stronger for Longer team and wider HIT services in the future.
Attendees at the launch event came from a range of organisations and services including HBC Adult Social Care, Community Development and Library Services as well as representation from

the NHS and 3rd sector organisations such as the Red Cross and Age UK.
For further information on the service model including referral criteria please email the HIT Ageing Well Team at age.well@halton.gov.uk.
Referrals into the service can be done using the general HIT referral form and emailed to HIT@halton.gov.uk

4.0 POLICY IMPLICATIONS

4.1 The support of the older population in Halton is a consideration in a wide variety of policy decisions, including housing policy, Adult social care policy, transport policy.

4.2 A preventative approach to health services across Halton will support local residents to live longer lives, and crucially to live longer of their lives in good health

5.0 FINANCIAL IMPLICATIONS

5.1 Adult Social care remains one of the local authorities largest areas of expenditure with demand rising with an ageing population. As such, preventative support to keep residents in good health is an essential part of reducing the costs of expensive intervention for residents whose health has deteriorated.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

The change to the service will prioritise intense support to residents to sustainably access community groups and improve their independence in the community.

6.2 Building a Strong, Sustainable Local Economy

As our service supports residents 55+ to improve their health and wellbeing we can support those still able to work to remain in good health.

6.3 Supporting Children, Young People and Families

The service will continue to look into the opportunities to promote intergenerational work within care settings with some early work in this area well received by residents and staff.

6.4 Tackling Inequality and Helping Those Who Are Most In Need

Residents isolated from the community are unable to access local health services or essential support services in a timely manner.

The team will be helping residents in their assessments access support for cost of living issues and housing support if required.

6.5 Working Towards a Greener Future

We will be promoting health classes such as local walking groups, encouraging residents to continue with active travel as a means of transport.

6.6 Valuing and Appreciating Halton and Our Community

As part of helping connect residents locally we will be building a portfolio of local activities to inform groups and residents what is available in Halton from both council offers and the 3rd sector.

6.7 Resilient and Reliable Organisation

By enhancing the prevention offer we hope to keep residents healthy and independent for longer reducing the pressure of demand on Adult Social Care services.

7.0 RISK ANALYSIS

7.1 Introduction of this service presents no additional risk to the Local Authority.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Through monitoring referral patterns and client database the Stronger for Longer Service will develop approaches to ensure equitable access to the service across different populations of local residents.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 The service aims to keep residents mobile whether its through falls prevention work, fresh start classes aimed at weight loss and exercise or walk and talk groups that meet locally on a weekly basis. All of this will keep residents engaged with active travel and reduce the need to for short travel using cars or taxis.

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

All reports must contain this heading. Background papers are described as those upon which you have relied to write your report. They could for example be Government legislation,

previous Board reports or Strategies. State the title of the document(s), where they can be inspected and a contact officer. **‘None under the meaning of the Act.**’

REPORT TO: Health & Wellbeing Board

DATE: 8 October 2025

REPORTING OFFICER: Chief Officer - Healthwatch Halton

PORTFOLIO: Health and Wellbeing

SUBJECT: Healthwatch Halton Annual Report 2024–25

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Healthwatch Halton Annual Report 2024–25, highlighting key activities, themes, and impact from the past year.

2.0 **RECOMMENDATION:**

RECOMMENDED: That

1) **the report be noted; and**
2) **the Board continues to support Healthwatch Halton in promoting patient voice and co-production across local health and care services.**

3.0 **SUPPORTING INFORMATION**

3.1 Healthwatch Halton spoke to over 5,800 people and delivered 276 outreach sessions in 2024–25.

3.2 The organisation supported more than 16,900 people through feedback collection and signposting, including 15,104 who received tailored information and advice.

3.3 15 reports were published, covering GP access, pharmacy services, care homes, children's A&E, and community diagnostics.

3.4 Impact highlights include clearer signage and letters at Whiston Hospital, improved communication at Warrington Hospital, and additional staffing in Children's A&E.

3.5 Targeted support reached underserved communities including LGBTQ+ residents, veterans, people experiencing homelessness, and digitally excluded individuals.

3.6 Volunteers contributed 32 days of time, supporting community engagement, Enter & View visits, and advisory input.

3.7 Statutory funding from Halton Borough Council totalled £131,251,

supplemented by £3,472 in additional income from ICS-funded projects.

3.8 Future priorities include:

- Access to primary care
- Women's health and maternity services
- Improving quality and dignity in care homes

4.0 POLICY IMPLICATIONS

4.1 The report aligns with national guidance on patient engagement, including the NHS Long Term Plan and PCARP.

4.2 Healthwatch insight informs local service design, helping to address health inequalities and improve outcomes.

4.3 4Continued collaboration with the One Halton system and Cheshire & Merseyside ICS supports integrated working.

5.0 FINANCIAL IMPLICATIONS

5.1 Core Healthwatch funding for 2024–25 was £131,251.

5.2 Additional project income from the ICS totaled £3,472.

5.3 There are no new financial implications for the Board.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

- Healthwatch directly supports public engagement in shaping and improving services.

6.2 Building a Strong, Sustainable Local Economy

- Improved access to care can enhance economic participation and community resilience.

6.3 Supporting Children, Young People and Families

- Projects included A&E access for children and SEND support improvements via Brookfield School.

6.4 Tackling Inequality and Helping Those Who Are Most In Need

- Targeted engagement supported digitally excluded residents, veterans, and others facing access barriers.

6.5 Working Towards a Greener Future

- Engaging Communities Solutions saved 4,914 car miles through use of public transport.

6.6 Valuing and Appreciating Halton and Our Community

- Through volunteering and outreach, local people are helping shape better care and support in Halton.

6.7 Resilient and Reliable Organisation

- The report highlights Healthwatch's adaptability and evidence-based approach to improvement.

7.0 RISK ANALYSIS

7.1 There are no direct risks arising from this report.

7.2 Continued statutory funding and partnership support are essential to maintain impact.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Healthwatch Halton is committed to equity and inclusivity, ensuring underrepresented voices are heard.

8.2 Outreach efforts specifically targeted vulnerable and seldom-heard groups.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 Healthwatch Halton's parent organisation promotes sustainability, reducing car travel and promoting digital access.

9.2 This aligns with Halton's broader commitment to environmental responsibility.

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

Healthwatch Halton Annual Report 2024–25, available at: www.healthwatchhalton.co.uk

REPORT TO: Health & Wellbeing Board

DATE: 8 October 2025

REPORTING OFFICER: NHS Director - Halton

PORTFOLIO: NHS

SUBJECT: One Halton Neighbourhood Programme Update

WARD(S) Borough-Wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Board with an update on Neighbourhood Health Implementation Programme: Health and Social Care and local development plans within Halton.

2.0 **RECOMMENDATION: That this presentation is received and noted.**

3.0 **SUPPORTING INFORMATION**

3.1 The attached presentation provides an update on the National Neighbourhood Health Implementation Programme: Health and Social Care and local plans within Halton.

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 and the work being undertaken with partners.

4.0 **POLICY IMPLICATIONS**

4.1 As the Neighbourhood Programme evolves during the coming period, One Halton Partnership will need to work collaboratively across local partners to further develop and implement plans.

5.0 **FINANCIAL IMPLICATIONS**

5.1 One Halton Partnership works collaboratively with both statutory and non-statutory organisations serving residents and patients within Halton. As the work 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**

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

NHS Cheshire and Merseyside ICB through One Halton Partnership arrangements supports the Council's Health & Wellbeing Board's priorities which seek to improve health, promote wellbeing, and support greater independence.

6.2 Building a Strong, Sustainable Local Economy

NHS Cheshire and Merseyside ICB through One Halton Partnership arrangements support the Council's Health & Wellbeing Board's priorities which seek to deliver integrated ways of working and engender a whole-place collaborative approach.

6.3 Supporting Children, Young People and Families

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.

6.4 Tackling Inequality and Helping Those Who Are Most In Need

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.

6.5 Working Towards a Greener Future

6.6 Valuing and Appreciating Halton and Our Community

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

intrinsically contribute to building a safer and better Halton.

6.7 Resilient and Reliable Organisation

NHS Cheshire and Merseyside ICB through One Halton Partnership arrangements seeks to be an effective resilient and reliable partner organisation in addressing health challenges and inequalities on a collaborative basis within place.

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.

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

'None under the meaning of the Act.'

National Neighbourhood Health Implementation Programme: Health & Social Care

Prepared by: Sarah Vickers – Programme Lead – Primary & Community Care

NHS Cheshire & Merseyside

Neighbourhood health guidelines 2025/26

(NHS England 30 January 2025)

Purpose: help integrated care boards, local authorities and health and care providers develop neighbourhood health services in 2025/26

Neighbourhood health model is intended to join up services in the community in a more effective way, particularly for people with more complex health and care needs, helping children thrive and supporting adults to stay independent for longer, improve health and wellbeing, and reduce avoidable pressures on health, social care and other public services.

Ask: for local systems to focus on supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations, developing and bringing together into an integrated service offer six core components of a neighbourhood health model

- Population health management
- Modern general practice
- Standardising community health services
- Neighbourhood multi-disciplinary teams
- Integrated intermediate care with a ‘Home First’ approach
- Urgent neighbourhood services

Neighbourhood health guidelines 2025/26 Continued…..

(NHS England 30 January 2025)

12. The focus in 2025/26 should be supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations. This cohort has been estimated at around 7% of the population and associated with around 46% of hospital costs, according to NHS England analysis from adapted Bridges to Health data. It is likely that systems will initially prioritise specific groups within this cohort where there is the greatest potential to improve levels of independence and reduce reliance on hospital care and long-term residential or nursing home care, both improving outcomes and freeing up resources so systems can go further on prevention and early intervention. This approach is likely to focus on around 2% to 4% of the population. Examples of population cohorts with complex needs include:

- adults with moderate or severe frailty (physical frailty or cognitive frailty, for example, dementia)
- people of all ages with palliative care or end of life care needs
- adults with complex physical disabilities or multiple long-term health conditions
- children and young people who need wider input, including specialist paediatric expertise into their physical and mental health and wellbeing
- people of all ages with high intensity use of emergency departments

Why Implement the Neighbourhood Model?

- Neighbourhood Health - 10 Year Health Plan priority and Government ambition to:
  - shift care from hospitals to community,
  - analogue to digital,
  - sickness to prevention.

- No single agency working alone can adequately deal with the multiple and often complex issues impacting on the health and wellbeing of populations.

- Current ways of working mean resources are not deployed as effectively as possible, creating pressure across the whole health and care system.

- Leading to poorer experience of care and outcomes for individuals and communities.

- Requires the coordinated mobilisation of the assets in a community including communities themselves.

What do our Neighbourhoods look like?

Two integrated neighbourhoods – Runcorn and Widnes:

- Share the same footprints as Halton's Primary Care Networks (PCNs).
- Optimise strong existing neighbourhood working and partnerships with the LA, providers / services and voluntary sector, building on PCN development to date.
- Co-terminus with Halton Borough Council's boundary and aligned to Adult Social Care and preventative public health delivery.
- Recognised by communities and politicians.
- Aligned to the national Neighbourhood requirements & NHS Cheshire and Merseyside Neighbourhood Framework.
- Focused around a cohort of patients to deliver: improved management, pro-active care including risk stratification & advanced care planning, medicine rationalisation, access to wider third sector support.
- Clearly defined and measured benefits and outcomes for patients, carers and staff.

Who needs to be involved?

Patient Cohort

Cohort 1 : Known to Health & Social Care teams with multiple LTCs / Frailty.
Moderate or severe frailty (Rockwood Score 6-9)

Cohort 2: **Rising Risk - Identified via an agreed mechanism e.g. Data Into Action**
Vulnerable / Mildly Frail (Rockwood 4 & 5)

Later Phase
Cohort 3: Generally Well - Pro-active activities to prevent deterioration and support healthy aging.
Fit / Well / Managing Well (Rockwood 1-3))

Carers & Families

One Halton Partners

All Partners have a role:

- Primary Care including:
  PCNs, General Practices, GP Federations, Community Pharmacy, Optometry and Dental Services.
- Community Services:
  Community Matrons, District Nurses, Specialist Teams.
- Secondary Care Services
- Adult Health & Social Care Teams
- Public Health Services
- Third Sector Services
- Communities, Patients & Carers

Draft Timelines

Milestone	Date
Commence discussions with – Adult Social Care & PCNs / Practices	PLT June 2025 & July / Aug 2025
Establish Steering Group & agree TOR	Meeting 15/10/25
Identify resources to support: - Engagement by General Practice - Programme & Project support	31/10/25
Agree scope & aims of Programme	31/10/25
Agree delivery structure & arrangements including enabling functions (IT, Estates & Workforce)	31/10/25
Develop Programme Plan & documentation, identifying Phase 1 workstreams and future phases & include Projects, Milestones, Clinical Model, Pathway Development, digital, workforce & patient.	30/11/25
Ongoing Implementation, Delivery & Monitoring	Ongoing

REPORT TO: Health & Wellbeing Board

DATE: 8 October 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 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 FINANCIAL IMPLICATIONS

5.1 NHS Cheshire and Merseyside work 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

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

NHS Cheshire and Merseyside ICB through One Halton Partnership arrangements supports the Council's Health & Wellbeing Board's priorities which seek to improve health, promote wellbeing, and support greater independence.

6.2 Building a Strong, Sustainable Local Economy

NHS Cheshire and Merseyside ICB through One Halton Partnership arrangements supports the Council's Health & Wellbeing Board's priorities which seek to deliver integrated ways of working and engender a whole-place collaborative approach.

6.3 Supporting Children, Young People and Families

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.

6.4 Tackling Inequality and Helping Those Who Are Most In Need

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.

6.5 Working Towards a Greener Future

6.6 Valuing and Appreciating Halton and Our Community

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

6.7 Resilient and Reliable Organisation

NHS Cheshire and Merseyside ICB through One Halton Partnership arrangements seeks to be an effective resilient and reliable partner organisation in addressing health challenges and inequalities on a collaborative basis within place.

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.

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

'None under the meaning of the Act.'

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:

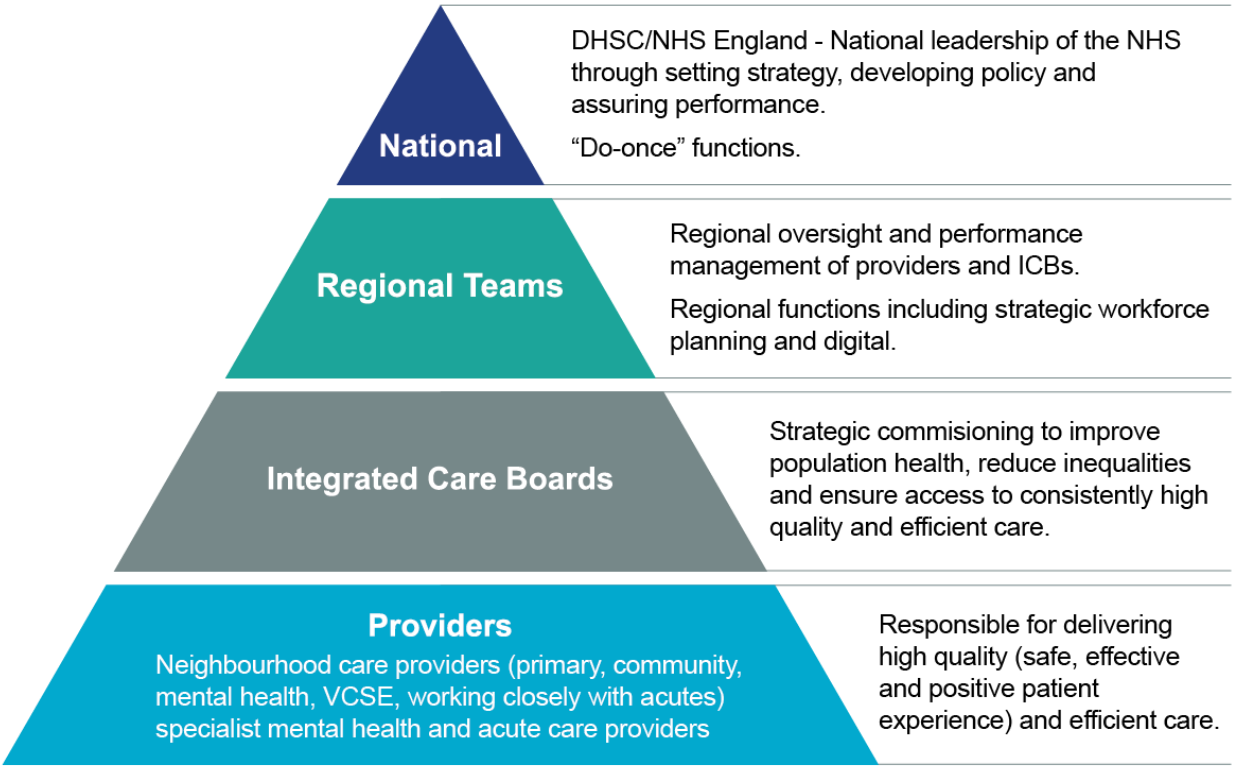
- **purpose** – why ICBs exist
- **core functions** – what they do
- **enablers and capabilities** – what needs to be in place to ensure success
- **managing transition** – supporting ICBs to manage this transition locally and the support and guidance that will be available.

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 & Wellbeing Board

DATE: 8 October 2025

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Joint Strategic Needs Assessment Summary

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

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

2.0 **RECOMMENDATION: That**

1) **the report be noted; and**
2) **the Board approves the draft summary for publication.**

3.0 **SUPPORTING INFORMATION**

3.1 **Background to the JSNA summary document**

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

Local authorities and the NHS, through health and wellbeing boards, are responsible to prepare the JSNA. This is a statutory responsibility as outlined in the 2007 Local Government and Public Involvement in Health Act (as amended) and retained in the latest Health and Care Act 2021. The public health team's data and intelligence staff lead on development of the JSNA on their behalf. The JSNA is developed as a series of chapters, on a rolling programme, with an annual summary.

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

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

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

3.2 **Local development of the JSNA**

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

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

Over the last year the focus of the JSNA has included:

- Pharmaceutical Needs Assessment
- Sexual Health JSNA
- Oral Health JSNA
- An update on life expectancy and healthy life expectancy
- Gypsy, Roma and Traveller health needs assessment
- Special Educational Needs JSNA profiles for 2024 and 2025
- A set of short reports for One Halton Living Well group covering hypertension, physical activity and healthy eating.

The next set of JSNAs for the remainder of 2025/26 include:

- Drugs & Alcohol
- Mental Health

The JSNA annual summary document is split into sections on:

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

This summary document is attached as Appendix 1.

3.3 **Key changes since the previous summary**

Despite the continuing challenges the borough faces, it remains the case that many of the health indicators show year on year improvements. So whilst the borough's health continues to be, generally, worse than the England average, these improvements show that we are moving in the right direction in some areas, despite the backdrop of a national cost of living crisis.

Some highlights include:

- Breastfeeding rates have improved.
- Halton remains above the national target of 75% uptake of flu vaccinations amongst those aged 65 and over (77.3%). This rate puts it statistically better than England. However uptake in other at risk groups does not meet the targets.
- Breast and cervical cancer screening coverage continue to improve.
- Hospital admissions due to falls injuries and hip fractures in people aged 65 and over have fallen in recent years, closing the gap between Halton and England. Levels for both are now statistically similar to the England overall rates.

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

- Life expectancy in the borough, birth and at age 65, remains statistically worse than England. Healthy life expectancy has reduced. This is resulting in a greater proportion of Halton residents lives being spent in ill health.
- Whilst the level of internal differences in life expectancy have fallen they remain substantial. For women it is 9.2 years and for men 10.4 years between the most and least deprived areas. For both men and women life expectancy was highest in Daresbury, Moore and Sandymoor ward and lowest in Central & West Bank for males and Halton Lea for females.
- There has been an increase in the levels of children living in poverty. The levels of both child poverty and older people living in poverty are statistically higher than the England averages. 1 in 4 children under 16 in Halton live in relative low income families (25.2%, an increase of 1.2%); almost 1 in 5 older people aged 60 and over live in poverty (18%).
- The levels of children achieving a good level of development by age 5 has fallen and remains statistically lower than the North West and England average.
- Despite MMR (Measles, Mumps and Rubella triple vaccination) uptake continuing to perform well compared to the national and regional averages, uptake levels have fallen recently. Cases of measles have increased locally, regionally and nationally.

- The proportion of 16-17 year olds not in education, employment or training has also increased.
- Levels of child and adult obesity are statistically worse than the North West and England averages. Over 7 in 10 adults in Halton are overweight or obese (73.6%) and the level has increased compared to the previous year (72.7%.)

3.4 **Developments for the JSNA during 2025 and 2026**

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

The process for agreeing and developing a work plan for the remainder of 2025/26 and into 2026/27 will be managed in collaboration with key stakeholders and members of the Health and Wellbeing Board.

One Halton
At the time of writing, it is not yet clear what will be the practical changes of the ongoing organisational changes to the NHS and Department of Health and Social Care. However, health inequalities remain and the JSNA will continue to underpin local work to address these challenges regardless of the new structures.

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

Whilst not developed for One Halton Local Place specifically, it nevertheless provides a useful source of outcome based metrics. It includes metrics across all of our One Halton Health and Wellbeing Strategy priorities – wider determinants, starting well, living well and ageing well. It also includes the All Together Fairer (formerly known as Marmot) Beacon Indicators. There are now many other dashboards within CIPHA such as Enhanced Case Finding, Frailty, Diabetes, Fuel Poverty and others.

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

4.0 POLICY IMPLICATIONS

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

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

5.0 FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

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

6.2 Building a Strong, Sustainable Local Economy

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

6.3 Supporting Children, Young People and Families

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

6.4 Tackling Inequality and Helping Those Who Are Most In Need

All issues outlined in this report focus directly on this priority; tackling inequalities and identifying health need is central to the work of Public Health.

6.5 Working Towards a Greener Future

The JSNA is key to informing steps to improve health and wellbeing and ultimately reduce the carbon footprint associated with healthcare appointments.

6.6 **Valuing and Appreciating Halton and Our Community**
Community safety is part of the JSNA. Having a thriving community with access to good quality affordable housing is crucial to the health and wellbeing of Halton residents.

6.7 **Resilient and Reliable Organisation**
The JSNA is a vital support tool for commissioners to use as part of the commissioning cycle. It includes information about service provision as well as population health and care needs. It thus enables commissioners to align service delivery with population health needs.

7.0 RISK ANALYSIS

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

8.0 EQUALITY AND DIVERSITY ISSUES

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

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 The JSNA is key to informing steps to improve health and wellbeing and ultimately reduce the carbon footprint associated with healthcare appointments.

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

None under the meaning of the Act

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HALTON JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

SUMMARY DOCUMENT 2025

Introduction

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

This document contains information, analysis and infographics which show the overall state of the borough - the population, economy, employment - and the health of people living in Halton. COVID-19 has undoubtedly had an impact on the health of the population of Halton. Not all of these impacts can be assessed right away, as they may be medium or long term.

In line with the 2022-2027 Health and Wellbeing Strategy, this report divides analysis into the strategy priority themes—wider determinants of health, starting well, living well, ageing well.

As the NHS prepares for reorganisation as set out in the NHS 10-year plan:

"ICBs will be strategic commissioners of local health services, responsible for all but the most specialised commissioning….to improve their population's health, reduce health inequalities and improve access to consistently high-quality services.

They will be expected to draw on a deep understanding of population need, and to make long-term decisions in the interests of improved outcomes…"

A key feature will be the Neighbourhood Health Model:

."..the NHS will need to work in much closer partnership with local government and other local public services with partners working together to develop a neighbourhood health plan under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund. "

Department of Health & Social Care and the Prime Minister's Office (updated July 2025) Fit for the future: 10 Year Health Plan for England

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

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

HALTON BOROUGH COUNCIL

OneHalton Working better together

Health in summary

The health of people in Halton remains generally worse than the England average. Halton is the 19th most deprived local authority in England (out of 151). 1 in 4 children live in relative low income families and this level has increased recently. Life expectancy for both men and women is lower than the England average. The top 5 causes of death are cancers, cardiovascular disease (heart & circulatory), mental & behavioural disorders (nearly all due to dementias) respiratory diseases and digestive diseases. Healthy life expectancy has reduced, resulting in Halton residents spending more of their life in ill health—20.5 years for men and 19.5 for women.

Health inequalities

Levels of deprivation and life expectancy vary across the borough. For males there is a 10.4 year gap and for women an 9.2 year gap in life expectancy at birth amongst those in the most deprived areas of Halton, compared to the least deprived. Life expectancy is highest in Daresbury, Moore and Sandymoor ward and lowest in Central & West Bank for males and Halton Lea for females.

Child health

Many child health indicators Halton show levels statistically worse than the England average. Good levels of development at age 5 have fallen and child poverty increased. The proportion of 16-17 year olds not in education, employment or training (NEET) has increased. Although the borough has levels of MMR (Measles, Mumps and Rubella aged 5) vaccination that are slightly higher than the England average these levels do not meet the 95% target (Halton levels at 86.7%) and they have fallen recently.

On a more positive note, the proportion of babies still breastfed at 6-8 weeks has increased. Whilst levels remain statistically worse than the England average, Halton rates have been static for some time so this increase is good to see. This is also the case for smoking at time of delivery, whilst still higher than England, levels have improved (reduced).

Adult health

It is a mixed picture of health for adults aged 16-64 across Halton with some indicators improving but some worsening.

Whilst the levels of adults who report they are physically active has increased (meeting Chief Medical Officer recommended levels), the proportion of the population overweight or obese has also risen from 72.7% to 73.6%. (England 64.5%). This puts Halton 9th highest across all local authorities in England and the highest across Cheshire & Merseyside. Despite the improvements in levels of physical activity, Halton remains statistically worse than the England average and 2nd lowest in Cheshire & Merseyside.

Smoking levels have increased slightly but remain statistically similar to England even though England levels continue to fall.

Rates of hospital admissions due to alcohol related conditions have risen slightly as has adult excess weight, but premature deaths (aged under 75) from all causes and cervical cancer screening coverage have improved.

Older People (aged 65+)

There have been a number of improvements including hospital admissions for both falls injuries and hip fractures; rates are now statistically similar to England. Life expectancy at age 65 has improved as have breast screening rates. Whilst flu vaccination levels are better than the England average and are over the 75% target, they have fallen.

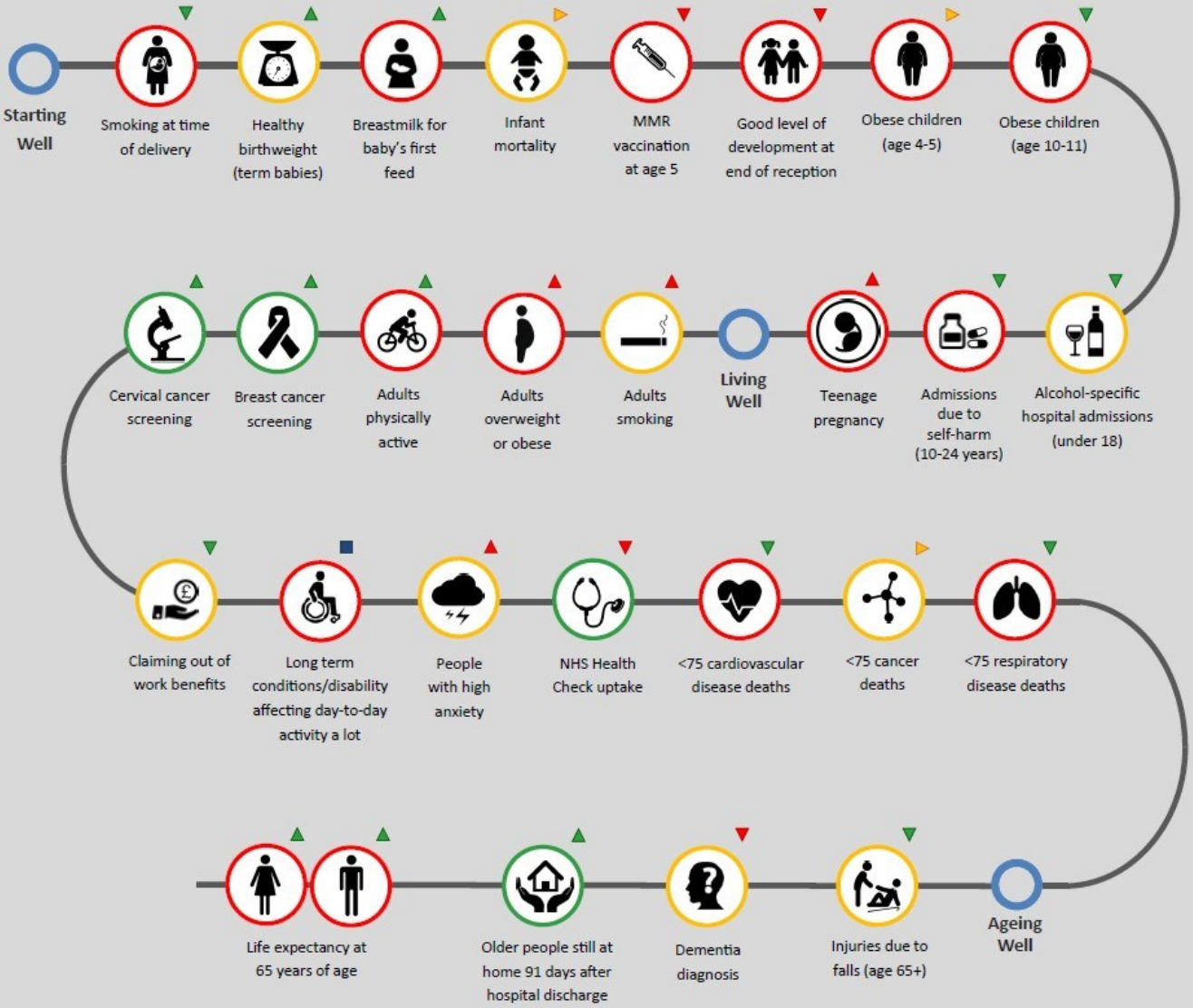
The proportion of people still at home 91 days after discharge from hospital has improved and is statistically better than the England average.

Further Halton data and trends can be found at **Public Health Outcomes Framework.**

HALTON'S LIFE COURSE STATISTICS

Halton's life course statistics 2025

A comparison to England



HALTON FACTS

Population

About **129,500** people live in Halton.

By 2043, this is projected to change:

age 0-14 ↓ 1.5%
age 15-64 ↓ 3.7%
age 65+ ↑ 5.3%

Deprivation

49% of Halton's population live in the top **20%** most deprived areas in England.

Child Poverty

25.2% of children aged 0-15 live in relative low income households

KEY

Direction of travel

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

Statistical significance to England

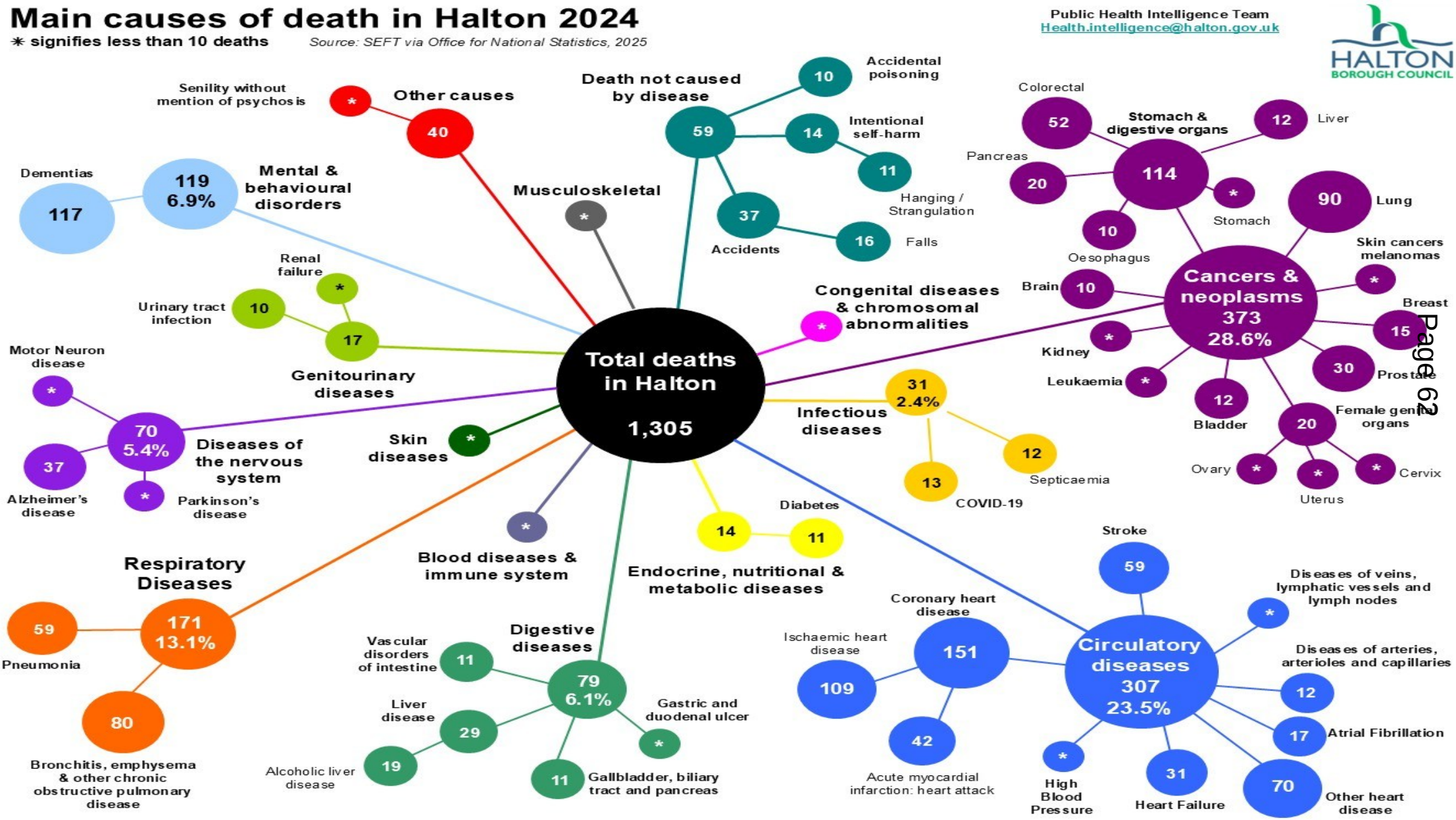
- Better
- No different
- Worse

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

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

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

CAUSES OF DEATH 2024



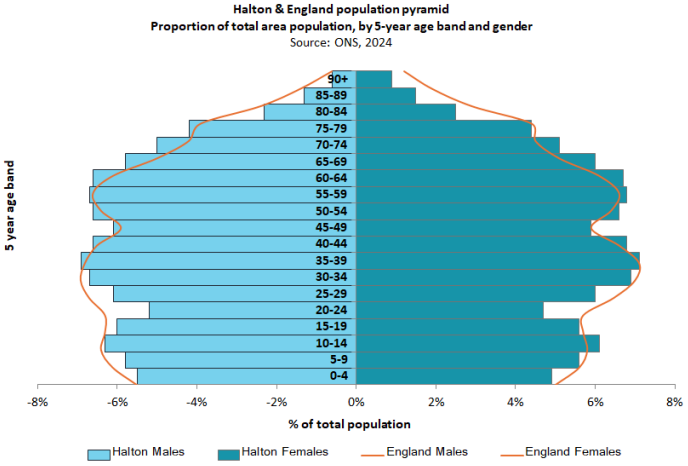
POPULATION

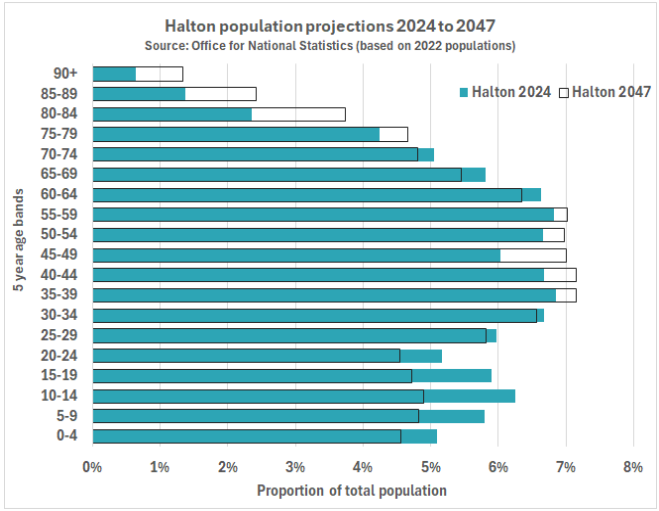
Population structure

There has been a shift towards a greater proportion of Halton's population now being in the 50-74 age bands when compared to the England average, rather than the 60-74 age band, as was previously the case. Halton has a lower proportion of the population aged between 15 and 34. This emphasises the potential for an ageing population to impact upon the borough's working age population.

This shifting population pattern is expected to continue over the next two decades. The proportion of people over the age of 70 is expected to increase and the proportion of children and people of working age is expected to decrease. This is also forecast to be the case nationally.

In 2024 8.6% of Halton's population were aged 75 and above (up from 7.4% in 2020), whereas, in 2047 Halton's projected population aged over 75 will be nearly double at 12.2% of the entire population of the area.





Ethnicity

The 2021 Census provides the most accurate picture of our local population broken down by ethnic groups. The data below shows Halton has a much smaller percentage of its population from non-white British ethnic backgrounds than the North West or England. Almost 94% of Halton's population is white British, compared to 74% in England as a whole.

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

Source: ONS, Census 2021

Employment

Overall Halton has slightly worse employment and unemployment rates compared to England. The borough has a higher proportion of households classified as workless (households where no-one aged 16 or over is in employment). These members may be unemployed or economically inactive. Economically inactive members may be unavailable to work because of family commitments, retirement or study, or unable to work through sickness or disability.

Economic activity rates April 2024 - March 2025

People aged 16-64	Halton		North West	England
	Numbers	%	%	%
Economically active	62,100	78.0%	76.7%	78.8%
In employment	59,300	74.5%	73.7%	75.7%
Employees	53,300	67.3%	65.5%	65.8%
Self-employed	6,000	7.2%	8.0%	9.6%
Unemployed (16-64)	2,700	4.3%	3.7%	4.0%
% of those economically inactive that are due to long-term sickness	4,600	27.3%	32.3%	27.1%
Workless households	7,800	20.3%	17.2%	13.5%

Source: Nomis, Labour Market Profile, using Annual Population Survey data

CENSUS POPULATION DATA BY PROTECTED CHARACTERISTICS

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

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

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

6.5% of Halton residents did report having a long-term health condition (physical and/or mental) which did not limit their day-to-day activities. Overall, 29.9% of Halton households contain one person who is disabled according to the equality act, and a further 9% contain two or more.

Marital status: The 2021 Census includes data on same-sex marriages and opposite-sex civil partnerships. These were not legally recognized in 2011 in England and Wales. Of Halton residents aged 16 years and over, 39.3% said they had never been married or in a civil partnership in 2021, up from 35.4% in 2011. This increase was similar to the North West and England averages. 42.2% said they were married or in a registered civil partnership. In 2021, just over 4 in 10 people (42.2%) said they were married or in a registered civil partnership, compared with 45.1% in 2011. The percentage of adults in Halton that had divorced or dissolved a civil partnership decreased from 9.8% to 9.6%.

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

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

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

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

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

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

Pregnancy: Pregnancy is not included in the Census but is a protected characteristic under the Equality Act. The latest annual data is for 2022 (ONS) and shows there were 1,901 conceptions. This equates to a conception rate of 79.5 per 1,000 women, higher than the North West (75.3) and England rates (71.5). England and Halton have seen an decrease in conception rates since 2020. The Halton number fell by 100 compared to 2020 (conception rate 84.4).

HEALTH INEQUALITIES

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

The King's Fund (2020)

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

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

Halton is a deprived borough relative to England as a whole. Based on the 2019 Index of Multiple Deprivation it is the 19th most deprived local authority in England (out of 151 upper tier authorities) and almost one third of its population live in areas classified in the 10% most deprived in England.

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

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

Life expectancy and healthy life expectancy

Life expectancy across Halton has been improving but remains below the regional and national averages. It means that on average Halton men can expect to live 2 years less than across England as a whole. For Halton women it is just under 3 years less. Despite general improvements to life expectancy, Halton residents spend less of their lives in good health compared to England and the years spent in ill health have actually increased for men.

Life expectancy

at birth	**77.1**	**80.5**	years (2021-23)
healthy life expectancy	**56.6**	**56.8**	years (2021-23)

Years spent in ill health

2011-13	**18.7**	**20.3**	years
2021-23	↑ **20.5**	↓ **19.5**	years

There are varying levels of deprivation and life expectancy within Halton meaning that there are internal inequalities. For women there is an 9.2 year gap between life expectancy at birth and for men it is 10.4 between the most and least deprived areas. Life expectancy is highest in Daresbury, Moore and Sandymoor ward and lowest in Central & West Bank for males and Halton Lea for females.

In an effort to address this Cheshire & Merseyside (and all its constituent Health & Wellbeing Boards) has become a **Marmot Community**. The **All Together Fairer** Board was established in 2022, working with Sir Michael Marmot's team at the Institute for Health Equity and local teams to address these significant challenges. A set of Beacon Indicators have been agreed to monitor progress towards this at both a Cheshire & Merseyside and local level.

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

WIDER DETERMINANTS OF HEALTH

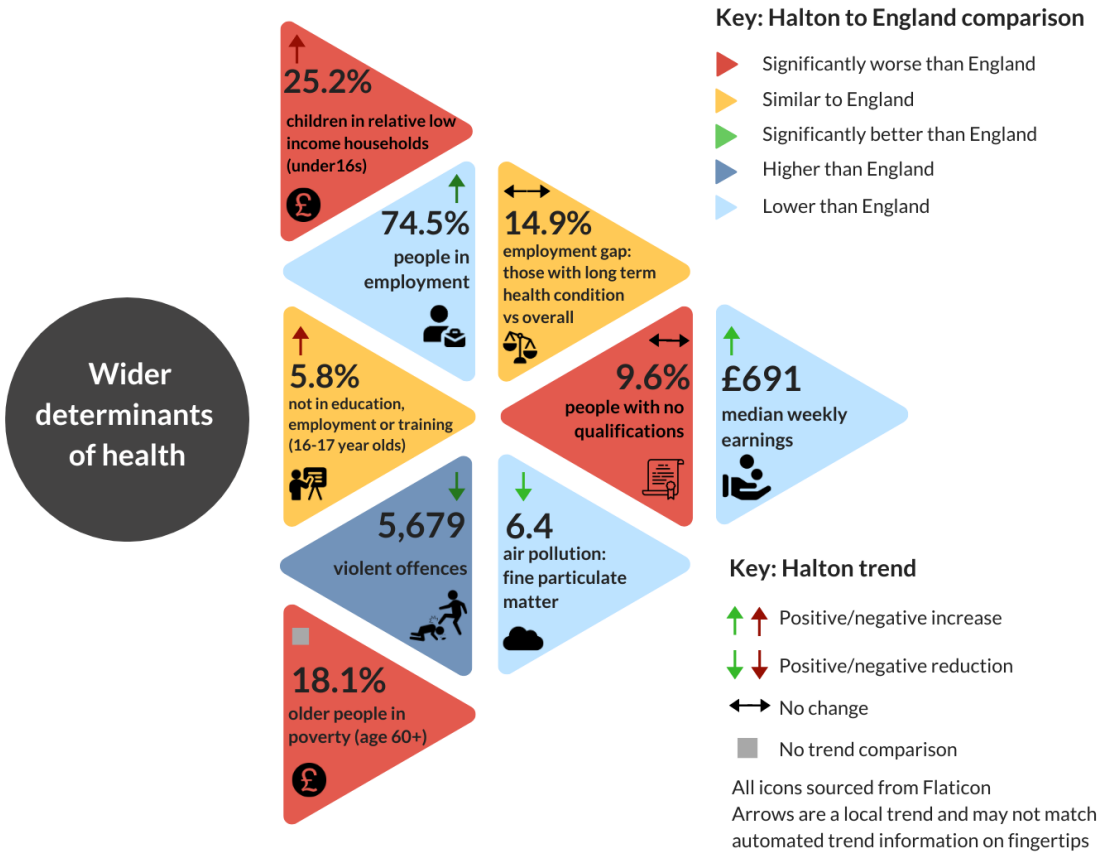
The wider determinants of health

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

King's Fund (2020)

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

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



1. https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health
2. https://fingertips.phe.org.uk/profile/wider-determinants/data#page/1/gid/1938133043/pat/15/ati/502/are/E06000006/iid/93754/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Published data is available from the Wider Determinants of Health | Fingertips | Department of Health and Social Care

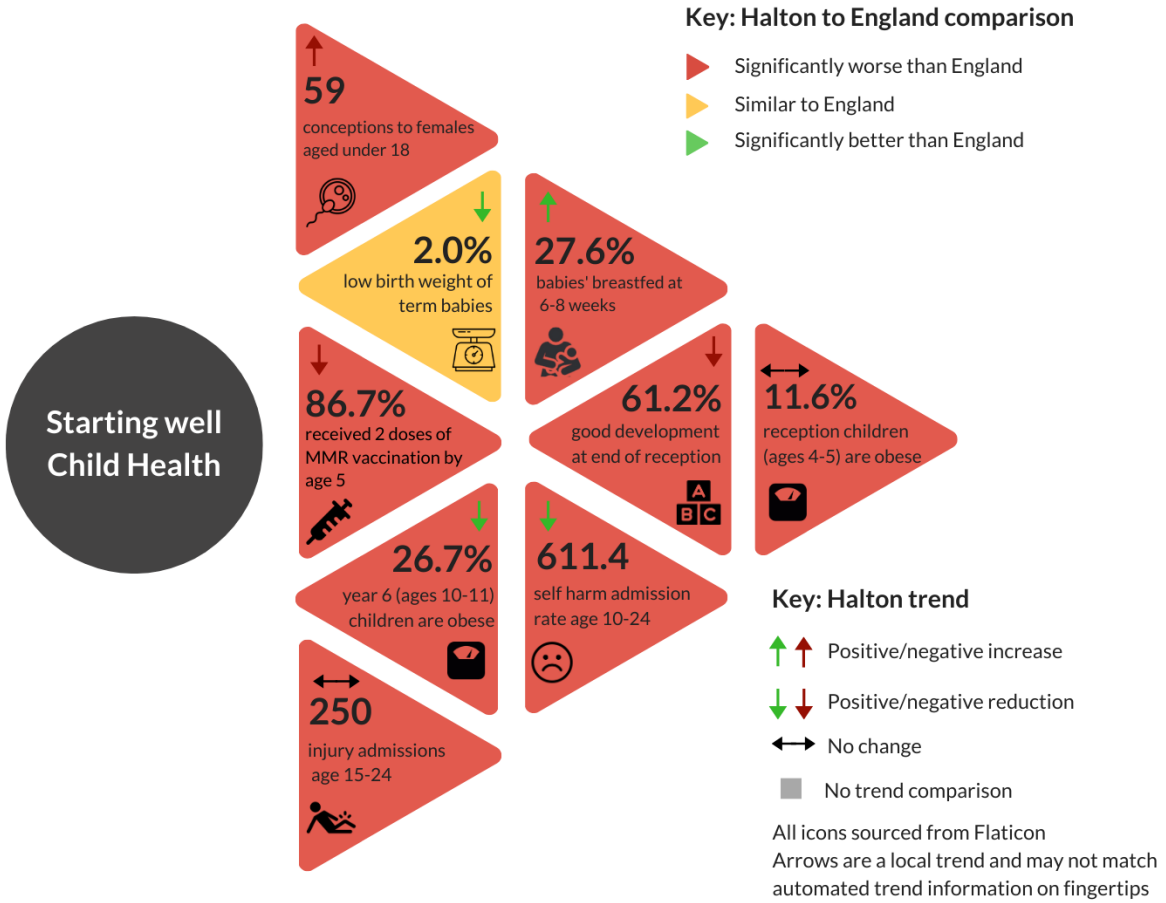
Child health

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

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

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

Published data is available from the Child and Maternal Health - Data | Fingertips | Department of Health and Social Care



LIVING WELL: WORKING AGE

Working age people's health

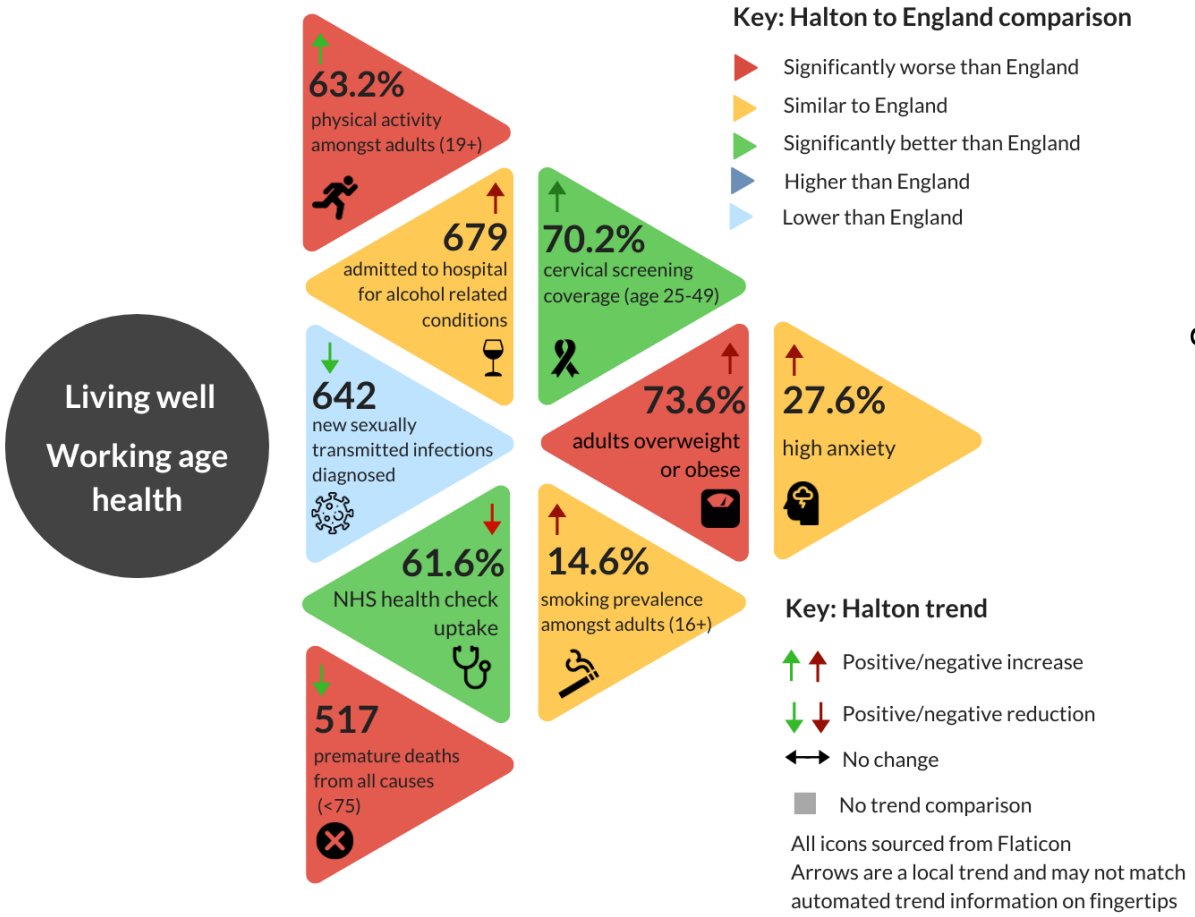
In the coming decades the proportion of the population who will be of working age is projected to reduce. With more people retired and not in work there will be a greater emphasis on social and financial support for those older people who have left employment. As such it is incredibly important that people who *are* of working age are physically healthy and mentally well.

'Lifestyle' factors are extremely important in helping to promote and maintain good health. Improving the prevalence of these lifestyle factors can go a long way to reducing the risk of premature mortality from all causes, specifically from cancer, respiratory conditions, cardiovascular disease and liver disease.

Smoking, low levels of physical activity, being overweight, drinking alcohol to excess and substance misuse are all factors that can influence health, but can be altered given the correct help and support to do so.

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

For published data on general health indicators see the Public Health Outcomes Framework | Fingertips | Department of Health and Social Care



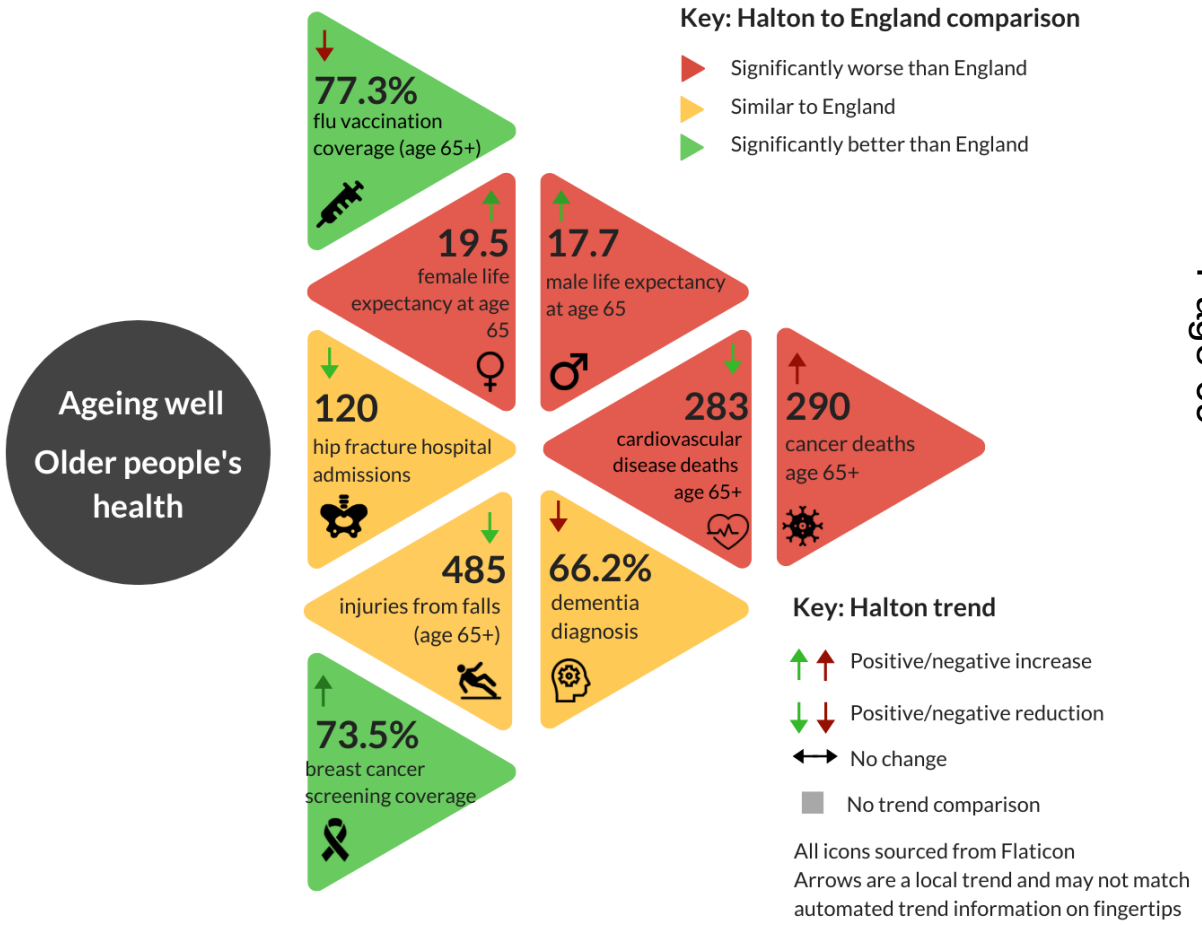
Older people's health

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

Life expectancy at birth in Halton remains lower than the national average, as does life expectancy at 65 years old. For the years 2021-23 it was estimated that at age 65 males could be expected to live on average a further 17.7 years and females a further 19.5 years. However over half of this is estimated to be spent in good health (55% for females and 55% for males). This is a higher proportion than the England average (47% and 45% respectively).

It is incredibly important to provide not just health and social care services, but also things like transport. This creates better mobility and access, promoting greater social inclusion, particularly for those who find it more difficult to make the most of the provision of such services.

There is a wide range of data on older people's health and wellbeing at Fingertips | Department of Health and Social Care although there is no longer a specific profile covering this life stage



FURTHER INFORMATION

JSNA chapters and further information

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

Completed JSNA chapters—as well as other public health evidence and intelligence - can be found through clicking this link:
https://www3.halton.gov.uk/Pages/health/JSNA.aspx

Public Health Evidence & Intelligence Reports and data

People & Groups

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

Behaviours & Lifestyles

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

Conditions

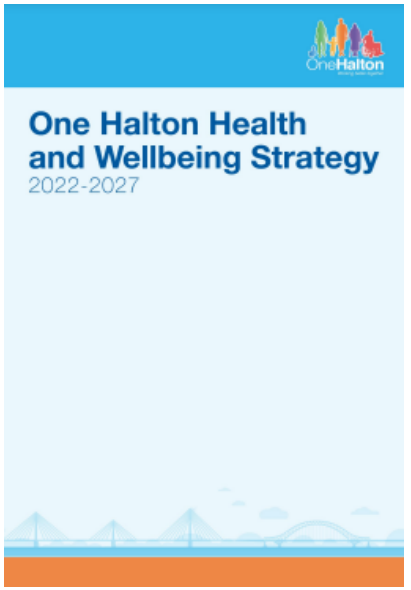
Cancer	Respiratory disease	Diabetes
Mental health	Long term conditions	Musculoskeletal conditions
Circulatory diseases	Excel 2016 ong term neurological	Dental

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

One Halton Health & Wellbeing Strategy

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

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



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

REPORT TO: Health & Wellbeing Board

DATE: 8th October 2025

REPORTING OFFICER: Jane Sanderson, Deputy Head of Quality & Safety Improvement, Cheshire & Merseyside ICB - Halton & Warrington Places

PORTFOLIO: Adult Social Care

SUBJECT: Halton Care Home Development Group

WARD(S) All

1.0 PURPOSE OF THE REPORT

1.1 This report aims to update the Health and Wellbeing Board on the work and progress of the Halton Care Home Development Group over the past 18 months, and to provide an overview of forthcoming plans.

2.0 RECOMMENDATION:

RECOMMENDED: That the report and associated appendix be noted.

3.0 SUPPORTING INFORMATION

3.1 The Care Home Development Group was established to promote a collaborative, system-wide approach to enhancing the care and support provided to individuals residing in care homes across Halton. The group aims to ensure alignment and coordination of initiatives across health, social care, and other key partners. Its focus is on improving standards within the local care home sector by:

- Facilitating joint working across agencies.
- Supporting the implementation of best practices.
- Driving quality improvement projects.
- Ensuring consistent and person-centred care delivery.

3.2 By working together, the group seeks to create a more integrated and effective support system for care home residents, to improve outcomes and experiences.

3.3 The following points provide an overview of some of the key initiatives and developments overseen by the Care Home Development Group aimed at supporting care homes staff to improve resident health and wellbeing needs.

3.4 Through collaboration with the Halton Health Improvement Team, opportunities identified within the Wellbeing Action Plan have been explored to support improved health outcomes and enhance the quality of life for care home residents. This work has focused particularly on addressing frailty, loneliness, and isolation. The development of targeted health and wellbeing training resources has further supported care home teams in delivering more person-centred care.

3.5 Utilising the Care Home Provider Forum, service leads have presented to care home teams, with the aim to raise awareness, improve networks and access to appropriate wraparound care, delivered at the right time and in the right place, to help prevent unnecessary hospital transfers, these include the HICAFS, Urgent Response Service and Later Life and Memory Service.

3.6 In addition, and to compliment wider efforts to ensure care homes are well supported to deliver integrated care, resources have been developed by the General Practice Care Home LES Development Group to clearly outline key contacts for primary care services, including those within Primary Care Networks (PCNs). This aims to improve clarity around roles and responsibilities, support timely and effective communication and enhance coordination of care for residents.

3.7 An ongoing programme of work focused on medicines management quality reviews is continuing across all care homes, including specialist service homes, to consider medication safety concerns, reduce associated risks, and minimise waste. Working alongside Health Improvement Team to support falls prevention, the Medicines Management Team have delivered the Halton Hydration Project which offered co-delivery, by multiple clinical specialisms, of hydration masterclass training to convey prevention messages to care home staff teams.

3.8 Halton In-House Homes have introduced an electronic care management system designed to enhance communication and information sharing between health and social care partners, supporting more integrated and efficient care delivery.

3.9 The implementation of a Trusted Assessor role is supporting care homes and prospective residents in accessing the most appropriate place of care, ensuring a smooth and positive experience during the transfer process.

3.10 The All Age Continuing Care Team has implemented a Digital Referral Portal, which has improved the efficiency, accessibility, and security for Continuing Health Care (CHC) and Funded Nursing Care (FNC) referrals, and requests for enhanced observations. Care Homes providers received focused education and training as part of

this initiative.

3.11 In partnership with NHSE and Chester University, qualified nurses working in social care settings have benefited from continued professional development opportunities through the OSCA-Social project. This short-term funded initiative created accessible learning environments to help participants develop procedural and clinical skills aligned with regulatory standards. Training was delivered via an onsite mobile training unit, offering simulation-based practice, education, and assessment to enhance existing clinical competencies.

3.12 The establishment of an Integrated Information Sharing Group has created a valuable platform for system partners to exchange information and identify themes and opportunities for quality improvement which are fed back to the Care Home Development Group to collaborate and explore actions in response.

3.13 A Clinical Peer Group has been established for registered nurses working across the Halton care homes across inhouse and independent homes. This group provides a valuable platform for sharing best practice, peer learning, and influencing broader quality improvement initiatives.

3.14 Working in collaboration with the Halton Palliative and End of Life Locality Group, care home staff are recognised as key partners in supporting residents to achieve their end-of-life care preferences. Staff have been offered access to Mayfly Training, which equips the workforce with essential knowledge and communication skills to support residents in understanding the messages and principles of Advanced Care Planning and reinforcing the importance of personalised and compassionate care. This also strengthens networks between care homes and subject matter experts through improving inks with the hospice and palliative care services.

3.15 The Care Home Dementia Group was established with the aim of reviewing the current Halton Dementia Strategy and identifying opportunities to enhance the support and services available within care homes. As part of this work, care home staff have received education from specialist dementia leads on key topics such as delirium. Additionally, a dementia quality audit tool has been developed to help care homes assess their own learning needs and identify areas for improvement.

3.16 A review of the Care Home Development Group Action Plan is currently underway, with a continued emphasis on health improvement initiatives to support care home residents in optimising their health and wellbeing.

3.17 A key priority of the group is to formally recognise the strong commitment of care home teams in caring and supporting our resident

population, through a celebration event of the care home sector. This will provide opportunities to acknowledge staff and the care they deliver but also strengthen engagement to inform our areas of focus and next steps.

3.18 Central to the reviewed action plan will be the integration of recommendations from the recently published Capacity Report: *Transforming Workforce and Quality in Residential Nursing Care Homes in the Borough*. The report outlines strategic actions designed to address key challenges within the sector, strengthen workforce retention and drive long-term transformation across the care home sector.

3.19 As an example of how a more integrated and effective support system for care homes can impact positively and improve outcomes and experiences of care home residents, attached **(Appendix 1)** a case study outlining the journey undertaken at Millbrow which resulted in a CQC rating of good during the summer.

4.0 POLICY IMPLICATIONS

4.1 None.

5.0 FINANCIAL IMPLICATIONS

5.1 None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**
The work of the group aims to improve the quality of care, improve well being and health provided to residents who reside in care homes

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

6.3 **Supporting Children, Young People and Families**
N/A

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**
Ensuring that residents who reside in care homes have equitable access to support available across Halton.

6.5 **Working Towards a Greener Future**
N/A

6.6 **Valuing and Appreciating Halton and Our Community**
Residents who reside in our care homes are an integral part of the community of Halton.

7.0 RISK ANALYSIS

7.1 Not applicable.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Not applicable.

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

MILLBROW CASE STUDY

The team at Millbrow were delighted to receive the 'Good rating' from CQC after improvements made in the home were acknowledged by the inspecting team. There were no regulation breaches and each domain received a 'good' rating leading to the overall good rating. Some areas of improvements were noted and are in the process of being actioned.

Millbrow was previously inspected in 2020 and received a 'requires improvement' rating. The main areas of concern that were noted during this inspection were medication management, audits and compliance documents.

There were two regulatory breaches: regulation 12 safe care and treatment and regulation 17 – Good governance.

I began managing the service as an acting manager during covid and officially took on the registration of the home in May 2023. I had worked with many of the staff at Millbrow for a number of years prior to this. There were a lot of residents that had been here a number of years and their family's who used to visit regularly. Good working relationships were made with visiting health professionals and residents and visitors to the home.

Improvement Plan

To enable us to improve the quality of service within the home and the CQC rating we constantly kept everything under review. We adapted to any challenges and looked at best approaches to solve problems. We reviewed lessons learnt following any incidents to help us improve the quality of care being received by residents.

During the inspection, the inspectors spoke with several resident's and several visitors to the home including relatives and health care professionals. They also spoke to several staff who were on duty including HBC staff and agency staff. They fed back to me that overall, the feedback was positive. Residents felt safe and relatives felt happy with the care their loved ones had received. Overall staff reported they were happy in their job and working at Millbrow but sometimes felt overstretched at times. The inspector was happy that I could evidence that I had listened to concerns and actioned them.

CQC Single Assessment Framework

Prior to the visit we had completed a CQC single assessment framework and detailed a number of quality statements, in relation to the assessed domains. Safe, effective, caring, responsive and well led. This tool detailed areas we were doing well in and areas we felt we needed to improve in.

CQC reviewed this during their onsite visit. This evidenced a willingness to improve the quality of the service and showed actions we would take to improve this.

Multi-disciplinary Team

We continue to have good relationships with other health professionals including meds management, Tissue Viability Nurse, General practitioner, Later life and memory service, social work teams, podiatrist. We also work well with the advocacy service who supported a number of resident's within Millbrow. This evidenced safe care, person centred care, working

effectively with other teams, rights of residents, assessing mental capacity.

Medication Management

We were able to evidence that we have improved the management of medication. We were also able to demonstrate that we have processes in place to enable us to identify any medication errors / discrepancies and evidence that these where delt with appropriately. During the visit they did identify a couple of areas of improvement but where happy that we could evidence that we had already identified these and had measures in pace to address these.

Any incidents were investigated and reported as appropriate. Any referrals were made as necessary which included safeguarding, provider concerns, CQC notifications. This evidenced open and honest approach, duty of Candor, legal duty of a registered manager.

Clinical Governance

Millbrow have a senior nurse in post and I myself am a registered nurse which means both myself and the senior nurse are able to offer clinical support and guidance to nurse's who where unsure about certain clinical aspects of care including wound management, deterioration in health and caring for an unwell resident. This resulted in the best care being given in a timely manner. Also, this offers a support network to the staff, and we are able to discuss things with a clinical view. This evidences safe care and treatment.

Feedback "You said we Did"

we reviewed any feedback we received. Open door policy in Millbrow which resulted in visitors coming to speak to me to discuss concerns in an informal manner. This was evidenced to CQC as we have not had a high level of complaints.

Compliance File

These are reviewed monthly but updated regularly as required throughout the month. CQC where able to look at the files and where happy that these where up to date and reviewed regularly. This evidenced a good oversight by the management team and also evidenced good governance systems in place.

Audits/Improvement Quality Plans

CQC commented that they could see that any issues they picked up on, that we were already aware through looking at the completed audits within the compliance files. This demonstrated a good oversight of the service by the management team.

Environment

Although CQC picked up that more work was needed to the environment in relation to décor they did say that they were happy it was a safe environment and did not impact on the safety of the residents. I was able to give them a plan which detailed purposed work which would be carried out in Millbrow which they were happy with.

REPORT TO: Health & Wellbeing Board

DATE: 8th October 2025

REPORTING OFFICER: Transformation Manager, Palliative & End of Life Care - NHS Cheshire & Merseyside.
End of Life Lead - One Halton Ageing Well Delivery Group

PORTFOLIO: Health and Wellbeing

SUBJECT: End of Life

WARD(S) All Wards

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the Health & Wellbeing Board Members of the continued work regarding End of Life (EOL) services in Halton under the direction of the One Halton Ageing Well Delivery Group.

2.0 **RECOMMENDATION: That**

1) the report be noted by Health & Wellbeing Board Members who consider its content, its relevancy to the work of their own organisation/department and opportunities for partnership working in future.

3.0 **SUPPORTING INFORMATION**

3.1 **What is the Need for the Project?**
Does Halton have a healthy EOL System? NHS England has targets relating to Advance Care Planning, Gold Standards Framework meetings and Cardiopulmonary resuscitation (CPR) discussion/decision. Halton is currently the worst performing of the 9 Places in Cheshire & Merseyside.

3.2 **The One Halton Palliative & End of Life Care (PEoLC) Locality Group.**
Project aims to develop an EOL system in Halton which builds relationships & understanding between stakeholders, breaks down silo working and improves services for Halton patients, their families and Carers.
A wide variety of stakeholders participate in the project including General Practice, Hospital Trusts, Community Services, Local Authority and Voluntary, Community, Faith and Social Enterprise Sector (VCSFE).

3.3 **Projects relevant to the NHS England targets:**

- **Advance Care Planning – The Halton Palliative Care & End of Life Personalised Care Plan (Halton PCP)**
  An electronic document (EMIS template) which records and shares the preferences of a patient (such as Place of Care, Place of Death or resuscitation status) across the EOL system. It's for any patient who has been identified as potentially being in their last 12 months of life.
- **EOL Training Opportunities**
  Training is provided which empowers colleagues to recognise the correct time to ask EOL questions, record responses and share with colleagues.
- **Support with Gold Standards Framework (GSF) Meetings**
  General Practice colleagues have been engaged to decide what Best Practice for GSF meetings in Halton looks like. Also ongoing support with any aspect of meetings.
- **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Forms**
  To encourage Practices having CPR discussions with patients we have been delivering DNACPR packs

3.4 **Other Projects for EOL System in Halton**

In 2024 the Locality Group completed the **'Getting to Outstanding'** self-assessment toolkit. Result was a detailed overview of how members view EOL services in Halton and these finding informed the **PEoLC Local Improvement Plan for Halton**.

Areas of focus for 2025-26 (other than projects listed above) include:

- Creation of formal EOL Pathways for Halton Place.
- Supporting the Cheshire and Merseyside (C&M) wide Place Based Needs Assessment project.
- Writing & adopting a Halton Place Equality & Diversity Strategy for PEoLC Services.
- Supporting Claire House with their C&M wide '10 Steps to Transition' project. Developing a Pathway for Transition between Paediatric and Adult services.
- Working with One Halton Ageing Well Delivery Group colleagues to create meaningful engagement vehicles.
- Supporting members to facilitate opportunities for public engagement in co-production and design of local services.
- Supporting the One Halton Ageing Well Board and Clinical Commissioning Network (CCN) colleagues to identify and commission PEoLC services from statutory and VCFSE organisations.
- Supporting the End of Life section of the Halton Dementia Plan. Dementia sub group which is co-chaired by colleague from the Alzheimer's Society.

- Involving Carers and Halton Carers Centre in work of Locality Group.

3.5 **Engagement with VCFSE organisations**
The Halton Compassionate Communities Network is facilitated by Halton & St Helens VCA. It involves the wider VCFSE in EOL work in a way that is meaningful for them. Includes events, forum meetings, documents, bereavement cafes and podcasts.

3.6 **Dying Matters – Engagement Work**
Looking to change people's opinions on death and dying and get them talking to friends and family. Talks are reviewed one month after to assess impact. Opportunity to attend team meetings for H&WBB members organisations greatly appreciated.

4.0 POLICY IMPLICATIONS

4.1 The projects within this workstream may have implications for policies across the Adult Social Care and Care Home sector.

5.0 FINANCIAL IMPLICATIONS

5.1 One of the overall outcomes of the EOL projects is to reduce costs across the health system. For example, a patient with a completed Halton Palliative Care & End of Life Personalised Care Plan (Halton PCP) is less likely to use A&E, be admitted to hospital or die in hospital. There are fewer Out of Hours connections and less unplanned activities for GPs.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence
The Halton Palliative Care & End of Life Personalised Care Plan promotes independence and allows patients to express preferences about the EOL services they wish to access. It improves their wellbeing as well as that of friends and family.

6.2 Building a Strong, Sustainable Local Economy
All of our projects have been achieved without spending any additional money but using resources differently. They are sustainable because they are not dependant on funding. Bringing the organisation together has made them stronger.

6.3 Supporting Children, Young People and Families
None associated with this report.

6.4 Tackling Inequality and Helping Those Who Are Most In Need
Patients from economically deprived neighbourhoods are more likely to die in hospital. A patient with a completed Halton Palliative

Care & End of Life Personalised Care Plan is more likely to have their preferences met.

6.5 Working Towards a Greener Future
Use of electronic documentation across the EOL system reduces use of paper. Fewer unnecessary conveyances to hospital reduces carbon footprint of ambulance services.

6.6 Valuing and Appreciating Halton and Our Community
The Halton Compassionate Communities Network promotes vital support on offer to Halton residents from existing Halton assets.

6.7 Resilient and Reliable Organisation
HBC Care Home Staff can access free training which supports them to their job. The use of the Halton Palliative Care & End of Life Personalised Care Plan increases links and partnership working with General Practice.

7.0 RISK ANALYSIS

7.1 NA

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Equity of service for all Halton Residents is a goal for all of the above EOL projects.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 Use of electronic documentation across the EOL system reduces use of paper. Fewer unnecessary conveyances to hospital reduces carbon footprint of ambulance services.

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

‘None under the meaning of the Act.’

REPORT TO: Health & Wellbeing Board

DATE: 8th October 2025

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Adult Social Care

SUBJECT: Better Care Fund (BCF) Plan 2025/26 – Quarter 1 Update

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To update the Health and Wellbeing Board on the Quarter 1 (Q1) BCF Plan 2025/26 following its submission to the National BCF Team.

2.0 RECOMMENDATION

RECOMMENDED: That the report and associated appendix be noted.

3.0 SUPPORTING INFORMATION

3.1 Following submission of the BCF Plan for 2025/26 in March 2025[1], quarterly monitoring has been mandated from Q1 2025/26 onwards. Attached is a copy of the Q1 report which was submitted in line with the national requirements.

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

- That we have a jointly agreed plans in place;
- We are implementing the BCF objectives;
- We are complying with the grant and funding conditions, including maintaining the NHS's contribution to Adult Social Care; and
- Complying with oversight and support processes.

3.3 **Tab 4 – Metrics**
As part of Q1 reporting, areas were given the opportunity to review and update their original plans for each of the metrics. However, following review, and based on information available, Halton have not amended their original plans.[2]

3.4 **Tab 5 – Expenditure**
This section required confirmation of an update to actual income received in 2025-26

[1] Letter received from NHS England on 11th June 2025, confirming approval of the Plan following the regional assurance process.
[2] *Note*: There was a glitch on the Metrics Tab, which meant that on the cover sheet (Tab 2) it appeared that this section hadn't been completed. The BCF National Team were aware of the glitch.

as well as spend to date. As can be seen the income received is what was planned.

Expenditure as at the end of Q1 was lower than 25% of the planned income. This is due mainly to quarterly contract invoices not being received and paid before the end of the first quarter. Usually these invoices are received in the following period and so should be reflected in the Q2 return.

3.5 In summary, no issues in relation to spend or activity at the end of Q1 are currently being reported. Spend and activity will continue to be monitored via the Better Care Commissioning Advisory Group, as part of the joint working arrangements between the Local Authority and NHS Cheshire & Merseyside (Halton Place).

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 FINANCIAL IMPLICATIONS

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

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

Exploring opportunities for integration further between Halton Borough Council and the NHS Cheshire & Merseyside will have a direct impact on improving the health of people living in Halton. The BCF Plan 2025/26 that has been developed is linked to the priorities identified for the borough by the Health and Wellbeing Board.

6.2 Building a Strong, Sustainable Local Economy

None identified.

6.3 Supporting Children, Young People and Families

None identified.

6.4 Tackling Inequality and Helping Those Who Are Most In Need

None identified.

6.5 Working Towards a Greener Future

None identified.

6.6 Valuing and Appreciating Halton and Our Community

None identified.

6.7 **Resilient and Reliable Organisation**

None identified.

7.0 RISK ANALYSIS

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

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified at this stage.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 None identified at this stage.

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

10.1 None under the meaning of the Act.

Better Care Fund 2025-26 Q1 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE).
https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction

https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any sigificant changes to planned spend.

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

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

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

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

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

Data needs inputting in the cell
Pre-populated cells

Note on viewing the sheets optimally

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

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

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

Checklist (2. Cover)

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

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.
2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

HM Government

NHS England

Better Care Fund 2025-26 Q1 Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

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

Health and Wellbeing Board:	Halton
Completed by:	Louise Wilson
E-mail:	louise.wilson@halton.gov.uk
Contact number:	0151 511 8861
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission? (Please provide name of HWB Chair)	Yes
If no, please indicate when the report is expected to be signed off:	

Checklist
Complete:
Yes
Yes
Yes
Yes
Yes
Yes

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

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	No
5. Expenditure	Yes

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

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2025-26 Q1 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Halton

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

Confirmation of Nation Conditions			
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:**	
1) Plans to be jointly agreed	Yes		Yes
2) Implementing the objectives of the BCF	Yes		Yes
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	Yes		Yes
4) Complying with oversight and support processes	Yes		Yes

Better Care Fund 2025-26 Q1 Reporting Template

4. Metrics for 2025-26

Selected Health and Wellbeing Board: Halton

For metrics time series and more details: BCF dashboard link

For metrics handbook and reporting schedule: BCF 25/26 Metrics Handbook

4.1 Emergency admissions

Actuals + Original Plan		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,852.8	1,732.0	1,933.4	1,993.8	1,913.2	1,732.0	2,013.9	1,711.8	1,812.5	1,933.4	1,711.8	1,772.3
	Number of Admissions 65+	460	430	480	495	475	430	500	425	450	480	425	440
	Population of 65+*	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
	Rate	1,921.3	1,860.9	1,848.8	1,824.6	1,792.4	1,623.2	1,816.6	1,570.9	1,635.3	1,611.1	1,429.9	1,699.8
	Number of Admissions 65+	477	462	459	453	445	403	451	390	406	400	355	422
	Population of 65+	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0

Do you want to update your Emergency Admission metric plan?	No

Please set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care. ↓

Updated Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	What is the rationale behind the change in plan?
Rate	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Number of Admissions 65+													
Population of 65+	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	

Assessment of whether goal has been met:	On track to meet goal
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.	N/A

You can also use this box to provide a very brief explanation of overall progress if you wish.	The UEC improvement programmes across the local systems continue to focus on the attendance and admission avoidance. Attendances, both walk-in an

Did you use local data to assess against this headline metric?	Yes
If yes, which local data sources are being used?	HES Data

4.2 Discharge Delays

Actuals	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	1.28	0.85	1.07	0.79	1.03	1.19	1.18
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	91.8%	93.0%	90.3%	92.2%	92.0%	90.7%	92.6%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	15.63	12.14	11.09	10.14	12.84	12.70	15.97

Original Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients	1.20	1.20	1.10	1.10	1.00	1.00	1.00	1.00	0.90	0.90	0.90	0.90
Proportion of adult patients discharged from acute hospitals on their discharge ready date	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	12.00	12.00	11.00	11.00	10.00	10.00	10.00	10.00	9.00	9.00	9.00	9.00

Do you want to update your Discharge Delay metric plan?	No

Please set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care. ↓

Updated Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	What is the rationale behind the change in plan?
Average length of discharge delay for all acute adult patients	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

Proportion of adult patients discharged from acute hospitals on their discharge ready date												
For those adult patients not discharged on DRD, average number of days from DRD to discharge												

Assessment of whether goal has been met:	On track to meet goal
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.	N/A
You can also use this box to provide a very brief explanation of overall progress if you wish.	There are still data quality issues for the recording of discharge ready delays but there has been improvements in NRTR numbers and the time while recor

Did you use local data to assess against this headline metric?	Yes
If yes, which local data sources are being used?	Hospital Discharge Monitoring

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q2 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	616.3	257.8	217.5	217.5	217.5	217.5
	Number of admissions	153.0	64.0	54.0	54.0	54.0	54.0
	Population of 65+*	24827.0	24827.0	24827.0	24827.0	24827.0	24827.0

Do you want to update your Residential Admissions metric plan?	No

Please enter plan number of admissions within the specific quarter

Please set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care. ↓

Better Care Fund 2025-26 Q1 Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board: Halton

Source of Funding	2025-26 Planned Income	2025-26 Updated Total Plan Income for 25-26	Q1 Year-to-Date Actual Expenditure	Checklist: Complete:
DFG	£2,475,102	£2,475,102	£446,275	Yes
Minimum NHS Contribution	£15,032,442	£15,032,442		Yes
Local Authority Better Care Grant	£8,613,534	£8,613,534		Yes
Additional LA Contribution	£0	£0		Yes
Additional NHS Contribution	£0	£0		Yes
Total	**£26,121,078**	**£26,121,078**		

	Original	Updated	% variance	
Planned Expenditure	**£26,121,078**	£26,121,078	**0%**	Yes

		% of Planned Income	
Q1 Year-to-Date Actual Expenditure	£3,292,137	**13%**	Yes

If Q1 Year-to-Date Actual Expenditure is exactly 25% of planned income, please provide some context around how accurate this figure is or whether there are limitations.	Expenditure to date is currently lower than 25%. This is due mainly to quarterly contract invoices not being received and paid before the end of the first quarter. Usually these invoices are received in the following period and so should be included in the Quarter 2 claim.	Yes
If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.	There has been no change in planned expenditure since the original plan.	Yes