Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS England

BETTER CARE FUND PLAN 2022/2023

HALTON

FINAL DRAFT 200922

Table of Contents

1.0 Cover ... 3

2.0 Stakeholders and how we have involved them ... 3

3.0 Executive summary ... 5

4.0 Governance ... 6

5.0 Overall BCF plan and approach to integration ... 8

6.0 Implementing the BCF Policy Objectives (national condition four) ... 9

7.1 Plans to support people to remain independent ... 9

7.1.1 Intermediate Care ... 9

7.1.2 Multi-disciplinary Teams ... 10

7.1.3 Anticipatory Care ... 11

7.2 Plans to improve discharge ... 11

7.2.1 Hospital Discharge Project ... 11

7.2.2 High Impact Change Model ... 12

7.0 Supporting unpaid carers. ... 13

8.0 Disabled Facilities Grant (DFG) and wider services ... 14

9.0 Equality and health inequalities ... 16

FINAL DRAFT 200922

1.0 Cover

Halton Health and Wellbeing Board

2.0 Stakeholders and how we have involved them

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

A new One Halton Health and Wellbeing Strategy from autumn 2022 – 2027 has been developed (currently going through approvals) for improving health and reducing health inequalities.

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

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

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

With partners being fully involved with the development of the Health and Wellbeing Strategy, as described in our previous plan, the BCF plan for 2022/23 runs parallel to this and all members of the Health and Wellbeing Board will approve the plan and the ambitions for the metrics, which for this current year the targets are aligned to the NHS Cheshire and Merseyside: Halton Integrated Care Board (ICB) agreed planning assumptions. The main trusts that we work alongside and that are members of the HWBB are:

FINAL DRAFT 200922

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

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

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

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

The establishment of a new governance structure, as detailed in section five, in particular the One Halton Operations and Delivery Sub-Committee (a multi-agency partnership), involves the main stakeholders from the acute trusts, who have been fully involved with the development of a Delivery Plan, setting out the key areas of opportunity to move forward with an integrated pathway approach, focussing on those areas that have a clear interface across health and social care.

In addition, the Finance and Performance Sub-Committee (a multi-agency partnership) is the strategic group overseeing Place Based monies, aligned to the local health and care system in Halton, including the Better Care (Pooled) Fund. As detailed in the governance section (5), a new Adult Finance Sub Group is being established at the end of August 2022 to oversee the management and monitoring of the Better Care (Pooled) Fund and monitoring contractual relationships with Providers financed by the Better Care (Pooled) Fund, through the implementation of a performance management framework. This group, previously known as the Better Care Development Group, have continued to undertake this role and set out the schemes and contractual arrangements within the Better Care Fund.

FINAL DRAFT 200922

3.0 Executive summary

During 2022/23, with the establishment of Place Based Systems and Boards across the country, in line with the White Paper Integrating Care: Next Steps to Building Strong and Effective Integrated Care Systems across England, published in February 2021, we continue to work together to transform services across the health and social care system to deliver sustainable change with maximum benefits to communities, residents and patients/users of services and their families and carers. This includes joint accountability and decision-making, improved commissioning and a move to integrated service delivery.

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

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

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

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

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

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

In addition to working towards these themes as a system, the Delivery Plan of the Operations and Delivery Sub-Committee (described in Section 4) sets out the key areas of opportunity for the ODSC to move forward with an integrated pathway approach. It focusses on how the ODSC will deliver on its priorities, through a whole-system approach, with two main priority aims to support people to live an independent life; and regain independence following a change in circumstances.

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

FINAL DRAFT 200922

4.0 Governance

New internal governance arrangements were implemented in September 2022/23. The previous arrangements including the Better Care Development Group (BCDG) and the Executive Partnership Board (EPB) ceased from August 2022 (these have been running concurrently alongside the new sub-committees for a number of months to ensure a smooth transition).

Under the new One Halton Place-Based Partnership, two new sub-committees of the One Halton Board have been established, covering the BCF, as detailed below:

Operations and Delivery Sub-Committee (ODSC) – membership includes the following stakeholders*: HBC, NHS Cheshire and Merseyside ICB: Halton place, Bridgewater Community HealthCare NHS Foundation Trust, Warrington & Halton Hospitals NHS Foundation Trust, St Helens & Knowsley Teaching Hospitals NHS Trust, Merseycare NHS Foundation Trust, Runcorn Primary Care Network, Widnes Primary Care Network, Cera Care, Premier Care Ltd and Halton & St Helens Voluntary & Community Action.*

Purpose and aims include:

- via appropriate joint working agreements/arrangements and reflecting the new ways of working; promote inter-agency cooperation to develop effective partnership working across place based Executive lead officers and key representatives, including provider collaboratives.

- Provide an assurance function to the One Halton Partnership Board by overseeing One Halton's system of operation and delivery work streams to ensure that the delivery of personalised, responsive and holistic care to those who are most in need within our community is in place, enabling One Halton's strategic objectives to be fulfilled.

- Provide a forum for place-based Executive representatives to share information, monitor performance, review and evaluate services, constructively challenge and develop a deeper appreciation of the local system requirements and associated pressures in order to improve quality, productivity and prevention.

- Have oversight and make effective decisions relating to day to day operational delivery and make recommendations to the One Halton Partnership Board where this would change the operational direction of services, with the aim of improving the local heath and care system to deliver better outcomes for the population of Halton.

- Operate within the statutory requirements of each organisation within the One Halton Partnership and assure compliance with member organisation's relevant financial, procurement and contractual standing orders.

FINAL DRAFT 200922

Finance and Performance Sub-Committee (FPSC) – membership includes: *HBC, NHS Cheshire and Merseyside ICB: Halton place, Bridgewater Community HealthCare NHS Foundation Trust, Warrington & Halton Hospitals NHS Foundation Trust, St Helens & Knowsley Teaching Hospitals NHS Trust, Merseycare NHS Foundation Trust.*

Purpose and aims include:

- Review financial performance against the associated Place-Based budgets, including :-
  - The Better Care (Pooled) Fund;
  - Agreed Aligned Budgets; and
  - One Halton Partnership support budget.

- Promote inter-agency cooperation to develop effective partnership working across place-based finance and key representatives (including provider collaboratives), making recommendations to the One Halton Partnership Board, aimed at supporting the delivery of One Halton's strategic objectives.

- Provide an assurance function to the One Halton Partnership Board by overseeing One Halton's system of financial management and to ensure that a robust financial strategy is in place, to enable One Halton's strategic objectives to be fulfilled.

- Provide a forum for place-based finance representatives and other Directors and/or Managers, as appropriate, to share information, constructively challenge and discuss Halton's overall place-based financial position and develop a deeper appreciation of the local system requirements and associated pressures.

- Work and make effective recommendations that aim to improve the local heath and care system to deliver better outcomes for the population of Halton.

- Operate within the financial statutory duties and budgets of each budget's host organisation within the One Halton Partnership and assure compliance with the host organisation's relevant financial, procurement and contractual standing orders.

FINAL DRAFT 200922

5.0 Overall BCF plan and approach to integration

With the newly established One Halton Operations and Delivery Sub-Committee (ODSC) from October 2021, with its main responsibilities including overseeing the operational delivery of the integrated local health and care system in Halton; and promoting inter-agency co-operation to develop effective partnership working across place based Executive lead officers and key representatives, including provider collaboratives, our approach to embedding integrated and person-centred health, social care and housing continues to improve. There has been a shift towards strategic commissioning and a more collaborative approach to planning and improving services. This means that, instead of focusing on procurement and contract management, the role of commissioners is to work closely with key partners across the system (including with providers) to understand population needs, determine key priorities and design, plan and resource services to meet those needs, so the structures being introduced in respect to One Halton and the provider collaboratives will support and enhance this way of working.

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

An evolving Delivery Plan sets out the key areas of opportunity for the ODSC to move forward with an integrated pathway approach. It focusses on how the ODSC will deliver on its priorities, through a whole-system approach. The areas identified are those in a shared space across health and social care, with a clear interface between health and social care.

There are two priority aims which will help inform the ODSC Work Streams to be undertaken. These aims are to support people to:-

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

The following Workstream Delivery Groups have been approved by the ODSC and are progressing, with monthly progress monitoring through the sub-committee. Further workstream areas are being considered by the ODSC.

AIM ONE	AIM TWO
To support people to live an independent life	**To support people to regain independence following a change in circumstances**
• Community Multi-Disciplinary Teams Working • Care Homes • Easy Access to Services (Single Point of Access – SPA)	• Intermediate Care and Frailty Service • Hospital Discharge • Family Hubs

FINAL DRAFT 200922

6.0 Implementing the BCF Policy Objectives (national condition four)

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

7.1 Plans to support people to remain independent

7.1.1 Intermediate Care

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

From 2020/21, significantly more people have received interventions in their own homes with reductions in length of stay in short-term bed based and community Reablement services. This has been achieved through the focused work of all staff, temporary changes in capacity in long term services (notably the block purchase of 500 hours of domiciliary care since February 2020), simplified processes for hospital discharge, focused multi-disciplinary / multi-agency work to improve pathways through short term services utilising nationally endorsed models (ECIST et al) concentrated on day to day caseload management.

This clearly demonstrates that investment in the right community resources can improve outcomes for individuals, reduce reliance on short-term community bed based services (and therefore reduce the number required), reduce the utilization of acute hospitals (with potential to reduce admissions, readmissions and length of stay) and enable further investment in the community infrastructure.

The frailty service commenced in 2019. As part of the reconfiguration for management of the pandemic, this service operated as a rapid response function to support those with higher levels of clinical need in the community and for hospital discharge drawing on community matron capacity. There were 552 people referred to the service (between December 2019

FINAL DRAFT 200922

and December 2021) with the vast majority coming from the community. A&E attends and length of hospital stays were reported at reduced by 15.7% and 20% respectively with 171 people deemed as avoiding a hospital admission (31%). The provision of clinical pharmacy review was calculated to make savings on both hospital admission avoidance and reduction in medications.

In December 2021, the Halton Intermediate Care and Frailty Services (HiCAFS) was launched. The new Service replaces the Rapid Access Rehabilitation Service (RARS), Capacity & Demand Team and the Halton Integrated Frailty Service (HIFS). One of the key elements of the new Service is the introduction of a Single Point of Access (SPA) for Intermediate Care and Frailty referrals (from Hospital and the Community), both for those requiring support within the community and those requiring an Intermediate Care bed.

In addition to the SPA an integral part of the new Service is an associated two-hour Community Rapid Response Function (CRRF) for those experiencing a crisis or at risk of hospital attendance/admission or residential care admission and who can be medically safely treated/cared for in a community setting. The aim of the CRRF is to make contact with the service user/patient being referred within two hours, however, for some individuals, this may not mean being physically seen by the Team.

The SPA is resourced by a multi-disciplinary team consisting of clinicians, nurses, therapists, administrative and social care staff and once referrals are received they are appropriately triaged/assessed and then passed through to the necessary service whether that be the Reablement Service, Oakmeadow Intermediate Care Unit or the Community Rapid Response Function. The aim for the service, as a whole, is for all referrals received by the SPA will have been reviewed, assessed and appropriately actioned within 72 hours of receipt.

7.1.2 Multi-disciplinary Teams

Another key collaboration that contributes steps to personalise care and deliver asset-based approaches and multi-disciplinary teams at place level is the Multi-Disciplinary Team Community project with the aim of defining and developing the culture, systems and pathways in which Community Multi-disciplinary teams in Halton will work and communicate in a continuous and integrated way. The main scope of the project includes a needs-based approach encompassing the whole population (adults, children, families, care homes) where we will identify a common set of principles for our population, underpinned by needs and solutions. A strengths and asset-based approach will be adopted throughout all partner organisations operating in Halton, and we will define what place means at delivery level (i.e. different levels of place e.g. Borough, Town, neighbourhood levels). An approach/service model with a common framework is being developed which will be adaptable to individuals' needs. The developments will be evidence and data driven to align with the needs of Halton's population. Learning lessons and best practice from elsewhere will be taken into account, as well as from our own work, both currently and that which commenced prior to the pandemic.

FINAL DRAFT 200922

The project will also include Integrated and accessible digital records, clarity of governance, responsibilities, structures and decision-making and co-location where appropriate.

7.1.3 Anticipatory Care

The National Anticipatory Care operating model is awaited and once available will be reviewed to ensure the schemes commissioned through the BCF align to the principles within the operating model. This review will also ensure any schemes outside of the BCF which support the delivery of the anticipatory care model are cognisant of the BCF schemes and align where possible.

7.2 Plans to improve discharge

A single co-ordinating provider for domiciliary care in the borough continues to play a crucial role in expediting hospital discharge, whilst the 'reablement first' approach detailed above, links directly to transfer to assess and hospital discharge.

Both hospital trusts use a discharge to assess (D2A) model. With the new HiCAFS service in place and increases in capacity in the discharge teams, continuing healthcare team and Intermediate Care will support the management of long lengths of stay and preventing hospital admission.

7.2.1 Hospital Discharge Project

The Hospital Discharge project group are currently undertaking a review the Hospital Discharge pathways, associated processes and performance in respect to Halton residents, with the aim of ensuring that Service Users receive timely and appropriate discharge from Hospital and that the systems and processes in place to support the Discharge pathways are fit for this purpose. Any improvements to current Hospital Discharge pathways would support the best outcomes for people leaving hospital, further reduce the length of stay of acute admissions and aim for a higher proportion of people to be discharged on the day that it is determined they no longer need the support of an acute hospital. Benefits include improved patient care, experience and satisfaction and overall efficiency and effectiveness of the Hospital Discharge process. As part of the review, work will be undertaken to assess how and what systems are used to record and report on performance.

FINAL DRAFT 200922

7.2.2 High Impact Change Model

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

Impact change	Action	How will you know it has been successful?
Change 1: Early discharge planning	The 100 day challenge for the high impact changes needs to be reviewed prior to winter and early discharge planning has been identified as a priority area to work on.	The percentage of patients with no right to reside will reduce to the national target of 10% and average lengths of stay will improve overall
Change 2: Monitoring and responding to system demand and capacity	System and partnership working needs to be part of the CMAST and Out of Hospital provider alliance workplans in collaboration with the Place Based delivery programmes. Winter preparations need to make the necessary capacity available for any increased demand and be able to be flexible to ensure escalation is possible if threshold triggers are reached.	Improved system partnerships and less congestion in set points of the pathway
Change 3: Multi-disciplinary working	Improvements have been made and capacity has been increased but there are still challenges and barriers to effective communication between the teams. Halton has a discharge steering group in place to review the current processes and make improvements. Without system interoperability there will be a limitation on the full extent to shared records.	Reduction in the time to gather all the information required to discharge a patient, and improved timeliness of social worker involvement in the discharge planning, which will reduce the time taken to arrange a care package and clear the hospital beds.
Change 4: Home first	All boroughs across Mid Mersey have different processes and are at different positions to be able to move to a home first and discharge to assess model. There needs to be agreement on a joint framework to move to a discharge to assess model.	Increased decisions about patient needs and care plans being made in their own home with their families. Reduced levels of patients remaining in hospital who no longer have the right to reside.
Change 5: Flexible working patterns	Continue the existing arrangements for seven day working and support the hospitals to increase the pathway 0 discharges over the weekends.	Improved continuous processes would reduce the variations between the peaks and troughs over the week.
Change 8: Improved discharge to care homes	The Enhancing Care in Care Homes plans should be in place by the end of the current financial year.	Reduction in patients being conveyed to hospital to receive care. Improved experience of residents in care homes.
Change 9: Housing and related services	Continue to monitor the situation and review if there are issues identified.	Reduction in delays to discharge due to waiting for home adaptations to be undertaken.

7.0 Supporting unpaid carers.

The Care Act 2014, the Children and Families Act 2014 and *People at the Heart of Care: Adult Social Care Reform White Paper 2021* introduced a number of reforms to the way that care and support for adults with care needs are met. It requires local authorities to adopt a whole system, whole council, whole-family approach, co-ordinating services and support around the person and their family and considering the impact of the care needs of an adult on their family, including children and empowering unpaid carers.

This means that children's and adults' services must have arrangements in place to assess young carers and ensure that no young person's life is unnecessarily restricted because they are providing significant care to an adult.

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

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

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

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

We are supporting unpaid carers through BCF funding allocated to Halton Carers Centre to deliver a Carers' Personalised Break Fund to enable carers to have a break from their caring role. This provides support to a range of carers that works towards the prevention, reduction and delay of the need for care and support for individuals and to improve people's wellbeing.

Further funding is allocated to support provision of a home-based respite care service, which provides breaks for carers and to assist people to live in their own homes to remain independent for as long as possible. This service provides home care normally provided by the unpaid carer and allows that carer to have respite from their role. BCF funding supports the provision of 6,085 hours of respite care in Halton to unpaid carers.

FINAL DRAFT 2022

8.0 Disabled Facilities Grant (DFG) and wider services

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

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

Halton have traditionally used mandatory grants for:

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

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

• Providing a 'fast track' scheme for low level adaptations not requiring a full social care assessment or a means test or for those facing end of life.
• The effective utilisation of new technologies to support independence e.g. telehealthcare.
• Provision of relocation grants to help people to move to a more accessible home.

FINAL DRAFT 200922

• Dealing with small repairs and heating problems, allowing people to live well in their home for longer and/or helping people to return to their home faster (e.g. hospital discharge)
• Issue of aids and equipment which allow people to maintain their independence for longer – including mobility aids and personal care equipment.

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

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

FINAL DRAFT 200922

9.0 Equality and health inequalities

The One Halton Health and Wellbeing Strategy 2022 – 2027 sets out how, as a system, we are aiming to work together to develop pro-active prevention, health promotion and identifying people at risk early, when physical and/or mental health issues become evident, will be at the core of all our developments, with the outcome of a measurable improvement in our population's general health and wellbeing. The BCF is considered as part of the wider borough work on health inequalities, and will contribute to the following actions to reduce inequalities in Halton:

- Supporting a community development asset-based approach and community-led initiatives that build capacity for local people to become more informed and involved in decision about their health.
- Improving access to services for people and groups most at risk of poor health
- Developing the health and social care workforce to ensure they have the knowledge, skills and understanding about how to identify and respond to need and inequalities, signposting and referring appropriately.
- Delivery of Core20PLUS5 NHS initiative supported by partners and the community

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

The Local Authority and the NHS Cheshire and Merseyside ICB - Halton place are also working together to develop services centred around care homes, including medication and dementia screening and strengthening clinical nursing support for residents and staff alike.

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

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[i] *As a result of the new Health and Care Act 2022, NHS Clinical Commissioning Groups (CCGs) ceased to exist in statutory form from 30th June 2022 and in addition, from 1st July 2022, there was a formalisation of the Integrated Care Systems into a new statutory body, an Integrated Care Board (ICB).*

In Halton, we acknowledged the establishment of NHS Cheshire and Merseyside which assumed the responsibility of NHS Halton CCG and as such all of the CCG's functions and duties transferred to the

FINAL DRAFT 200922

ICB, along with all CCG assets and liabilities, including the CCG's previous commissioning responsibilities and contractual agreements.

As such, the current Joint Working Agreement (JWA) (Pursuant to S.75 of the National Health Service Act 2006), between Halton Borough Council (HBC) and NHS Halton CCG, which relates to the Better Care (Pooled) Fund, between HBC and NHS Halton CCG covering a period of 3 years (1st April 2020 to 31st March 2023), transferred over NHS Cheshire & Merseyside ICB following the dissolution of the NHS Halton CCG on 30th June 2022.

FINAL DRAFT 200922