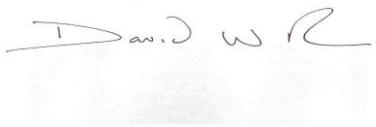
Public Document Pack

Health and Wellbeing Board

Wednesday, 29 March 2017 2.00 p.m.
Karalius Suite, Halton Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on 5th July 2017

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

Part I

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HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 18 January 2017 at Karalius Suite, Halton Stadium, Widnes

Present: Councillors Polhill (Chair), T. McInerney, Woolfall and Wright and S. Banks, S. Barnard, P. Cook, G. Ferguson, J. Hester, T. Hill, M. Larking, D. Lyon, M. McIntyre, E. O'Meara, R. Strachan, M. Pickup, C. Samosa, S. Semoff, L Thompson, T. Tierney, A. Williamson, P. Williams

Apologies for Absence: A. Marr, H. Patel, D. Parr, M. Sedgewick, S. Wallace Bonner and S. Yeoman

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB19 MINUTES OF LAST MEETING

The Minutes of the meeting held on 12th October 2016 having been circulated were signed as a correct record.

HWB20 PRESENTATION - EMERGENCY CARE IMPROVEMENT PROGRAMME FOR HALTON (ECIP) VISIT TO WARRINGTON AND HALTON HOSPITALS - STEVE BARNARD TO ATTEND

The Board received a presentation from Steve Barnard, Improvement Manager, Warrington and Halton Hospitals NHS Foundation Trust, which outlined the Emergency Care Improvement Programme (ECIP). The ECIP was created in 2015 to focus support on local health and social care systems with long-term challenges in the delivery of the National Accident and Emergency Access Standard. The Programme incorporated the Emergency Care Intensive Support Team, bolstered with a broadened professional range of clinicians and social care experts.

The presentation outlined the focus of ECIP, the tools that could be used to transform performance, how data was used to help clients to achieve effective outcomes and

progress to date. The Board noted that the four priority areas for improvement were:-

- Developing system leadership;
- Assessment prior to admission;
- Doing today's work today; and
- Discharge to assess.

RESOLVED: That the presentation be noted.

HWB21 ONE HALTON HEALTH AND WELLBEING STRATEGY 2017-2022

The Board considered a draft copy of the One Halton Health and Wellbeing Strategy 2017–2022. The Strategy was an overarching Strategy to improve health in Halton. The new Strategy would build upon the successes of the previous Strategy and outline the key priorities the Health and Wellbeing Board would focus on over the next five years. It was noted that the Strategy provided a framework for local action and a set of action plans with timescales and leads were also being developed. The new Strategy provided:-

- An overview of One Halton;
- Principles of how we will work together;
- A joint vision, new priorities and how and why these were chosen;
- An updated health and wellbeing profile for Halton;
- An outline of the progress made since 2013 and the challenges that remained;
- Examples of innovative work already being undertaken within Halton that take a place based approach, working with local people and using local assets e.g. Well North, Healthy New Towns;
- What we will do as a system at scale to make a difference; and
- How we will measure success.

The Board was advised that the Strategy had been developed using a partnership approach and was developed by a multi -agency steering group. In addition, a wide range of Halton residents had been consulted on the new Strategy to ensure that the principles and priorities were reflective of the experience and needs of the local community. The final version of the Strategy would be shared with all key partners (including local people) and would be available on line.

RESOLVED: That the draft Strategy be noted and the Board supports the development of Action Plans for each

priority.

HWB22 CHESHIRE AND MERSEYSIDE SUSTAINABILITY AND TRANSFORMATION PLAN

The Board received a presentation from Simon Banks, Chief Officer, Halton Clinical Commissioning Group, (CCG) which provided an overview of the Cheshire and Merseyside Sustainability and Transformation Plan (STP). The STP set out the following four key priorities for Cheshire and Merseyside:

- Support for people to live better quality lives by actively promoting health and wellbeing;
- Working together with partners in local government and the voluntary sector to develop joined up care;
- Designing hospital services to meet modern clinical standards and reducing variation in quality; and
- Being more efficient by reducing costs, maximising value and using the latest technology.

The Cheshire and Merseyside STP was submitted to NHS England on the 21st October 2016 and, following review by NHS England, was published on 16th November 2016.

Members were advised that the Cheshire and Merseyside STP was designed to address the challenges of the region in terms of population health and wellbeing, quality of care and financial sustainability. The majority of delivery would be through the plans developed by the three local delivery systems. It was noted that Halton CCG was part of the Alliance Local Delivery System (LDS) which consisted of:

- Four CCGs (Warrington, St. Helens, Halton and Knowsley);
- Five NHS providers (Five Boroughs Partnership NHS Foundation Trust, Bridgewater Community NHS Foundation Trust, St. Helens and Knowsley Teaching Hospitals, Warrington and Halton Hospital Foundation Trust and Southport and Ormskirk Hospitals).

The Alliance LDS was also engaging with local authorities covering the Boroughs of Halton, Knowsley, St. Helens and Warrington. The Alliance LDS built upon the work already being done at a local level and the proposals submitted by Alliance LDS included options and models of transformation for the local health system that aimed to address a funding shortfall of £202m, whilst at the same

time improving health, wellbeing and outcomes.

Following formal publication of the Cheshire and Merseyside STP, the proposals were now being developed into outline plans and would commence wide scale programme of engagement and communication during 2017.

The presentation outlined to the Board the progress to date in Halton which included a local picture of how the LDS proposals built upon what was already planned and happening in Halton, including examples of how the LDS would positively impact on Halton residents.

RESOLVED: That

1. the contents of the Cheshire and Merseyside Sustainability and Transformation Plan (STP) be noted; and

2. the commitment to continued local engagement and the requirement to comply with statutory requirements for public involvement and to seek the views of the Health and Wellbeing Board about the next phase of local engagement be noted.

HWB23 SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2015/16

The Board considered a presentation by the Independent Chair of the Halton Safeguarding Adults Board (SAB), which outlined the Annual Report 2015/16. The Board was advised on the role of the SAB, the criteria for the Council to investigate (Section 42 Care Act), Deprivation of Liberty Safeguards and achievements in Halton. The main findings highlighted in the report included:

- Referral numbers had been steady and in line with national figures;
- In 2015/16 Halton Safeguarding Unit received 769 number of referrals;
- Women over 65 living at home were most at risk of abuse; and
- Physical abuse was the highest category of reason for referral but neglect and financial abuse was also noticeable.

RESOLVED: That the report be noted.

HWB24 OLDER PEOPLE JOINT STRATEGIC NEEDS ASSESSMENT

The Board considered a report of the Director of Public Health, which provided an update on the Joint Strategic Needs Assessment (JSNA). Following the JSNA focus on Children in 2013/14 and Lifestyles and Long Term Conditions in 2014/5, the 2015/16 JSNA focussed on the Health, Wellbeing and Social Care needs of older people i.e. those people aged 65 and over.

In July 2015, a multi-agency steering group was established to oversee the development of the JSNA. A number of interrelated but stand-alone chapters were agreed by the Steering Group and these were completed by September 2016 and were available on the JSNA webpage. A copy of the Halton JSNA 2015/16 had been previously circulated to Members of the Board.

RESOLVED: That the findings of the Older People's JSNA be noted.

HWB25 PUBLIC HEALTH PREVENTION PROGRAMME FOR ALCOHOL, BLOOD PRESSURE AND ANTI MICROBIAL RESISTANCE

The Board considered a report of the Director of Public Health, which sought support to roll out prevention programmes at scale in Halton hospitals, primary care and community and to incorporate them in the Cheshire and Merseyside Five Year Forward View Plan. The prevention programme would focus on blood pressure, alcohol misuse and antimicrobial resistance in Halton and out of Halton services, such as hospitals. The report highlighted priority interventions and key priority areas for local action within the three intervention programmes.

RESOLVED: That

1. the roll out of prevention programmes at scale commencing with blood pressure, reduced harm from alcohol and antimicrobial resistance be supported; and

2. the prevention programmes are incorporated in the Cheshire and Merseyside 5 Year Forward View Plan.

Meeting ended at 3.30 p.m.

REPORT TO: **Health and Wellbeing Board**

DATE: **29th March 2017**

REPORTING OFFICER: **Strategic Director, People**

PORTFOLIO: **Health and Wellbeing**

SUBJECT: **Dementia Update**

WARDS: **All**

1.0 PURPOSE OF THE REPORT

To provide an update to the Board on Dementia diagnosis rates, services and priorities.

2.0 RECOMMENDATION: That the report be noted.

3.0 SUPPORTING INFORMATION

3.1 Dementia Strategy and Dementia Delivery Group

The Halton Dementia Delivery Group is a multi-agency group that represents health, public health, social care, voluntary/community sector and carers and is responsible for the delivery of the 'Living Well with Dementia in Halton' Strategy. This strategy aims to encourage early, accurate diagnosis and to ensure health, social care services and the community/voluntary sector are organised so that those living with dementia, and their carers, have access to care and support that is informed by best practice and meets local demands. The Dementia Delivery Group reports to the overarching Mental Health Oversight Group.

The strategy runs from 2013-2018, with the delivery plan being updated in early 2017, in line with the refresh of the overarching All Age Mental Health Strategy. Actions in the delivery plan will also take into account recommendations from the ADASS North West Dementia Perspectives report.

3.2 Dementia Diagnosis Rate in Halton

There is a target set locally by NHS Halton Clinical Commissioning Group (CCG) of a diagnosis rate of 75% by March 2017.

Halton reached a diagnosis rate of 72% in April 2016, however following this, the tool used for data capturing was changed, meaning only people aged 65+ with a diagnosis contributed towards the rates, excluding all those identified with early onset. As Halton practices had a significant

number of patients with early onset, this resulted in a sudden drop in the diagnosis rate. From April 2016, the prevalence figures for Halton were also increased, resulting in another drop of the diagnosis rate. The latest available (October 2016) had the Halton diagnosis rate for people over the age of 65 at 72%.

Work has been done locally to focus efforts on improving diagnosis rates, including regular contact with practices by NHS Halton CCG to raise awareness of the use the Dementia Quality Toolkit (DQT) and maintaining data quality through regular cleansing. The DQT consists of a series of reports and queries run directly on GP systems to identify patients who may have dementia, but who are not coded as such within the practice.

It is now widely accepted that diagnosing dementia enables individuals to gain access to care and support, and therefore support better outcomes for people. Whilst dementia is an incurable, progressive disease, a diagnosis as early as possible and that is done in a timely manner, allows people with the disease to have the opportunity to make decisions about their future care and support, whist they are able. Work has been undertaken locally to ensure that post diagnosis support within the community is varied and responsive to people's needs, working alongside clinical treatment and support to enable people to live well with dementia for as long as possible. Work has been underway to inform Primary Care of positive changes to the Halton Post Diagnosis Community Pathway, further encouraging practices to diagnose dementia through reassurances that there is access to appropriate, quality community provision that is in line with NICE recommendations.

A care home screening pilot took place over a 4 week period in March 2016, with the Later Life and Memory Service Care home Liaison Team (CHL) screening patients in care homes (where families gave consent), who did not have a diagnosis of dementia. This resulted in 18 people being diagnosed. Due to the success of the pilot, the CHL has rolled this out to all other care homes from September 2016.

In April 2017 the calculation that NHS England uses to derive the local diagnosis rates will change again. However, NHS Halton CCG expects that this will have a positive impact on Halton's diagnosis rate; therefore the target of 75% will remain for 2017/18.

3.3 Later Life and Memory Service Performance (LLAMS)

The revision of the The Halton Later Life and Memory Service (LLAMS), delivered by 5 Boroughs Partnership in 2013, has offered rapid access to specialist cognitive assessment, diagnosis and intervention and treatment for those living with dementia, and for those with a functional mental illness who have later life needs. The service model provides the following:

- A single point of access
- Same day screening & prioritisation of all referrals by a senior nurse
- Same day face to face assessment for urgent referrals
- Face to face assessment within 10 working days for all non-urgent referrals
- Crisis intervention and rapid response where deemed necessary following assessment

Since 2013, the LLAMS pathway has seen an increase in referrals. Ninety eight percent (98%) of referrals are being offered an appointment within 10 days of referral, 99% of all urgent referrals are seen within 24 hours.

3.4 Post Diagnosis Community Pathway

The pathway underwent review during 2015/16, with a Prime Provider model being adopted for 2016/17 on an initial 2 year contract, with an option to extend for a further year. The pathway offers a single point of access, information upon diagnosis and at each stage of the person's dementia journey, ongoing navigation support through the dementia pathway through the Dementia Care Advisor service, signposting to appropriate support provided by pathway partners, community and voluntary sectors and other sources of dementia specific and universal information and support, access to recreational groups, peer support and on-going support for carers – including information, activities and caring skills training and the Halton Admiral Nurse Service providing specialist support for the most complex and/or severe cases.

3.5 Later Life and Memory Service Care Home Liaison Team (CHLT)

The Care Home Liaison Team (CHL) are commissioned by NHS Halton CCG through 5BP, to improve patient care, reduce the level of psychiatric morbidity within care homes and prevent inappropriate admissions/readmissions into acute and secondary care. This includes assisting and supporting care home staff, families and carers to understand the journey of dementia through education, training, supervision and role modelling.

3.6 START (Strategies for Relatives)

START is an eight session manual based intervention aimed at promoting the development of coping strategies for carers of people with dementia. The intervention equipping carers early on in their caring journey with acceptance and positive techniques. The University College London (UCL) trial of START showed that this intervention reduced depression and anxiety for family carers of people with dementia. Even up to two years later people who received this support were able to manage their caring role and changes they may face, with less anxiety and symptoms of depression than those who didn't receive the support.

A small local pilot was undertaken in 2015/16 to test the need and suitability of the intervention in Halton. From January 2017 Halton Carers' Centre include START as part of their offer to Dementia Carers, with supervision from Halton Positive Behaviour Support Team.

3.7 Living Well Memory Screening Training

After a small local pilot, training to screen for memory problems using the NICE recommended 6CIT tool has been developed by Halton's Integrated Health and Wellbeing Team. Training on awareness and undertaking screening is now available to front line staff in partner organisations. The intervention supports the 'every contact counts' approach by the use of non-clinical community based staff in identifying signs of possible memory or cognition problems, and the use of the 6CIT tool and referral pathways. The aim is to promote awareness of dementia amongst front line professionals and increase dementia diagnosis rates through early intervention. The pilot, and subsequently developed training programme, also incorporates falls risk assessment and assessment of social isolation/loneliness.

3.8 Halton Dementia Action Alliance (DAA)

Since late 2014 the Halton DAA has gained 30 active member organisations representing health, social care, voluntary, community, recreation, retail, faith, housing and emergency services. All of which have action plans detailing what actions they are taking to improve the lives of people living with dementia, and their carers. However, the wider DAA network is growing, with between 60-120 people representing a range of organisations attending the quarterly events. DAA members and those participating in the wider DAA network have contributed to the Dementia Chapter of the Joint Strategic Needs Assessment, the START pilot and subsequent roll out of the intervention by Halton Carer's Centre, the Living Well pilot and subsequent development of the training programme and service developments such as the formation of a younger carers Dementia support group delivered by Halton Carer's Centre and the revision of the post diagnostic community pathway.

The DAA has provided the vehicle for Halton to achieve 'Working towards becoming a dementia friendly community' status, which it has held since early 2015.

3.9 Healthy New Town Project

One aspect of Halton's Healthy New Town (HNT) development is the redesign of health and social care services, using innovative approaches, to meet current and future needs. One such involves Runcorn Shopping Centre (RSC) to deliver a dementia-friendly environment. This will use digital technology to support individuals to shop and socialise safely and with confidence. In addition, RSC staff will

be skilled to identify and address individuals with dementia as a means of further developing our 'safer in town approach.'

If successful, the hospital site within the planning area will be linked with GP practices and will deliver integrated health and social care teams to provide in-reach and out-reach support across the community. This will be in existing health venues, in people's homes and in community spaces and in outdoor 'clinical' facilities. These teams will incorporate a range of disciplines from doctors to domiciliary support, community psychiatry to holistic therapists and health improvement specialists. This will ensure provision can address challenges such as dementia through the provision of good quality residential and home care services, alongside wellbeing enhancing activities and support.

3.10 Halton Admiral Nurse Service

Admiral Nurses are specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia. They offer support to families throughout their experience of dementia that is tailored to their individual needs and challenges. The team provides families with the knowledge to understand the condition and its effects, the skills and tools to improve communication, and provide emotional and psychological support to help family carers carry on caring for their family member.

The service comes with an element of a *given* remit to work with those patients and families with the most complex needs as a result of coping with a diagnosis and the associated behaviours. However, the Admiral Nurse Service has been tailored to the needs identified in Halton, and complements the range of existing community provision within the borough.

3.11 Joint Strategic Needs Assessment (JSNA)

The dementia chapter of the Older People's JSNA was published in September 2016, which outlines the current and projected level of need of people living with dementia in Halton. The JSNA goes some way to identify emerging issues and key priorities. The JSNA chapter can be viewed at http://www4.halton.gov.uk/Pages/health/JSNA.aspx

3.12 Emerging Issues:

Reviewing Dementia Priorities

NHS Halton CCG are looking to focus their next set of dementia priorities around working with Halton Council Quality Assurance Team to identify ways of training all care home staff in how to recognise the signs of dementia and screen patients appropriately. The CCG are also keen to explore technology based support if it is available and has evidence base and plans to expand the Dementia Friends initiative and increase membership of the Halton Dementia Action Alliance.

Secondary Care Data

Continue working with GP practices and secondary care in the sharing of information between primary and secondary care, particularly around diagnosis.

North West Coast Strategic Clinical Dementia Network Group

Continued participation in the Dementia Clinical Network provides targeted support, tools and resources to aid better understanding and improvements in local dementia diagnosis rates and post diagnostic care and support. This network has representation from NHS Halton CCG and Halton Borough Council.

Beyond the Front Door

Halton DAA are supporting Life Story Network (part of Liverpool DAA) in the Department of Health funded 'Beyond the Front Door' project, which will explore issues relating to the concept of 'home' to better understand the sense of identity and wellbeing for people living with dementia in order to improve post-diagnostic and multi-agency support. The objective is to develop a set of products that support staff in working with people affected by dementia across the range of agencies (Housing, NHS Trusts & NHS and LA Commissioners), with responsibility for both commissioning and providing meaningful post diagnostic care and support. From August 2016, representatives from Halton have been present in several focus groups of older people via Halton Housing Trust, along with two Halton Housing Trust staff participating in the focus group session for the housing sector. Multi- Disciplinary work-shops took place in December 2016 to progress this work.

4.0 POLICY IMPLICATIONS

There are a number of policy drivers for the work of the Dementia Delivery Group, namely:

'Living Well with Dementia: A National Dementia Strategy' aimed to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care.

The Prime Minister's Challenge on Dementia 2020 aims to deliver major improvements in dementia care and research by 2020.The Prime Minister's Challenge provides a framework which directs national and regional action. The goal is to make a real and positive difference to the lives of people affected by dementia.

The Care Act 2014 is designed to create a principle where the overall wellbeing of the individual is at the forefront of their care and support. To

promote individual wellbeing, their needs, views, feelings and wishes should be considered in all aspects of their wellbeing from physical and mental health, through dignity and respect to control over their daily needs, access to employment, education, social and domestic needs and the suitability of their accommodation. Whilst the Act incorporates care and support across the board, when thinking about how dementia services are developed, the Local Authority and health care partners need to consider the following:

• access to services that help prevent their care needs from becoming more serious
• access to good information to help them make informed choices about their care and support have a range of good care providers to choose from
• the public know how to access independent financial advice
• the public know how to raise concerns over the safety or welling being of someone with care needs

Living well with dementia in Halton ‘local strategy and implementation plan compliments other work programmes including the Halton Sustainable Communities Strategy, Mental Health Strategy, the Halton Health and Wellbeing Strategy, Carer’s Strategy Action Plan, Falls Strategy and Loneliness Strategy.

Halton Health and Wellbeing Strategy prioritises Mental Health across the life course, including dementia and organic cognitive decline.

Care and Support services in Halton are in line with recommendations out lined in **NICE Quality Standards and Guidance for Dementia:**
NICE Pathway for Dementia
NICE Quality Standard 1: Standards of care for people living with dementia
NICE Quality Standard 30: Supporting people to live well with dementia.
NICE guidance Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset?

Halton Dementia Delivery Group contributed to the 2016 ADASS ‘Dementia Perspectives, State of the Region Report’. The report made a number of recommendations, many of which Halton could demonstrate that progress was already being made locally. The ADASS report findings; best practice and recommendations will be considered in the refresh of the Halton Dementia Strategy Delivery Plan.

5.0 FINANCIAL IMPLICATIONS

The resource implications of the activities outlined above have been approved through the appropriate boards i.e. Operational Commissioning Committee (OCC), Service Development Committee.

6.0 RISK ANALYSIS

None identified at this time

7.0 EQUALITY AND DIVERSITY ISSUES

None identified at this time.

8.0 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: 29 March 2017

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Bowel Cancer Screening Intervention

WARD(S) Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 To provide an update to Health & Wellbeing Board of the research study undertaken around Bowel Cancer Screening in Halton.

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

3.0 **SUPPORTING INFORMATION**

3.1 Bowel Screening is currently led by Public Health England but performance is monitored at local authority level. (2.20 National Screening Programmes)

3.2 The Bowel; Screening programme offers screening every 2 years to all men and women aged 60-74. People eligible for screening receive an invitation letter explaining the programme, along with an information leaflet explaining the benefits and risks of screening.

About a week later, the programme should send a faecal occult blood sampling kit. The kit includes simple instructions for:

- completing sampling at home
- sending the samples to the laboratory

The sample is then processed and the results sent to the individual within 2 weeks.

3.3 Currently the Halton screening uptake is 52.2% with a North West average of 55.9% and a National Average of 57.1%. The Public Health Outcome Framework (PHOF) and the NHS Outcome Framework both share two key indicators around Cancer which are:-

- Cancer diagnosed at stage 1 and stage 2 (PHOF 2.19, NHSOF 1.4vi)
- Under 75 mortality rate from cancer (PHOF 4.05, NHSOF 1.4)

Cancers diagnosed at Stage 1 currently have a survival rate of 91% against less than 10% at stage 4.

3.4 Through established links with Primary care and as part of the Health Improvement Specialist's dissertation on his Masters at the University of Chester, a piece of research was undertaken to improve screening percentage across 3 GP practices. Through established links from Health Improvement work, two practices in Widnes and one in Runcorn were identified to take part in an 8 week intervention period.

The intervention aimed to target non-responders to the screening invite by telephoning people once their GP practice was informed by the Regional Screening hub. Health Improvement Health Trainers were given bespoke training about the programme, kit and utilising their already established behaviour change skills were deployed into the three practices to contact people who declined the original invitation.

240 non-responders were targeted (the most recent 80 per practice). As a result of the telephone calls and an agreement with the regional screening hub, replacement kits were ordered directly from the practice. Results showed an average increase in screening by almost 10% (9.7%) as a result of the intervention. Most non-responder interventions are mail based and yield on average only a 1-6% increase.

4.0 POLICY IMPLICATIONS

This highlights the potential to make a huge impact across Halton by increasing the rate above both the North West and England average, and more importantly saving Halton lives through early detection.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Through early diagnosis (i.e. Stage 1 and stage 2) treatment costs can be significantly reduced by up to nearly £10,000 per case diagnosed.

6.0 RISK ANALYSIS

6.1 N/A

7.0 EQUALITY & DIVERSITY ISSUES

7.1 It has not been appropriate, at this stage, to complete a Equality Impact Assessment (EIA)

8.0 BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972.

None under the meaning of the Act.

REPORT TO: Health and Wellbeing Board

DATE: 29 March 2017

REPORTING OFFICER: Director of Public Health

PORTOLIO: Health and Wellbeing

SUBJECT: Integrated Wellness Service

WARD(S): Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 To provide an update to the Health and Wellbeing Board of the performance of the Integrated Wellness Service for the period January – December 2016.

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

3.0 **SUPPORTING INFORMATION**

3.1 Halton's Integrated Wellness service comprises Halton Health Improvement team and Sure Start to Later Life and is an in House service within Halton Borough Council. The integrated team via Divisional Manager is jointly accountable to the Director of Public Health and Health Protection and the Director for Adult Services.

3.2 The current functions of the Integrated Wellness Service can be summarised into three areas, as follows: -

- Start Well – Working within the community and schools to give every child in Halton the best possible start in life.
- Live Well – Helping adults and families lead healthier and more active lifestyles
- Age Well – Supporting healthy and active ageing for all people in the Borough.

The team plays a significant role in addressing the five priorities contained in Halton's Health and Wellbeing Strategy (2015 – 2018) and works with local clinicians and Health and Social Care colleagues to deliver innovative, evidence based and measurable interventions such as breastfeeding support, stop smoking, healthy weight, falls prevention and access to low level early intervention and prevention services across the community.

3.3 The most recent performance report (Halton Integrated Wellness Service Review January – December 2016) demonstrates the positive health and wellbeing outcomes delivered by the integrated

service - please refer to full report included as appendix A.

3.4 Throughout 2016, the service has launched several new programmes including pre-diabetes, Youth Health Champions, Your Baby and You, Age Well training and specialist exercise programmes for stroke and cancer, as well as the continuation of all our successful existing programmes.

The Health Improvement Team was a finalist at the RSPH Health and Wellbeing Awards this year in the Healthier Lifestyles category, in recognition of its innovative work to reduce health inequalities across Halton. The team was also featured on national TV on ITV's Tonight programme in October for its work on pre-diabetes (impaired glucose regulation) which is leading the way in preventing diabetes across Cheshire and Merseyside.

The service continues to promote local, regional and national public health campaigns such as One You, Maketime Halton, Be Clear on Cancer and Change 4 Life.

Overall, The service has seen an upturn in people accessing all of our initiatives, extending the reach of our programmes across Cheshire and Merseyside. In total, over the period we have engaged with in excess of 18,000 people across our range of programmes and work continues to develop and grow the service throughout 2017.

4.0 POLICY IMPLICATIONS

The Integrated Wellness Service contributes to the outcomes outlined in Halton's Health and Wellbeing Strategy. The service also contributes to the outcomes required by Public Health, NHS Better Care Fund and Adult Social Care Outcome Frameworks.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The service will continue to look to generate income via training and the delivery of external contracts.

6.0 RISK ANALYSIS

6.1 N/A

7.0 EQUALITY & DIVERSITY ISSUES

7.1 It has not been appropriate, at this stage, to complete a Equality Impact Assessment (EIA).

8.0 **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 BOROUGH COUNCIL

Halton Integrated Wellness Service

Incorporating Halton Health Improvement Team and Sure Start to Later Life

Performance Review January - December 2016

START WELL

LIVE WELL

AGE WELL

It has been yet another busy period for the service. Throughout 2016, we have seen the launch of several new programmes including pre-diabetes, Youth Health Champions, Your Baby and You and specialist exercise programmes for stroke and cancer, as well as the continuation of all our successful existing programmes.

The Health Improvement Team was a finalist at the RSPH Health and Wellbeing Awards this year in the Healthier Lifestyles category, in recognition of its innovative work to reduce health inequalities across Halton. The team was also featured on national TV on ITV's Tonight programme in October for its work on pre-diabetes (impaired glucose regulation) which is leading the way in preventing diabetes across Cheshire and Merseyside.

We continue to promote local, regional and national public health campaigns such as One You, Maketime Halton, Be Clear on Cancer and Change 4 Life.

Overall, we have seen an upturn in people accessing all of our initiatives, extending the reach of our programmes across Cheshire and Merseyside. In total, over the period we have engaged with in excess of 18,000 people across our range of programmes and services.

RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
HEALTH & WELLBEING AWARDS 2016
HEALTHIER LIFESTYLES
FINALIST

New Developments for 2016

Start Well

Youth Health Champions

The Youth Health Champion Award is a Royal Society for Public Health Level 2 programme designed to give young people the skills, knowledge and confidence to act as peer mentors, increasing awareness of healthy lifestyles and encouraging involvement in activities to promote good health. The Health Improvement Team has designed a programme to be delivered in schools across Halton to Year 9 pupils.

For the school there are many benefits. The scheme supports PSHE messages and improves the health and wellbeing of students and staff and will lead to increased health literacy across the school and community.

For students, this is a nationally accredited certificate that can provide a foundation for future careers in health or social care while increasing knowledge and understanding of healthy lifestyles and behaviours and encouraging peer support within the school community.

In 2016 we began work with two secondary schools. 15 pupils from St Peter and Paul Catholic College completed the course in June 2016 and in September 2016 15 pupils from The Heath School began the course and are due to complete by June 2017. We are in discussions with more secondary schools to take part in 2017 and we are also developing a scheme for primary schools.

Your Baby and You

In partnership with Halton Family Nurse Partnership, Halton Health Improvement Infant Feeding Team, Halton Health Visitor Service & Halton Children's Centres Your Baby and You is a new programme of friendly, relaxed and informative ante-natal workshops where parents to be can learn all about pregnancy, infant feeding, birth and parenting.

Starting in June 2016, the programme will reach over 1000 women over the next 12 months.

Rethink Your Drink Sugar Campaign

Education around sugar and its health harms has always formed a key part of our weight management programmes for both children and adults. But with increased media and political coverage in recent months, the team developed a wide ranging campaign to draw attention to the high levels of sugar in popular soft drinks and encourage children and parents to swap to low or sugar free alternatives.

Posters and flyers were distributed to all schools and children's centres as well as GPs and community venues. The campaign was also incorporated into the team's successful Fit 4 Life programme and the Halton Healthy Schools Initiative.




Live Well

IGR - Diabetes Prevention Programme

This year has seen an innovative partnership between General Practice and Health Improvement in terms of people being diagnosed with Impaired Glucose Regulation (Pre-Diabetes). Health Trainers who are based at 13 of the 16 practices in Halton, are now seeing people in a 1-1 consultation on behalf of the practice. The practices have historically struggled to meet both the demand and the expertise needed in lifestyle education. The appointment has personalised education and action plans and allows a swift and seamless referral onto lifestyle services such as Weight Management, Exercise Referral.

Over the last 6 months we have seen over 500 people many of which have gone onto lifestyle services and lowered their weight and importantly their blood sugar levels, hence preventing diabetes.

Healthy Living Pharmacies

On behalf of NHS England, Halton's Health Improvement Team was chosen to deliver the face to face Health Champion training on the Healthy Living Pharmacy Programme across Merseyside and Cheshire. The Health Improvement Team attended 23 leadership events to encourage and enrol pharmacy staff onto the Royal Society of Public Health "Understanding Health Improvement" Level 2 qualification. These were held at 9 venues across Cheshire and Merseyside by Health Improvement, with everyone who attended passing the award. This increases the knowledge and confidence of pharmacy staff to have conversations with customers about many health topics and engage more actively with some of the national health campaigns as part of the NHS England Healthy Pharmacy initiative.

Cheshire Fire and Rescue

Cheshire Fire and Rescue Service have received Bowel Cancer Screening training from the Health Improvement Team and CRUK. The training will give staff working for Cheshire Fire and Rescue Service the confidence to encourage residents over 65 who live in Halton to take part in the National Bowel Screening Programme. Research suggests that bowel cancer screening can lower the risk of dying from bowel cancer.

Bowel Cancer Screening as well as slips, trips and falls, smoking cessation and alcohol reduction is part of the first phase of the new Safe and Well home visit being rolled out to residents living in Halton and will contribute to the health and winter mortality agenda.

Mental Health Team

For Mental Health Awareness Week in May 2016 we adopted the Champs "Maketime" campaign (#maketimehalton) which encompasses the 5 Ways to Wellbeing. The campaign provides real examples of how local residents can achieve positive mental health and wellbeing. Over 800 people were engaged during Mental Health Awareness Week and 388 '5 Ways' pledge cards were completed. The campaign has been delivered through face to face events as well as online and through social media. To date, the campaign has received over 20,000 social media impressions.

For World Mental Health Day on 10 October 2016, our team hosted a showcase event for local professionals and residents focusing on children and young people's mental health services in Halton. The event was attended by more than 80 people and has received extremely positive feedback.

Stop Smoking Service

The service has delivered 6 days of smoking cessation training to 30 (5BP) Mental Health staff working across Halton and Warrington in order for the staff to deliver cessation to their residential clients and in line with Smokefree Legislation for Mental Health establishments. The service has increased their venues from 19 sessions per week to 25 to include new sessions in the Brooker Centre, Halton Hospital, CGL, Leisure Centres and Citizens Advice. The team also promoted the national Stoptober campaign throughout October 2016 and was a key partner in the Recovery Walk in September, hosted by Halton.

Age Well

Age Well Training

- Age Well training emerged from a successful Living Well pilot in 2014/5. The pilot work focussed on increasing the skills of community staff to use screening tools to identify people aged 75+ in the community at risk of memory loss, falls or loneliness. Clinical pathways were used to identify the uptake of the screening.

- A variety of methods were used to promote the training with attendance at team meetings, local partnership events, Dementia Action Alliance, internal borough council teams, mail shots, telephone calls opportunistic conversations and asking delegates on the training.

- A wide range of teams were contacted across Halton particularly those who have a front line community staff. They were as follows:-

  Wellbeing Enterprises, library services, domiciliary care, day care, residential care, Halton Housing Trust, Liverpool Housing Trusts, SS2LL, Bridge Builders, Health Improvement Team, Age UK, Dementia Action Alliance members, SCIP workers & transport services.

To date 52 Delegates have been trained across 3 training sessions. 4 More are planned and booked up to end of March 2017.

Bowel Screening Follow-up Pilot

An innovative scheme piloted in 2016 found that follow up phone calls by health trainers to non-responders were far more effective in encouraging people to participate in the bowel screening programme.The 3 GP practices involved in the pilot saw a 9% increase in uptake of the screening invitiation.

Coffee in a box

Partnerships in Prevention agencies have combined with Runcorn Shopping Centre to develop a discounted coffee event in "The Box" area of the centre. Karl Clawley, the centre manager has been instrumental in resourcing the event. It is called "Coffee in a Box" and takes place every Wednesday lunchtime. It is designed to attract older people who may be experiencing loneliness.

The marketing of the event has been extensive with a number of positive stories and photographs in the local press but it is likely to be a number of months before the event engages larger numbers of lonely older people.

To date approximately 50 sessions have been held over the year with 15 to 20 people attending every week.

Affordable Warmth

In September 2016, a new Winter Warmth Campaign was launched - **Keep Warm, Keep Healthy this Winter**. Aimed at the most vulnerable communities - elderly, people with long term conditions, young children, the campaign linked with other existing campaigns such as Stay Well this Winter, Flu immunisation, Merseyside Collective Switch and has been delivered in partnership with social landlords, citizens advice, energy saving charities and others.

The campaign also ties in with the Council's Affordable Warmth Strategy which launches in February 2017.




Ongoing Activity

Start Well

100%

Of schools in Halton engaged in **Healthy Schools Initiative**

-73%

73% reduction in under 18 **alcohol admissions since 2007 (to 2014) - 48.6 per 100,000**

142

Families engaged in **Introducing Solid Foods** with **90%** introducing solids to their baby **after 5 months**

1014

Pupils engaged in schools **Healthitude** programme

1605
Women supported to **breastfeed** their babies

Breastfeeding friendly

350
local venues now accredited **Breastfeeding Friendly**

144

Vulnerable **families** supported to improve **parenting** and access to **community** services

Rethink Your Drink sugar campaign launched to educate children and parents about sugary drinks

999

School children aged **7-16** engaged in **Fit4Life schools** programme

Live Well

1021

New Weight Management clients with **75%** losing weight at **6 months (combined service with 5BP)**

60.8%

Stop Smoking **Quit Rate** - up from 55%

637

IGR (Impaired Glucose Regulation) referrals received

1173

NHS Health Checks carried out in GP practices, workplaces and the community

Live Well (continued)

596

Residents and Front Line Professionals received **alcohol awareness training or IBA**

919

Clients set a quit date with our **Stop Smoking Service**

1691

People engaged with around **early detection of cancer** and **screening**

277

People with **long term conditions** engaged in **specialist exercise classes**

46%

Pregnant smokers quit with Stop Smoking Service

Age Well

389

People referred to **Sure Start to Later Life**

936 hours

Visits by volunteers to vulnerable older people

2515

People attended trips & day trips organised through **Sure Start to Later Life** service

685

Older, lonely & vulnerable adults helped to engage with their community, reduce isolation and improve independence

575

Attendances at 8 **Grangeway Get Together** events

192

IT Support sessions delivered to people in their own homes

750

Residents engaged in **Halton Falls Service** with **200** attending **Age Well Exercise**

52

Front Line Professionals received **Age Well Awareness training**

Marketing and Communications

Working in partnership with local, regional and national partners, the Health Improvement Team's marketing and communications service has promoted over **50** public health campaigns and awareness days in 2015 and 2016, including **Stoptober**, **Be Clear on Cancer** and **Stay Well this Winter** as well as regional campaigns including **CRUK's North West bowel screening** campaign and the Cheshire and Merseyside **'Maketime'** mental health campaign.

We have also developed local campaigns such as '**Rethink your Drink**' - encouraging people to swap sugary drinks to low or sugar free alternatives and '**Sun Safe**', promoting sun safety and skin cancer awareness during the summer of 2016.

The service is also responsible for the continued development and promotion of ongoing services such as **Fit 4 Life**, **Fresh Start**, and the **Halton Stop Smoking Service**.

Other communications and projects include:

- **46** press releases issued in 2016 with coverage in Halton press as well as the wider Merseyside region
- social media promotion of health improvement services
- design and distribution of campaign and service materials
- localisation of regional and national campaigns (e.g. **#maketimehalton** and **PHE's One You**)
- adoption of the **Active Halton** branding for the Health Improvement Team and promotional materials
- working closely with Halton Borough Council's central marketing and communications team
- rebrand of the **Fresh Start** programme to increase appeal to a wider audience, particularly men
- coordinating Health Improvement promotion at **83** events including Vintage Rally and Party in the Park

Training

Health Improvement has continued to develop and extend its training programme. We have an in-house team of qualified trainers and is an accredited training provider Royal Society for Public Health and City and Guilds Training and Qualifications. We also offer bespoke training for professionals and the public around subjects such as cancer, alcohol awareness, mental health, suicide prevention, ageing well, and tobacco control.

Public Health and Social Care

Health Improvement Team continues to work with the wider public health and social care teams within Halton Borough Council on various campaigns and workstreams including winter warmth, flu, older people's services and social care.

Partnerships

The Health Improvement Team has strong working relationships with local, regional and national organisations, including:

- CHAMPS
- Healthier Futures
- Halton CCG
- 5 Borough Partnerships
- Wellbeing Enterprises
- Citizens Advice Bureau
- Widnes Vikings
- Public Health England
- NHS England
- Cheshire Fire Service
- Cheshire Police
- Royal Society for Public Health

Coming up in 2017

Be Clear on Cancer / CRUK Bowel Screening Pilot - North West England: January - April 2017

Following the success of CRUK's 2016 campaign, in early 2017 they will be partnering with PHE's Be Clear on Cancer campaign to promote bowel screening across North West England. This will be the first Be Clear campaign to focus on screening messages. In Halton, we will be supporting the campaign and promoting to our local communities.

Bowel Screening Pilot - Halton GP practices

Following the successful pilot with 3 Halton GP practices in 2016, Health Trainers from the Health Improvement Team will be placed in more practices in 2017 to make follow up phone calls to non-responders to bowel screening invitations.

This work will be coupled with the ongoing work with GP practices to implement practice action plans to increase screening rates for bowel, breast and cervical cancer.

Cheshire Fire Service - Blood Pressure Checks

As a result of the successful roll out of the bowel screening training for Cheshire Fire & Rescue Service for their safe and well checks, discussions are under way for Health Improvement Team to offer a wider training programme with an emphasis on blood pressure checks.

Change 4 Life - Be Food Smart National Campaign - Launches January 2017

Halton Health Improvement Team will be supporting this high profile national campaign locally through schools, children's and community centres and local PR. The campaign aims to educate families with children aged 5-11 about the dangers of hidden sugar, salt and fat in food and encourage healthier eating habits for the whole family.

Resources provided by Public Health England will be distributed to community venues, schools, and local groups from January 2017.

REPORT TO: Halton Health and Wellbeing Board

DATE: 29 March 2017

REPORTING OFFICER: Director of Public Health.

PORTFOLIO: Health and Wellbeing

SUBJECT: Pharmaceutical Needs Assessment

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide members of the Board with a briefing on the Pharmaceutical Needs Assessment (PNA), including risks associated with it and proposed local governance.

2.0 RECOMMENDATION: That

1) **a Board level sponsor for the PNA be nominated;**
2) **the financial risks associated with the PNA be logged through Halton Borough Council's risk assessment and register process; and**
3) **the Board note the establishment of a local steering group to oversee the PNA development process in line with the national regulations. This group needs to report back to the Board on the draft before the statutory consultation begins and following this period detailing our responses to feedback.**

3.0 SUPPORTING INFORMATION

3.1 The pharmaceutical needs assessment (PNA) is a statutory document that states the pharmacy needs of the local population. This includes dispensing services as well as public health and other services that pharmacies may provide. It is used as the framework for making decisions when granting new contracts and approving changes to existing contracts as well as for commissioning pharmacy services. First detailed in the NHS Act 2006 where PCTs were divested with the responsibility for producing the PNA, since 1 April 2013 this responsibility now sits with Health & Wellbeing Boards.

3.2 Background to the PNA

A PNA details the current pharmaceutical service provision available in the area and where there may need to be changes to this in the

future because of changes to the health needs or geographical location of the local population. It covers a 3-year period. Any changes to community pharmacy provision within the lifetime of the PNA can be detailed in supplementary statements to keep the document up-to-date.

The PNA enables all commissioners of community pharmacy services to make sure that any new contracts granted and pharmaceutical services commissioned are based on the information provided in the document. It means that anyone wishing to open a new pharmacy in the area needs to include in their application their plans to meet the needs of local people as identified in the PNA.

When making decisions about provision against levels of need, pharmacy provision is not taken in isolation. In some cases pharmacies are the sole provider of the service but in others there is a mix of provision.

The next PNA will be Halton's third document. The first PNA to cover Halton was the 2011-2015 Halton & St Helens PCT document, with the second one specifically covering Halton signed off by Halton Health & Wellbeing Board covering 2015-2018, published 1 April 2015.

A steering group has recently been established to oversee the next version of the PNA, chaired by a consultant in public health.

3.3 **Changes effective from 1 April 2013**

From April 1st 2013 health and wellbeing boards (HWBs) have had a statutory responsibility to publish and keep up to date the PNA. Health & Wellbeing Boards are also responsible for producing the Joint Strategic Needs Assessment (JSNA). Giving local authorities the responsibility for conducting both PNA and JSNA strengthens the links between the two documents and there may be opportunities, for combined working on both documents.

The responsibility for making decisions on pharmacy applications based on the PNA passed to NHS England from this date. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, effective from 1 April 2013, stipulate both the process for developing the PNA and minimum content. This includes a statutory 60 day consultation period.

3.4 **Department of Health Community Pharmacy Review Implementation**

Implementation of the funding settlement, as part of delivery of The Five Year Forward View, includes a 6% reduction in NHS England funding. Community pharmacy will play its part in delivering these

efficiency savings. The vision is for community pharmacy to be integrated with the wider health and social care system. During the development of the PNA, subject to the outcomes of the Judicial Review granted to the Pharmaceutical Services Negotiating Committee, implementation of this review will start to come in to effect. The PNA will need to take account of any changes this brings about in community pharmacy provision.

The Pharmacy Access Scheme has been designed by Department of Health to ensure a baseline level of patient access to NHS community pharmaceutical services, specifically those pharmacies where patient and public access would be materially affected should they close. Under this two pharmacies within Halton have been identified as appropriate to support via the scheme.

3.5 **Commissioning arrangements**

NHS England are mandated under the same regulations to use the PNA when making decisions on applications to open new pharmacies and dispensing appliance contractor premises.

Public health teams and clinical commissioning groups should also use the PNA to inform their commissioning decisions on locally-commissioned services from community pharmacies. Robust, up-to-date evidence is important to ensure that community pharmacy services are provided in the right place and meet the needs of the communities they serve.

3.6 **Proposed arrangements for producing Halton's 2018-21 PNA**

It is proposed to use the current framework developed across Merseyside to produce the next Halton PNA. This will ensure that although each local authority PNA will be developed locally and differ according to the local area and population, it will continue to be in the same format which will make it easier to use and review.

A Cheshire and Merseyside group of local authority PNA leads, the NHS England pharmacy contracts team and representatives from the Local Pharmaceutical Committees have started to meet to discuss common elements of the PNA, both content and information gathering exercises. This will avoid duplication of effort and enable easy sharing of information, especially in relation to the requirement to consider cross-border provision as part of the PNA.

The Health & Wellbeing Board is asked to nominate a board-level sponsor with responsibility for the PNA, with the management of the PNA being passed to the local steering group led by public health. The steering group will oversee the operational development and consultation for the PNA, reporting report back to the Health & Wellbeing Board for approval at strategic stages of the process, in line with the regulations.

It is important to ensure that all information within the PNA is

accurate and up to date, and this can be achieved by ensuring that all relevant stakeholders are represented on the steering group. The membership includes:

- Public health teams,
- NHS England area team,
- Clinical Commissioning Group,
- Local pharmaceutical committee (LPC),
- representation from the local community (Halton & St Helens CVA),
- Healthwatch,
- an elected representative from the Health & Wellbeing Board.

There are several key points in the PNA development at which a report must be submitted to the Board:

- once the draft is completed this will be submitted to Board for approval to publish it for the statutory 60-day consultation period.
- Following the consultation period we are required to provide a response to each point that is fed back through the consultation process, making any necessary amends to the PNA document. This feedback, our responses and amended PNA should be submitted to Board, for their approval to publish.

The PNA must be published by 1 April 2018 at the latest on a publically accessible website. The JSNA is published on Halton Borough Council website so the PNA will be made available alongside the JSNA.

3.7 **Resources**

This is a large piece of work which will extend over a considerable period of time. As well as information gathering from the organisations commissioning services from pharmacies as to current and future needs, there needs to be extensive work done by public health teams mapping the health and social needs of the local population compared to provision of pharmaceutical services. Work also needs to be done looking at future changes that could impact upon pharmaceutical need such as a new housing estate, closure of a local industry, firm plans for health arising from JSNA. The local population will also need to be consulted as to their views on current provision of pharmaceutical services and aspirations for future pharmaceutical services.

3.8 **Proposed next steps**

- Nominate board level sponsor for PNA
- Steering group to:
- Start to populate the PNA with information already available such as JSNA

- Start to gather information from community pharmacy providers to update current PNA
- Ask the local community for feedback on current pharmacy services and aspirations for future pharmacy services
- Speak to local authority planners and healthcare commissioners to determine future planning of housing, industry and healthcare.

4.0 POLICY IMPLICATIONS

4.1 The health needs identified in the JSNA should be used to develop the PNA.

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

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Any legal challenges to decisions based on information in the PNA may open the Health & Wellbeing Board up to Judicial Review. This can have significant financial implications.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Improving the Health of Children and Young People is a key priority in Halton and this should be reflected in the PNA, detailing service provision that is appropriate to this age group.

6.2 **Employment, Learning & Skills in Halton**
Not applicable

6.3 **A Healthy Halton**
All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**
Not applicable

6.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. Pharmacies provide a vital primary health care service to residents across the borough, are located within the heart of communities and offer open access to trained health professionals for advice on a wide range of issues.

7.0 RISK ANALYSIS

7.1 Failure to comply with the regulatory duties fully may lead to a legal challenge, for example, where a party believes that they have been disadvantaged following the refusal by NHS England over their application to open new premises based on information contained in the PNA.

7.2 The risk of challenge to the Health & Wellbeing Board who produced that PNA is significant and Boards should add the PNA to the risk register.

7.3 The development process, including the use of national guidance, involvement of local expertise throughout and statutory consultation, that has been detailed above will mitigate against this risk. HBC Solicitors will be consulted at key stages in the PNA development to further ensure any potential risks are identified and mitigated.

7.4 Recent communication from NHS Digital, the national body responsible for NHS data including hospital admissions, has reduced public health teams access to some of the data necessary to produce the PNA. This has been raised at the highest levels within Public Health England and the Association of Directors of Public Health. A data sharing agreement between Halton Borough Council Public Health Team and NHS Digital has been applied for but the approval process has thus far been slow. The team are continuing to pursue this as the most robust long-term solution. They are also working with colleagues across Cheshire & Merseyside on alternative short-term solutions.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The PNA seeks to provide intelligence on which to base decisions about service provision that are based on levels of need across the borough. 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 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None under the meaning of the Act.

REPORT TO:	Health and Wellbeing Board
DATE:	29 March 2017
REPORTING OFFICER:	Director of Public Health, and Director of Commissioning, Halton CCG
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Health and Wellbeing Strategy
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with the final version of the **One Halton Health and Wellbeing Strategy (2017-2022).**

2.0 RECOMMENDED: That the Board approves the final version of the Strategy and supports the development of Action Plans for the identified priorities.

3.0 SUPPORTING INFORMATION

3.1 The One Halton Health and Wellbeing Strategy is an overarching strategy to improve health in Halton. The new Strategy will build upon the successes of the previous strategy and outlines the key priorities the Health and Wellbeing Board will focus on over the next five years (2017-2022).

3.2 The new Strategy provides:

- An overview of One Halton.
- Principles of how we will work together.
- A joint vision, new priorities and how and why these were chosen,
- An updated health and wellbeing profile for Halton.
- An outline of the progress made since 2013 and the challenges that remain.
- Examples of innovative work already being undertaken within Halton that take a place based approach, working with local people and using local assets e.g. Well North, Healthy New Towns.
- What we will do as a system at scale to make a difference.
- How we will measure success.

3.3 The Strategy has been developed using a partnership approach and was developed by a multi-agency steering group. The group was co-chaired by the Director of Public Health and Director of Commissioning for NHS Halton CCG it included membership from NHS Halton CCG, Health Watch, Halton & St Helens Council for Voluntary Services, HBC Children's Services, HBC Adult Social Care, HBC Public Health and a representative of the public.

3.4 The Strategy recognises that we will only be successful if all partners (including local people) play their part. The Strategy therefore outlines agreed principles of how we will work together. In order to deliver the One Halton Health and Wellbeing Strategy all partners will work in the following ways:

- Engage with and understand the needs of our local communities.
- Intervene early to prevent ill health.
- Early identification and support for clinical conditions.
- Skills developments to ensure people have the confidence to manage their own health and wellbeing.
- Ensure people are at the centre of planning and delivery of services.

3.5 Available evidence of health needs has been used to identify issues of particular significance for the borough. The priorities are backed by a strong evidence base considering the local JSNA, Right Care benchmarks and performance against the range of national and local targets. They include:

- Children and Young People: improved levels of early child development
- Generally Well: increased levels of physical activity and healthy eating and reduction in harm from alcohol
- Long-term Conditions: reduction in levels of heart disease and stroke
- Mental Health: improved prevention, early detection and treatment
- Cancer: reduced level of premature death
- Older People: improved quality of life

3.6 We believe that success in delivering against the Strategy can only be achieved by working in partnership with local people. Therefore, in developing the new Strategy we have consulted with a wide range of Halton residents to ensure that the principles and priorities are reflective of the experience and needs of our local communities. Engagement was undertaken by the voluntary sector, Health Watch and One Halton portfolio directors using pre-existing networks and forums for engagement e.g. Halton Peoples Health Forum. The feedback received has be used to inform the new One Halton Health and Wellbeing Strategy.

3.7 Once approved the final version of the Strategy will be shared with all key partners (including local people) and will be available online.

4.0 POLICY IMPLICATIONS

4.1 The Health and Wellbeing Strategy will inform collaborative action for the Council, NHS, Social Care, Public Health and other key partners as appropriate.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 No additional funding required. However the strategy will inform future activity and spending across the system.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton. The Health and Wellbeing Strategy will include child development as a priority.

6.2 Employment, Learning & Skills in Halton

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

6.3 A Healthy Halton

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

6.4 A Safer Halton

Reducing the incidence of crime, improving Community Safety and reducing the fear of crime have an impact on health outcomes particularly on mental health.

6.5 Halton's Urban Renewal

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing.

7.0 RISK ANALYSIS

7.1 Developing the Health and Wellbeing Board Strategy does not present any obvious risk however, there may be risks associated with the resultant recommendations. These will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 This is in line with all equality and diversity issues in Halton.

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

Appendix A: One Halton Health and Wellbeing Strategy

One Halton Health and Wellbeing Strategy

2017-2022

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Foreword

Councillor Rob Polhill

Leader of the Council and Chair of the Health and Wellbeing Board

Welcome to our ***One Halton Health and Wellbeing Strategy.***

The new One Halton Health and Wellbeing Strategy 2017 – 2022 is an overarching strategy to improve health in Halton. It has been jointly developed after consultation with Halton Borough Council, NHS Halton Clinical Commissioning Group, the voluntary sector, Community Health Services, Hospital Trusts, Health Watch, the blue light services, housing and local community groups.

Our first Health and Wellbeing Strategy 2013 - 2016 provided us with an excellent platform to take forward our good track record of partnership working. It enabled us to focus extra effort on a few key health challenges for local people. The new strategy seeks to build on this work so improving health is embedded in all our systems and within the local community.

Through the One Halton model, that engages local people and all partners, we propose that we start now to radically change the way we do things so that by 2022 fewer people will be suffering from poor health. Effective prevention and early action can deliver a 'triple dividend' by helping people to stay well and live healthy lives, thus reducing the demand for costly services and creating the conditions for a prosperous economy. We will take a whole systems approach and focus on people and places. We know that people who have jobs, good housing, meaningful activities and are connected to families and community feel, and stay, healthier. We will work at scale to implement evidence based interventions and

mobilise local communities to engage in their own health. We recognise the need to shift services into the community and make use of and build upon community assets.

We will work across the life course with identified and agreed priorities in each age group. As we go through the next five years and achieve our ambitions in those priorities we will then review our strategy and replace that priority with a new one.

With Halton's strong commitment to good health for all, integrated partnership, joint budgets, collaborative design, good quality and innovative services I am sure we can achieve our ambition.

Cllr Rob Polhill

Executive Summary

Our vision: **One Halton working together to improve the health and wellbeing of the people of Halton so they live longer, healthier and happier lives**

Our priorities for 2017-2022:

Children and Young People: improved levels of early child development

Generally Well: increased levels of physical activity and healthy eating and reduction in harm from alcohol

Long-term Conditions: reduction in levels of heart disease and stroke

Mental Health: improved prevention, early detection and treatment

Cancer: reduced level of premature death

Older People: improved quality of life

Our priorities contribute to our shared outcomes:

- More Halton children do well at school by reaching a good level of development educationally, socially and emotionally
- Healthy fit workforce to drive economic prosperity with fewer people suffering long term conditions from the age of 50
- More people will be supported to stay well and live independently for as long as possible
- People lead full, active lives using a wide range of facilities within local communities including good quality housing, parks, arts and cultural facilities, leisure services and safe cycling routes
- Reduced demand on services, improved quality and access
- More efficient use of financial resources

Delivering this Strategy

Ultimate responsibility for the implementation of the Strategy lies with the One Halton Health and Wellbeing Board, however, in order to deliver our vision and priorities we need everyone who lives and works in Halton to take an active role. We are passionate about improving the health and wellbeing of people living in Halton. Local residents, statutory, voluntary, community and commercial organisations all have an important role to play in achieving this goal.

The One Halton Health and Wellbeing Strategy is aligned with the NHS 5 Year Forward View. It aims to deliver the *"triple aim"* of improved health and wellbeing, transformed quality of care delivery, and sustainable finances. The Strategy sets the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on prevention and early intervention. It does not replace existing strategies, commissioning plans and programmes, but influences them.

Integration is key to our strategic approach with all partners working together to deliver: joint commissioning, culture change through community development, training for all staff in how to deliver health messages so every contact counts, development of multi-disciplinary teams and joint advocacy and policy work.

Ultimate responsibility for the monitoring of the implementation of the Strategy lies with the Health and Wellbeing Board who are accountable to the public.

A governance structure and One Halton priority groups will oversee the development and delivery of these priorities. Each group will be responsible for the development of an action plan setting out what all stakeholders will do to deliver the outcomes we want. They will use a life course approach and ensure each action plan includes action to maximise prevention and early intervention, provide high quality treatment based on need and supports people in both the short and long term.

Vision and Priorities

Our vision: Working as one to improve the health and wellbeing of the people of Halton so they live longer, healthier and happier lives

Our priorities for 2017-2022:

- **Children and Young People: improved levels of early child development**
- **Generally Well: increased levels of physical activity and healthy eating and reduction in harm from alcohol**
- **Long-term Conditions: reduction in levels of heart disease and stroke**
- **Mental Health: improved prevention, early detection and treatment**
- **Cancer: reduced level of premature death**
- **Older People: improved quality of life**




One Halton

The One Halton Health and Wellbeing Strategy is our borough based plan to improve the health and wellbeing local people, their families and communities. This includes all people who live and work in Halton regardless of their age, gender, ethnicity, sexuality or occupation.

Our collective ambition is that Halton people live healthy lives in vibrant communities; that there is a fundamental change towards people managing their own health, we work towards the development of local care organisations, which are mostly in the community, with hospitals only used for specialist care. Hospitals will work together so everyone can benefit from high standards of specialist care and we will share clinical and non-clinical functions across lots of organisations.

Our purpose is 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 whenever possible and ensuring high-quality hospital services for those who need them. We want to support people to stay well in their homes, in particular to avoid crises of care that can result in hospital admission. General practices will support and empower individuals and communities by promoting prevention, self-care, independence and resilience. We will work with local people and with partner organisations including healthcare providers and the voluntary sector. This will ensure that the people of Halton experience smooth, co-ordinated, integrated and high-quality services to improve their health and wellbeing.

Through signing up to deliver this One Halton Strategy we are jointly:

- Taking **ownership** of where we are now. We all recognise progress has been made but that there is more work to do
- Being **responsible** for delivering on the agreed priorities and actions set out within this strategy.
- Making a **commitment** to make things better. For us to be successful all partners in Halton need to play their part including our local people
- Being **accountable** for developing systems that deliver more joined up approaches to delivering services

Halton has a vibrant and an active, participative, General Practice community. We have 16 practices all of whom are involved and engaged in the development of the Halton Vision and General Practice Forward View. We are extremely proud of the progress we have made and the commitment from our partners to continuously improve the health and wellbeing of the population of Halton.

With our members we commit to delivering better care, better health and better value; investing in a sustainable provider landscape within a system that holds everyone to account. Our vision as set out within our GP strategy is about "Involving everybody in improving the health and wellbeing of the people of Halton" with key values focused on People, Partnership, Openness, Caring, Honesty, Leadership, Quality and Transformation. Our commitment is to stabilise general practice, develop teams and partnerships, transform services and invest primary care.

Principles of working together

As outlined we will only be successful in delivering this strategy if all partners (including local people) play their part. We have therefore agreed principles of working together. In order to deliver the One Halton Health and Wellbeing Strategy all partners will work in the following ways:

- Engage with and understand the needs of our local communities
- Early intervention to prevent ill health
- Early identification and support for clinical conditions
- Skills developments to ensure people have the confidence to manage their own health and wellbeing
- Ensure people are at the centre of planning and delivery of services
- Work with local primary care, community and hospital providers to deliver accountable care
- Engage with and include the voluntary and third sector in all programmes

In order to do this we need to:

- Engage with people to better understand their motivation and offer options
- Work as integrated teams
- Ensure consistent communications across health and care providers
- Find or identify those people who do not access care
- Provide the very best in care, now and in the future
- Act as advocates for policies that reduce health inequalities
- Consider the impact of poverty and how this can be tackled
- Use innovative solutions, such as digital applications, to provide care and information

These will help us to

- **Build a social movement**
- **Reduce variation in care across the borough and compared to England**
- **Develop a wide range of ongoing community conversations**
- **Reduce unnecessary demand and help focus services on those most in need**
- **Identify and further develop community advocates and champions**
- **Make the most of 'back office' services to increase efficiency**

Building on the success of our first Health and Wellbeing Strategy

In Halton we have a good track record of partnership working to improve health and wellbeing. The Halton Health and Wellbeing Board was established in 2013 and one of its first actions was to develop a Health and Wellbeing Strategy to improve the health of the local population. Halton's first Health and Wellbeing Strategy covered the period 2013 to 2016 and set out the vision for Health and Wellbeing in Halton. The Strategy was the overarching document for the Health and Wellbeing Board outlining the key priorities the Board has focussed on over the past three years.

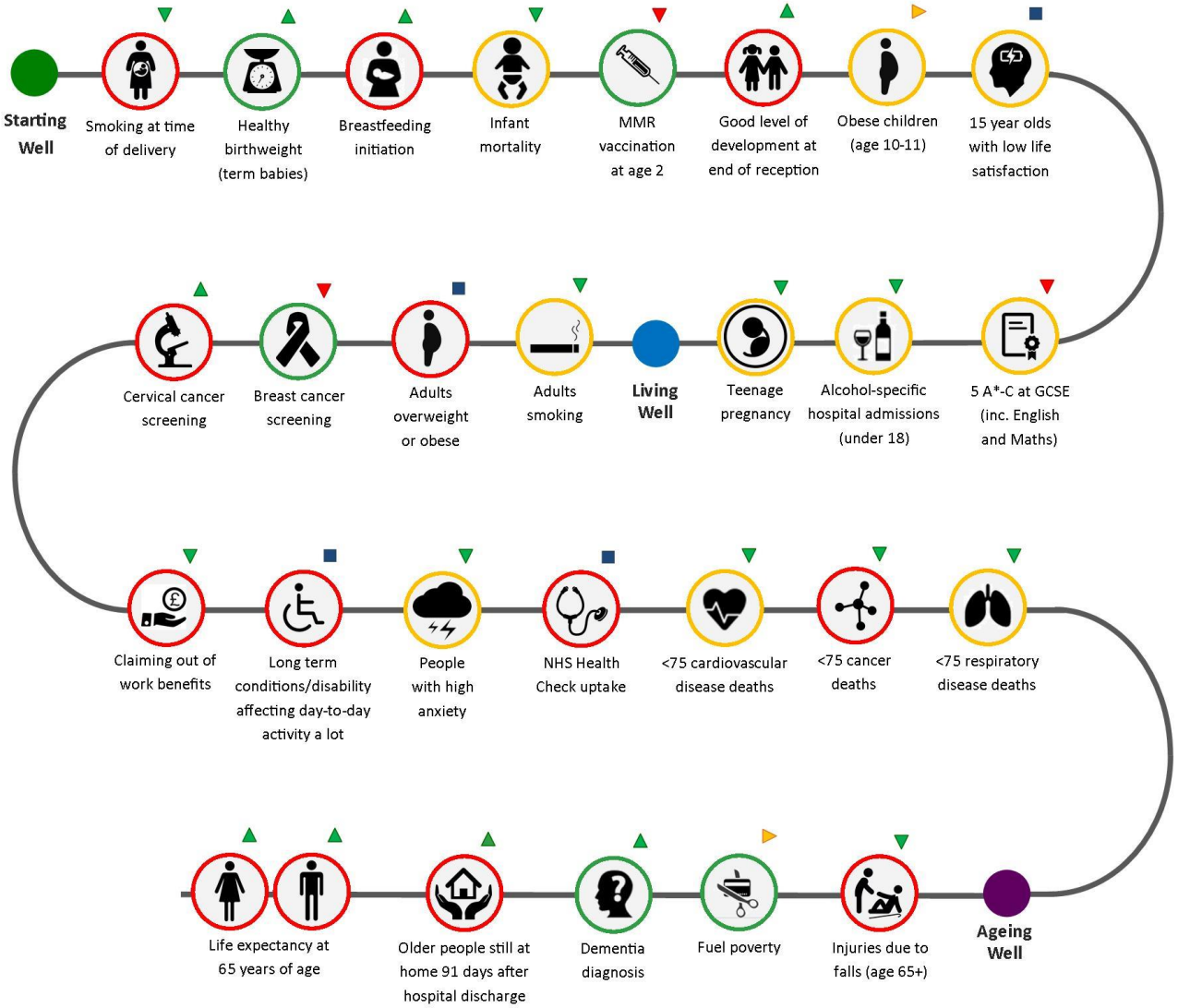
We are pleased to report that good progress has been made against the original priorities, including:

- An increase in the number of children achieving a good level of development by the end of reception
- A reduction in the number of young people admitted to hospital due to drinking alcohol
- An increase in early diagnosis of cancer and cancer deaths reducing
- Extra investment in falls prevention services
- A major review of child and adult mental health services in Halton

Full details of the progress made against the original priorities are outlined in **Appendix 1.**

Halton's Lifecourse Statistics 2015-16

A comparison to the North West



HALTON FACTS

Population

About **126,350** people live in Halton.

By 2030, this is projected to change:

age 0-18 ↓ 3.7%

age 19-64 ↓ 7.6%

age 65+ ↑ 46.4%

Deprivation

48% of Halton's population live in the top **20%** most deprived areas in England.

Child Poverty

24.5% of children aged 0-15 live in poverty in Halton

KEY

Direction of travel

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

Statistical significance to North West

- Better
- No different
- Worse

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

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

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

How did we decide on our priorities?

The new One Halton Health and Wellbeing Strategy needs to reflect current priorities from elsewhere in the system whilst maintaining a local focus that is evidence based and reflects local people's views. Since 2013 when first strategy was published there have been significant developments within the policy landscape. The new strategy is aligned with developing system level plans across Local Authorities and the NHS.

The priorities are backed by a strong evidence base considering the local Joint Strategic Needs Assessment, NHS benchmarking and performance data against the range of national as well as local targets. They cover the two biggest killers locally as well as issues that reduce the quality of people's lives. We have listened to our local communities in deciding both the priorities themselves and some of the key actions needed. We have also chosen the priorities based on were we believe we need to enhance current activity.

One Halton priorities have been developed using the following approach:

- Engagement – with GPs, partners and providers as well as patients and public – this is the research phase to ascertain what needs to change and how it can change. This stage lays the foundations for the programme and determines effective buy-in
- Consultation – once firm plans are in place, the CCG will consult with all stakeholders on plans before they are approved and implemented
- Informing – targeted communication will run through the entire programme to ensure all stakeholders are kept informed at every stage of the programme

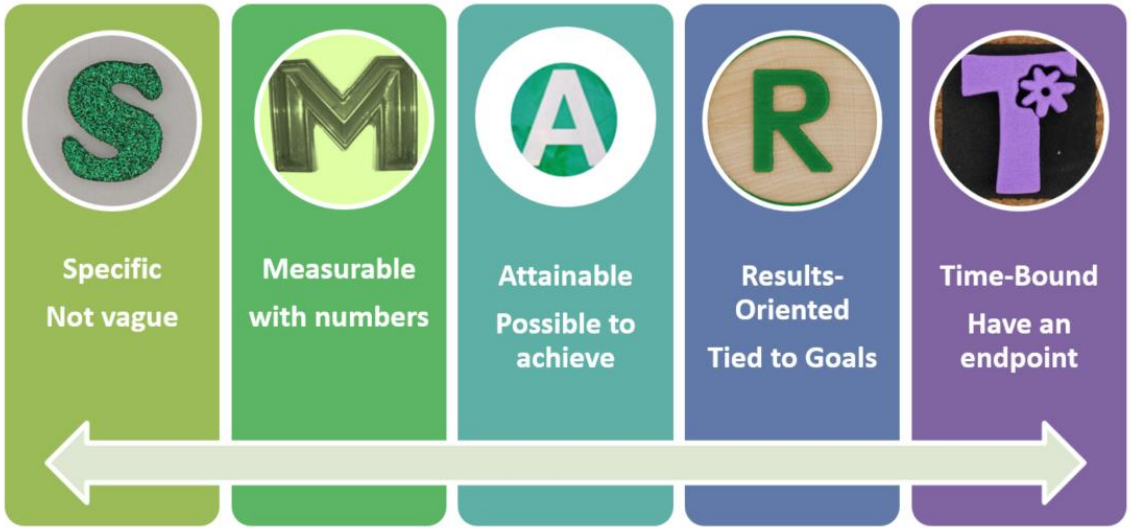
For this strategy further consultation has been undertaken by One Halton portfolio directors using pre-existing networks and forums for engagement e.g. Halton Peoples Health Forum. For each priority a set of key actions were identified. There was wide spread community support for all the key actions we had identified as being needed to tackle each priority.

A fuller *'Story behind each of the priorities'* is covered over the next few pages.

How will we know if we have been successful?

A governance structure and One Halton priority groups will oversee the development and delivery of these priorities. Each group will be responsible for the development of an action plan setting out what all stakeholders will do to deliver the outcomes we want. They will use a life course approach and ensure each action plan includes action to maximise prevention and early intervention, provide high quality treatment based on need and supports people in both the short and long term. Objectives developed will be *SMART.*

A *SMART* objective is:



Ultimate responsibility for the monitoring of the implementation of the Strategy lies with the Health and Wellbeing Board who are accountable to the public.

The Story behind the priorities

Improved levels of early child development

What is the issue?

- By 3 years of age children in families living below the poverty line are 8 months behind in language and 9 months behind in school readiness compared to those with incomes above the poverty line.
- Activities such as daily reading, regular bedtimes and library visits can improve cognitive development
- Despite improvements, 2016 data shows Halton still has one of the lowest percentage of children achieving a good level of development at age 5 in England: 61.9% of Halton children compared to 66.7% for England
- Accidental injury levels are higher than nationally at 180.1 per 10,000 Halton children aged 0-4 years of age compared 129.6 per 10,000 in England

3 Key actions partners and the public feel are important

1. Enhancing school readiness programmes.
2. Additional action to prevent child accidents.
3. Expanding parenting programmes and local Home Start schemes.

Outcomes: what would success look like?

- Improvement in the percentage of children achieving a good level of development at age 5.
- Reduction in Child poverty levels.
- Reduction in percentage of women smoking at time of delivery.
- Increased percentage of women breast feeding (initiation and at 6-8 weeks).
- Reduction in the rate of A&E attendances and hospital admissions amongst those age under 5 (generally and due to accidents).
- Reduction in under 18 conception rates.
- Increased reading skills in primary school aged children.
- Increased influenza vaccination uptake amongst pregnant women and young people aged under 5.
- Increased reading skills in primary school aged children.

Generally Well: increased levels of physical activity & healthy eating and reduction in harm from alcohol

What is the issue?

- Obesity levels in early childhood and in adults are above the national level with 11% of 4 and 5 year olds and 31% adults obese.
- There are clear links with heart disease, stroke, cancers, respiratory and dementia
- Only 45% adults eat at least 5 portions of fruit & vegetables per day and less than half (48%) take enough exercise. Levels of exercise are lower than England (57%) and are especially low amongst women
- There are been significant improvements in the level of hospital admissions due to alcohol, especially for those aged under 18. However, levels remain higher than nationally for both under 18s and amongst the whole population: under 18s 48.6 per 100,000 in Halton compared to 36.6 per 100,000 for England with 805 per 100,000 all age in Halton compared to 641 per 100,000 for England as a whole

3 Key actions partners and the public feel are important

1. Mapping the public's access to fresh food.
2. Enhancing the infant feeding programme.
3. Promoting women's exercise programmes.

Outcomes: what would success look like?

- Increased percentage of children and adults achieving recommended levels of physical activity
- Increased percentage of children and adults meeting the recommended '5-a-day' of fruit and vegetables on a 'usual day'
- Reduced levels of children and adults who are overweight and obese
- Reduced rates of hospital admissions due to alcohol for those aged under 18
- Reduced overall rates of alcohol-related hospital admissions
- Reduced death rates due to alcohol-related liver disease

Long term conditions: heart disease and stroke

What is the issue?

- Despite improvements in the number of people with long term conditions diagnosed, there is still under diagnosis of hypertension (high blood pressure) where only about 61% of Halton people thought to have the condition are diagnosed.
- Death rates from heart disease continue to fall but remain the second single biggest killer in Halton. The borough still ranks one of the lowest in England: ranks 126 out of 150 local authorities for heart disease and 111 out of 150 local authorities for stroke (where 1 is the best and 150 the worst).
- Smoking prevalence has reduced to 20.1% but this is still higher than the England average of 6.9%.

3 Key actions partners and the public feel are important

1. Screening in the community for atrial fibrillation (irregular heartbeat).
2. Enhancing early diagnosis of heart disease and self-care programmes.
3. Increasing screening for hypertension (high blood pressure) in community pharmacies, general practice and other community settings.

Outcomes: what would success look like?

- Reduce smoking prevalence overall and amongst routine and manual groups and reduce the gap between these two groups
- Increase the percentage of adults who undertake recommended levels of physical activity and eat at least five portions of fruit and vegetables per day.
- Improve early detection and increase the proportion of people treated in line with best practice and reduce the variation at a GP practice level.
- Reduce the level of hospital admissions due to heart disease, stroke and hypertension.
- Reduce the premature (under 75) death rate due to cardiovascular disease and stroke.

Improved Mental Health

What is the issue?

- 1 in 4 people attending their GP seek advice on mental health problems
- Levels of hospital admissions due to self-harm are significantly higher than England, 307.4 per 100,000 compared to 191.4 per 100,000 for England
- 8,365 (8.4% of patients aged 18+) are diagnosed with depression, a higher rate than the England average.
- 30% of people with dementia are not diagnosed.
- Many social factors make children more at risk of development mental health problems. Halton has poorer outcomes than England for many of these and an estimated 10.2% of 5-16 year olds with mental health problems

3 Key actions partners and the public feel are important

1. Review the current Child and Adolescent Mental Health Services
2. Enhancing services for adults with personality disorders
3. Redesigning adult mental health services

Outcomes: what would success look like?

- Improved diagnosis rate for common mental health problems and dementia
- Reduced level of hospital admissions due to self-harm
- Improved access to talking therapy services and increased percentage completing treatment and percentage recovery
- Improved overall wellbeing scores and carers' wellbeing scores
- Reduced excess under 75 mortality in adults with serious mental illness (compared to the overall population)
- Increased percentage of care leavers with good mental health

Reduction in early deaths from cancer

What is the issue?

- Death rates remain some of the highest in the country with Halton ranking 142 out of 150 local authorities. It is the single biggest cause of death locally
- The rate of new cancers per year (incidence) is highest for lung (121.5 per 100,000 Halton compared to 79.8 for England), bowel (82.5 per 100,000 compared to 72.9 for England) and breast (187.8 per 100,000 compared to 169.9 for England).
- Smoking rates have been falling but remain above the national average, 20.1% of Halton adults smoke compared to 16.9% for England.
- The proportion of cancers caught early has been rising and is similar to the England average at 51.5%.
- Cancer screening rates have improved but are still lower than nationally. This is especially so for bowel screening uptake which is 50.1% in Halton compared to 57.6% for England

3 Key actions partners and the public feel are important

1. Enhancing the public awareness of early detection programmes.
2. Developing a new Tobacco Control Strategy and Action Plan.
3. Enhancing support for bowel screening to improve uptake.

Outcomes: what would success look like?

- Reduced smoking prevalence overall and amongst routine and manual groups and reduce the gap between these two groups.
- Increased uptake of breast, cervical and bowel screening.
- Improved percentage of cancers detected at an early stage
- Improved cancer survival rates (1 year and 5 year).
- Reduction in premature death due to cancer in the under 75s.

Improved quality of life for older people

What is the issue?

- Halton has a higher than average aging population and this trend will continue. The 65+ population increased by 3% between 2001 and 2011 compared to a 1.6% increase across England as a whole
- Compared to the national average Halton men aged 65+ live 1.4 years less than men across England as a whole with Halton women living 2.3 years less.
- Halton women spend 50.6% of their lives disability free. The figure for men is 51.3%. This compares to the England averages of 53.2% of woem.2% for women and 57% for men
- The numbers with dementia increased from 634 in 2010/11 to 934 in 2015/16. It is predicted this rise will continue
- Older people are concerned about remaining healthy, independent and connected to others
- The service older people most frequently cite as being of concern to them is transport

3 Key actions partners and the public feel are important

1. Marketing campaign on how to prevent loneliness.
2. Develop an older people's transport group.
3. Develop a directory of services for older people.

Outcomes: what would success look like?

- Increased life expectancy at age 65
- Increased disability free life expectancy at 65
- Improved access to transport
- Reduced levels of loneliness
- Reduction in level of hospital admissions due to falls and hip fractures
- Increased uptake rates for Influenza, pneumococcal and shingles vaccination
- Reduction in permanent admissions to residential and nursing homes

Example of how we are already working as "One Halton"

Case study 1: Well North: Well Halton

A Department of Health response to the Due North Report published in 2014 which highlighted the disparity in health outcomes between the north and the south of England. Well North's goals are to :-

- address inequality by improving the health of the poorest, fastest
- increase resilience at individual, household and community levels
- and reduce levels of worklessness, a cause and effect of poor health

The programme must be delivered the most deprived 10% of areas in the country. Well North seeks to make visible previously invisible at-risk people and attempt to solve, rather than manage, their illnesses and anxieties. Underpinning Well North is the recognition that for health inequalities to be addressed effectively, interventions must be built on developing community based programmes, which enable empowerment, control, self-determination and the freedom to lead lives that people have reason to value. Halton's approach is centred on three hubs:

1. Windmill Hill – building on community assets to support a bottom up approach for an Intergenerational Family Centre with Multidisciplinary teams, including a long term solution of access to medical services.

2. Halton Brook – building on a well-established community sector and multiple physical assets which lacks the expertise to capitalise on these in a way that will make them sustainable.

3. Well Widnes (Virtual Community Health Hub) – Building opportunities to create "start up and support" business models in the wards of Kingsway and Ditton between the public, private and voluntary, community and social enterprise (VCSE) sector to design, implement and govern a potential community Hub to stimulate entrepreneurship to improve the health and wellbeing of our local population.

Case Study 2: Healthy New Towns

Halton's Healthy New Town (Halton Lea) is all about people and community. People's needs and desires for a better environment, better housing and healthy community living. Our aim is to achieve this by designing-out elements which contribute to local poor health and designing-in better information, technology and services that promote health and wellbeing. To achieve all of this our immediate priorities and aims are:

1. *To develop a Masterplan for the Healthy New Town project:* This will involve a regeneration of the current hospital site and the derelict buildings adjacent to Runcorn Shopping Centre
2. *Focus on Runcorn Shopping Centre (RSC):* Halton Lea will not just be a place to shop, but a meeting place for health and social care knowledge exchange, local presentations, information about training and local employment as well as social interaction. We will link the RSC with the hospital site, multidisciplinary teams and the Halton Lea community via 'Community Navigators'
3. *Halton Hospital site:* We aim to reduce health inequalities and create a better community where people can access health and social care services more easily. This will improve their quality of life and wellbeing
4. *Digital Technology* as a cross-cutting theme: This will be a cross-cutting theme. Our aim is to link the Hospital site, Runcorn Shopping Centre and the Halton Lea community digitally. This will allow people to have access to services and information wherever they happen to be. We will continue to explore digital solutions to help support self-management, particularly among those with long-term conditions living at home

Appendix 1: Progress since 2013 (linked to Page 4 building upon success)

Priority	Some key actions delivered during the 2013-16 strategy lifetime	What impact has this had	Why it remains a priority or not
Alcohol	• Alcohol Strategy developed • Public Health Annual Report on Alcohol showcased local action • Halton chosen by the Home Office to be a Local Alcohol Action Area	• Hospital admission rates for under 18s have been falling. Halton levels are now similar to England and lower than the North West rate • Alcohol related admissions amongst adults have also been falling, closing the gap. However, Halton rates remain higher than England	The partnerships we have developed and the actions plans they have been implementing are now well established. These will continue. This means we no longer need to keep Alcohol as a local priority.
Cancers	• New cancer strategy developed • Halton Action on Cancer partnership established	• Cancer incidence increasing and now higher than England level • Screening uptake remains lower than England • increase in percentage of cancers diagnosed at an early stage with levels similar to England • Cancer death rates under 75 years continue to fall. However, some increases recently, including cancer deaths considered preventable • HPV vaccination rate higher than England and North West. • Smoking prevalence decreased amongst adults as a whole and for routine and manual workers. However, the gap remains. Figures for 2015 also show an increase from the downward trend	We continue to strive towards improving preventative action, early detection and treatment. There have been some significant gains such as reduced smoking prevalence and increased survival rates. However, as Halton still ranks as amongst one of the poorest areas for cancer outcomes (primarily death rates under age 75) we need to keep a focus on cancers.
Child Development	• Early years strategy developed • New partnership group established to oversee its implementation	• Infant death rates as well as healthy weight at birth and obesity of Year 6 children have all been improving and are now similar or better than the England average • Both smoking at time of delivery and breast feeding initiation rates are worse than the England average. However, there have been improvements in both indicators • Obesity levels at Reception age remains higher than England	As the data shows we have made improvements in many outcomes for young children. The main indicator being used to judge the success locally, 'the proportion of children achieving a good level of development at the

Priority	Some key actions delivered during the 2013-16 strategy lifetime	What impact has this had	Why it remains a priority or not
		• Improved proportion of children achieving a good level of development at end of reception ('school readiness'): 37% in 2013 to 61.9% in 2016. However, there remains a substantial gap between Halton and England • Child poverty was 25.9% in 2011 and fell to 23.6% in 2013	end of reception' has improved. However, we recognise our progress has been slow compared to some similar boroughs. As such we need to maintain a focus on this work.
Falls amongst older people	• Falls Strategy developed • Extra investment in falls prevention services • Links with care homes • Fire Service home safety checks include consideration of falls hazards and referrals where appropriate	• Following a slight reduction between 2012/13, the rates have seen small year on year increases • Admissions due to hip fractures decreased in 2012/13 but have since increased again	We have seen significant reduction in the number of people admitted for hip fractures but not a reduction in falls. We will continue this work and continue to monitor outcomes through the Healthy Ageing priority work programme.
Mental Health	• Mental Health Strategy across all ages developed, with an action plan • Major review and adult mental health services • Improved access to 'talking therapies' known as IAPT	• Self reported wellbeing scores have been falling • It is estimated nearly 20% of adults 16-74 years have common mental health problems. 8.4% have a diagnosis of depression. These are higher levels than England • Referrals, percentage entering and completing IAPT have all increased. Levels entering IAPT treatment higher than England with levels completing similar • Admissions due to self harm statistically higher than England and North West • Suicide rates similar to England	Despite some improvements, mental health remains the single biggest cause of ill health and disability in Halton. Services have been reviewed but not all new models of care have been fully implemented yet. We therefore need to maintain a focus on this area.

Insert logos of all organisations

Members of the One Halton Health and Wellbeing Board

Warrington and Halton Hospitals NHS Foundation Trust

St. Helens and Knowsley Hospitals

Halton Children's Trust

Halton Safeguarding Children Board

NHS Halton Clinical Commissioning Group

NHS England

Halton Borough Council

Healthwatch

Bridgewater Community Healthcare NHS Trust

Halton and St. Helen's Voluntary and Community Action

5 Boroughs Partnership NHS Foundation Trust

Halton Housing Trust

Cheshire Police

Cheshire Fire Service

We’d love to hear from you

Do you have stories about a local group you are involved with? Do you have any comments about this strategy or any of the ideas in it?

Please contact us at:

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WA7 5TD

Telephone: 0303 333 4300