This Business Plan extract contains information in relation to the delivery of the Council's following strategic priority area

A Healthy Halton

Our overall aim is to improve the health and wellbeing of Halton people so that they live longer, healthier and happy lives.

The priorities from the Health Policy and Performance Board in relation to Adult Social Care have been identified as:

- Care Homes – Funding and Sustainability;
- Supported Housing/Accommodation Review;
- Acute Trusts/Acute Mental Health – National pressures and how these translate into local pressures; and
- Accountable Care System.

Key Developments

ADULT SOCIAL CARE

1. Older People

i) **Transforming Domiciliary Care (TDC)** – The TDC programme aim is to progressively refine and implement an outcomes model for domiciliary care into a workable, effective solution, delivering clear outcomes for service users in terms of independence, wellbeing, and commissioners in terms of value for money. As part of the TDC programme, a re-tender of domiciliary care took place during 2017/18 to move to one centralised provider developing a flexible, responsive and holistic care provision model. A Programme Board is providing oversight of the overarching TDC programme which comprises 5 to 6 senior representatives from key stakeholders. This group ratifies all major decisions relating to the Programme and reports into the SMT for Adult Social Care.

ii) **Sustainability and Quality of the Care Home Sector: –** Work is ongoing with NHS CCG and care home providers to ensure we continue to improve the health and wellbeing of people who live in care homes. A Care Home Development Project Group has been formed to enable stakeholders representing key sectors to work collaboratively in exploring and implementing identified work streams. The work streams aim to:

- Share best practice and resources via sector-led improvements;
- Deliver dignified, quality, outstanding care within residential and community settings;
- Be proactive and identify early warnings of potential reductions in quality;
- Provide value for money and sustainability; and
- Provide seamless transfers of care to and from hospital.

2. Adults with Learning and/or Physical Disabilities

i) **Transforming Care** - Recognising the importance of effective transition for people with disabilities and/or complex needs (including those with autism), Halton established a dedicated

Transition Team early in 2017 alongside the development of a new multi-agency Transition Protocol for the period 2017-2020. This approach ensures that legislative obligations are met and the transition process is joined up across education, health and social care with increased and targeted co-ordination and communication from all agencies starting from Year 9 (age 13/14) up to the age of 25 years or until an individual's appropriate transfer into generic adult services.

i) **All-Age Autism Strategy** - A new All-Age Autism Strategy has been developed and will be implemented on 1st April 2018, based on the Government's *Think Autism* initiative. This is a high level strategy, designed to support people with autism in Halton, ensuring that services across Halton work in collaboration with key partners to move forward the priorities set out in ***Think Autism***. The strategy has been developed jointly with HBC, NHS Halton CCG, NW Boroughs NHS Foundation Trust, children with Autism and their families/carers, adults with Autism and their families/carers and providers of Autism services across Halton. A Delivery Plan focusses on the current gaps in services, where investment and resources to improve areas needs to be and where outcomes need to be improved.

3. Adults with a Mental Health Condition:

Halton's Dementia Delivery Plan for 2018/19 was developed in conjunction with people living with dementia, carers, voluntary and community sector and professional health and social care stakeholders. The priorities of the dementia delivery plan for 2018/19 include: Working with Hospital partners to understand the experience for people living with dementia, GP dementia care plan reviews, care home education and understanding local booked respite provision. The Halton Dementia Delivery Group are tasked with monitoring the implementation of the local Dementia Strategy and oversee the partnership work required to deliver actions on the dementia delivery plan.

4. Safeguarding:

i) **Deprivation of Liberty Safeguards** - Deprivation of Liberty Safeguards (DoLS) came into force on 1 April 2009 as a response to an identified breach of the European Convention on Human Rights. This is a particular challenge for the Council in responding to this large increase in the number of DoLS assessments and making sure we keep people safe. As a result of the mounting criticism of DoLS the Government requested the Law Commission undertake a review and in March 2017, they produced their final proposal on a replacement for the DoLS, and suggested amendments to the Mental Capacity Act itself. The changes to the act are to incorporate the new scheme, called the Liberty Protection Safeguards (LiPS), and to strengthen people's rights in areas such as best interest decisions. The Government confirmed that it will provide its final response to this report in Spring 2018.

ii) **Making Safeguarding Personal -** Making Safeguarding Personal is a joint Local Government Associated (LGA) and Association of Directors of Adults Social Services (ADASS) programme that supports Councils and their partners to develop outcomes-focused, person-centred safeguarding practice. The approach aims to facilitate a shift in emphasis in safeguarding from undertaking a process to a commitment to improving outcomes alongside people experiencing abuse or neglect. Making Safeguarding Personal is a shift in culture and practice in response to what is known about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances their involvement, choice and control as well as improving their quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. The key message about this approach

is a shift from a process supported by conversations to a series of conversations supported by a process.

5. Carers:

Halton has in place a joint carer's strategy with Halton NHS CCG, "Recognising, Valuing and Supporting Carers in Halton" which is due for review this year. In terms of Carers satisfaction of services, a bi-annual survey is undertaken focussing on carer reported quality of life, overall satisfaction of carers with social services and the proportion of carers who report that they have been included or consulted in discussions about the person they care for. This survey is due to take place during the Autumn 2018.

6. Homelessness

i) **Homelessness -** During the past few years there has been a National increase in homelessness. Halton also continues to experience a gradual increase in homelessness presentations, with the main causes identified as loss of home due to family exclusions, relationship breakdown or the loss of a private sector tenancy.

ii) **Homelessness Prevention** – Prevention is key to reducing homelessness, and the introduction of a number of preventative initiatives has proven successful among statutory and none statutory homeless households. This change from reactive assessment to proactive prevention, coupled with a housing options service, proved to be a significant factor in improvement and overall service delivery.

iii) In accordance with statutory requirement, Halton is undertaking a review of the **Homelessness Strategy,** which will identify key priorities and a devised action plan for 2018 - 2023. A consultation event is planned for February 2018 to ensure partner agency involvement and determine local priorities. The introduction of the Homelessness Reduction Act is due to be implemented on 1st April 2018 and will impact upon homelessness provision and service delivery. The 'Gold Standard' which previously steered the Homelessness Strategy has now been superseded by the new Act. The strategy will reflect the 'Housing First Model' and will cover current activity around the resettlement of refugees.

PUBLIC HEALTH

The key developments for Public Health are: A 2018 – 2023 Whole System Healthy Eating and Exercise Strategy and Action Plan to tackle the challenge of overweight and obesity in the local population; a refresh to the Sexual Health Strategy and recommissioning of the service; linking in with the Cheshire & Merseyside Cancer Alliance to highlight the importance of early detection and recognition of signs and symptoms; joint working across Cheshire & Merseyside on Mental Health with a particular emphasis on tackling self-harm in young people and reducing suicide rates; building on our strategy to tackle high blood pressure by working with community pharmacies and implementing quality improvement programmes for Primary Care; and focussing on the Thrive Model for Child Mental Health which will ensure swift access to support and services.

1. Healthy Weight

Overweight and obesity present a big Public Health challenge both nationally and locally. This is really due to its association with serious chronic diseases such as Type 2 diabetes, hypertension and hyperlipidaemia. These are major risk factors for cardiovascular disease and cardiovascular related deaths. Obesity is also associated with cancer, disability, reduced quality of life and can lead to premature death (Healthy Lives, Healthy People, A call to action on obesity in England).

In 2016/17, 26.6% of Reception year children in Halton were overweight or obese and 38.1% in Year 6. The Active People Survey for 2012 also indicates that adult levels of excess weight are estimated at 74%, which also gives cause for further concern.

The causes of obesity are complex. Tackling obesity requires action at every level, from the individual to society, and across all sectors.
In Halton we promote a coordinated life course approach to tackling overweight and obesity which recognises the barriers local people face when trying to practice a healthy diet or undertake regular physical activity. The focus on healthy weight rather than obesity reflects intentions to encourage people from an early age to maintain a healthy weight, to minimise the stigma attached to the term obese and encourage people to see their weight in a positive way.

A review of weight management services in Halton is currently underway to ascertain the best model of service delivery moving forward. Alongside this, Public Health England, the Local Government Association and the Association of Directors of Public Health have entered into a partnership with Leeds Beckett University with a view to designing local whole systems approaches to assist in preventing and tackling obesity. Halton is one of only 6 local authority areas across England chosen as a pioneer site. Pioneer status means that we will supported by Leeds Beckett University and Public Health England to make a major step change in dealing with this important and challenging issue.

The programme recognises the crucial role of local authorities (LAs) in tackling and working to prevent obesity. As well as having responsibility for many of the contributing factors (leisure services, parks and green spaces, planning, economic regeneration) local authorities can play a key co-ordinating role for engaging wider partners (health, education, housing providers, and the community and voluntary sector).

Pioneer status will enable us to build upon local partnership work and best practice to develop a whole system approach. We will test a draft route map and tools to support it: this process will take Halton (local authority and wider stakeholders) through the process of thinking through why obesity matters in its widest context, who needs to be involved in bringing about change, and creating an action plan that is evidence-based, personal to and owned by the local area.
In effect, it is envisaged that the results of this work will provide the framework for Halton's Healthy Weight Strategy.

2. Sexual Health

In Halton, we recognise that good sexual and reproductive health is an important aspect of health and wellbeing and it is crucial have information, confidence and are able to make choices that are right for them. Improving the sexual health of the whole population to make sure that people are free from stigma and safe from sexual abuse or exploitation is of paramount importance.

We are working with local partners to refresh our Sexual and Reproductive Heath Strategy, which is due to be finalised soon. The strategy has taken on board local consultation and has identified priorities for action based on local need and consultation responses.

3. Cancer

Cancer remains one of the main causes of death and illness for residents in Halton. Death rates remain some of the highest in the country and are the biggest single killer locally. Our highest rates for cancer are lung, bowel and breast; these are related to lifestyle issues. Smoking rates have been falling but alcohol-related hospital admissions and obesity rates for adults remain high.

Efforts in Halton focus on preventing cancer through promoting healthy lifestyles (not smoking, maintaining a healthy body weight, being active, eating a healthy and balanced diet, reducing alcohol consumption and enjoying the sun safely) and we are working to improve cancer survival rates by promoting the early detection and effective treatment of cancer. The proportion of cancers caught early is similar to England and survival rates have been rising. Cancer screening rates have improved but are still lower than nationally. This is especially so for bowel screening uptake.

Halton is closely associated with the various work streams across the Cheshire and Merseyside Cancer Alliance and is supporting the development and implementation of a Cheshire and Merseyside wide Cancer Prevention Plan.

4. Mental Health

Mental Health is a key health and wellbeing priority and as such, is supported by the Mental Health Strategy and Action Plan. This provides a robust framework which identifies need and co-ordinates activity across the life-course from maternal mental health, through to childhood and into old age. The strategy also covers the spectrum of need from prevention and early intervention to treatment services.

1 in 4 people attending their GP seek advice on mental health problems and levels of hospital admissions due to self-harm are significantly higher than the England average. Many social factors make children more at risk of development mental health problems.

Currently suicide rates in Halton are lower than the England average across all ages and gender but in line with national trends, this is rising. Halton has a current suicide prevention strategy and action plan and are currently involved in collaborative work across Cheshire and Merseyside on the Zero Suicide strategic approach which has been highlighted as best practice at national level.

Halton has an ageing population and in 2017, had a diagnosis rate of 76.2% of those over 65 years of age. This is higher than the national average and represents a positive approach to case finding, diagnosis and access to treatment.

5. Cardio-Vascular Disease (CVD)

This remains a local priority as a quarter of all deaths in Halton are caused by cardiovascular diseases and one in five of the CVD deaths are premature (occurring in people under 75 years of age). The prevalence of strokes was 2% last year; the two biggest risk factors for this are hypertension and atrial fibrillation. For men in Halton 1 in 20 deaths are due to coronary heart disease and for women

it is higher at 1 in 13. Hypertension is the most common long term condition in Halton, and the second highest risk factor for early death and disability, addressing high blood pressure has already been identified as a prevention priority locally as well as regionally for the Cheshire and Merseyside Health and Care Partnership (formerly STP)

There is no single solution to tackle CVD, and a systems wide response is required to prevent, detect and optimally manage these conditions. The C&M strategy to tackle high BP, 'Saving lives: Reducing the pressure' was launched in May 2016 and set out a series of high-level deliverables for 2016-2018. Work on tackling blood pressure and on Atrial Fibrillation (AF) has already started with partners across the region which has direct local benefits. The lifestyle risks that contribute to cardiovascular disease are largely preventable and include lack of physical activity, excess alcohol consumption, smoking and obesity. The Health Improvement team offers a diverse range of services to enable people moderate their lifestyle risks, the underlying causes of these causes remain societal contributing factors like poverty, educational attainment and the built environment.

6. Child Development

Child development continues to be the main priority for children for the One Halton Health and Wellbeing strategy, and the team are working to improve outcomes through a range of different avenues. A child development action plan is in progress.

In Halton 24% of children live in poverty despite the majority of their parents being in full time employment. 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. However, 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.

North West Boroughs Healthcare have been jointly commissioned by the CCG and Public Health to deliver the Tier 2 children and young people's mental health service (CAMHs). This service has been in place since July 2015 and, as well as providing the targeted mental health service provides mental health and wellbeing training for staff working with children and young people, such as schools, school based face-to-face work and an online counselling service. Additional support for schools to enhance wellbeing includes Mindfulness, Youth connect 5 for parents and cyber bullying.

Over the past 12 months, work has started to develop a new model of service delivery for CAMHs known as THRIVE. This new approach seeks to remove the existing Tiers of service provision linked to different levels of need and join these up across the system. This approach should provide a more seamless approach that focusses on the holistic needs of children and young people.

7. Emerging Issues in Public Health

Public health is facing a continued reduction in funding from both local and national budget reductions. A significant challenge going forward will be the continued need to meet council financial efficiency expectations alongside a reduction in the Public health funding allocation.

The development of the One Halton Accountable Care structures will provide challenge to public health in ensuring that prevention is embedded within new developing structures and work streams as a key priority. It is also vital to ensure that widespread system change does not destabilise the existing programmes and initiatives.

Appendix 1

Objectives, Milestones and Measures

Adult Social Care

Service Objective: 1	Working in partnership with statutory and non-statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for people with Complex Care needs.		
Key Milestone(s) (17 / 20)	**Mental Health:** ▪ Monitor the Local Dementia Strategy Action Plan, to ensure effective services are in place. **Mar 2020**. **Homelessness:** ▪ The Homelessness strategy be kept under annual review to determine if any changes or updates are required. **Mar 2020**.		
Responsible Officer:		**Linked Indicators:**	ASC 11, 12 (A), (B), 13, 14, 15, 16, 17

Service Objective: 2	Working in partnership with statutory and non-statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for vulnerable people		
Key Milestone(s) (17 / 20)	▪ Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target **2020.** ▪ Integrate frontline services with community nursing **2020**. ▪ Monitor the Care Management Strategy to reflect the provision of integrated frontline services for adults **March 2020.**		
Responsible Officer:		**Linked Indicators:**	ASC 01, 02, 03, 04 (Annual Collection Only)

Service Objective: 3	Continue to effectively monitor the quality of services that are commissioned and provided in the borough for adult social care service users and their carers.		
Key Milestone(s) (17 / 20)	▪ Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets. **March 2020.** ▪ Monitor and review all ASC milestones in line with three year planning cycle. **March 2020.**		
Responsible Officer:		**Linked Indicators:**	ASC 21, 26, 27, 28, 29, (Annual Collection Only) ASC 22, 23, 24, 25 (Biennial Collection Only)

Service Objective:	Working in partnership with statutory and non-statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for vulnerable people		
Key Milestone(s) (17 / 20)	**Safeguarding:** ▪ Monitor and review all milestones in line with three year planning cycle. **March 2020**.		
Responsible Officer:		**Linked Indicators:**	ASC 18, 19, 20 (A), (B), 21 (Annual Collection Only)

Service Objective:	Effectively consult and engage with people who have Complex Care needs to evaluate service delivery, in the form of an annual survey to highlight any areas for improvement and contribute towards the effective re-design of services where required		
Key Milestone(s) (17 / 20)	▪ Monitor and review all ASC milestones in line with three year planning cycle. **March 2020.**		
Responsible Officer:		**Linked Indicators:**	ASC 21, 26, 27, 28, 29, (Annual Collection Only)

Service Objective:	Ensure that there are effective business processes and services in place to enable the Directorate to manage, procure and deliver high quality, value for money services that meet people's needs		
Key Milestone(s) (17 / 20)	▪ Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place. **Mar 2020**. ▪ Monitor and review all ASC milestones in line with three-year planning cycle. **Mar 2020**		
Responsible Officer:		**Linked Indicators:**	N/A

Ref	Description	16/17 Actual	17/18 Target	17/18 Actual	18/19 Target
ASC 01	Permanent Admissions to residential and nursing care homes per 100,000 population 65+ ***Better Care Fund performance metric***	515.3	635		

ASC 02	Delayed transfers of care (delayed days) from hospital per 100,000 population. ***Better Care Fund performance metric***	5245	5247		
ASC 03	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population. ***Better Care Fund performance metric***	18657	17570		
ASC 04	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B) ***Better Care Fund performance metric***	62.12%	63%		
ASC 05	Percentage of items of equipment and adaptations delivered within 7 working days	93%	96%		
ASC 06	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support – include brief definition) (Part 1)	74%	80%		
ASC 07	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support – include brief definition) (Part 2) DP	44%	46%		
ASC 08	Proportion of adults with learning disabilities who live in their own home or with their family (ASCOF 1G)	86.9%	87%		
ASC 09	Proportion of adults with learning disabilities who are in Employment (ASCOF 1E)	5.94%	5%		
ASC 10	Out of Borough Placements – number of out of borough residential placements	32	30		
ASC 11	Percentage of adults accessing Mental Health Services, who are in employment.	8.1%	TBC		
ASC 12 (A)	Percentage of adults with a reported health condition of Dementia who are receipt of services.	52.86%	TBC		
ASC 12 (B)	Percentage of Carers who receive services, whose cared for person has a reported health condition of Dementia.	11.57%	TBC		
ASC 13	Homeless presentations made to the Local Authority for assistance In accordance with Homelessness Act 2002.	New	500		
ASC 14	Homeless Households dealt with under homelessness provisions of Housing Act 1996 and LA accepted statutory duty	New	100		
ASC 15	Homelessness prevention, where an applicant has been found to be eligible and unintentionally homeless.	New	1650		

ASC 16	Number of households living in Temporary Accommodation	1	17		
ASC 17	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough)	6.62%	6.00%		
ASC 18	(SCS SH5) Percentage of VAA Assessments completed within 28 days	83.5%	88%		
ASC 19	Percentage of existing HBC Adult Social Care staff that have received Adult Safeguarding Training, including e-learning, in the last 3-years (Previously PA6 [13/14] change denominator to front line staff only.	48%	56%		
ASC 20 (A)	DoLS – Urgent applications received, completed within 7 days.	73%	80%		
ASC 20 (B)	DoLS – Standard applications received completed within 21 days.	77%	80%		
ASC 21	The Proportion of People who use services who say that those services have made them feel safe and secure – Adult Social Care Survey (ASCOF 4B)		82%		
ASC 22	Proportion of Carers in receipt of Self Directed Support.	99.4%	99%		
ASC 23	*Carer reported Quality of Life (ASCOF 1D, (this figure is based on combined responses of several questions to give an average value. A higher value shows good performance)*		N/A		
ASC 24	*Overall satisfaction of carers with social services (ASCOF 3B)*		N/A		
ASC 25	The proportion of carers who report that they have been included or consulted in discussions about the person they care for (ASCOF 3C)		N/A		
ASC 26	Do care and support services help to have a better quality of life? (ASC survey Q 2b) ***Better Care Fund performance metric***		93%		
ASC 27	Social Care-related Quality of life (ASCOF 1A). (This figure is based on combined responses of several questions to give an average value. A higher value shows good performance)	19%	20		
ASC 28	The Proportion of people who use services who have control over their daily life (ASCOF 1B)	74%	80		
ASC 29	Overall satisfaction of people who use services with their care and support (ASCOF 3A)	71.80%	70		

Public Health

Service Objective 1	**Weight Management**		
Key Milestone(s) (17 / 20)	▪ Development and ratification of a healthy weight strategy ▪ Demobilisation of current specialist tier 3 weight management provider and provision of an in house integrated healthy eating and exercise service to include support across the life course ▪ Increase the percentage of children and adults achieving recommended levels of physical activity. ▪ Increase the percentage of children and adults meeting the recommended '5-a-day' on a 'usual day'. ▪ Reduce the levels of children and adults who are overweight and obese.		
Responsible Officer:	Elspeth Anwar	**Linked Indicators:**	PH 02 a, PH 2.06, PH2.11, PH 2.12, PH 2.13

Service Objective 2	**Sexual Health**		
Key Milestone(s) (17 / 20)	▪ Ratification of Sexual and Reproductive Health Strategy for Halton ▪ Feasibility assessment of a Cheshire and Merseyside wide Joint commissioning for sexual and reproductive health services ▪ Increase coverage of HIV testing ▪ Increase the proportion of 15-24 years olds screened for chlamydia ▪ Increase the portion of women choosing Long Acting Reversible Contraceptive methods such as Intra uterine devices.		
Responsible Officer:	Sarah Johnson Griffiths	**Linked Indicators:**	PHOF indicator 2.04 PHOF indicator 3.02

Service Objective 3	**Cancer**
Key Milestone(s) (17 / 20)	• Reduce smoking prevalence overall and amongst routine and manual groups and reduce the gap between these two groups. • Increase uptake of cancer screening (breast, cervical and bowel).

	• Improved percentage of cancers detected at an early stage. • Improved cancer survival rates (1 year and 5 year). • Reduction in premature mortality due to cancer.		
Responsible Officer:	Sarah Johnson Griffiths	**Linked Indicators:**	PH 2.14, PH 2.19, PH 2.20, PH 4.05

Service Objective: 4	**Mental Health**		
Key Milestone(s) (17 / 18)	• Creation and roll out a package of age relevant self-harm programmes across all schools in Halton • Achieve Suicide Safer Community Status across the C&M footprint • Reduced level of hospital admissions due to self-harm. • Improved overall wellbeing scores and carers' wellbeing scores. • Reduced excess under 75 mortality in adults with serious mental illness (compared to the overall population). • Reduce suicide rate		
Responsible Officer:	Sarah Johnson Griffiths	**Responsible Officer:**	PH 2.23, PH 4.10

Service Objective 5	**CVD**
Key Milestone(s) (17 / 20)	▪ Ensure local delivery of the National Health Checks programme in line with the nationally set achievement targets ▪ 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.

Responsible Officer:	Ifeoma Onyia	**Linked Indicators:**	PH 2.22, PH 2.14, PH 4.04

Service Objective 6	**Child Development**		
Key Milestone(s) (17 / 20)	▪ Improvement in the percentage of children achieving a good level of development at age 5. ▪ Reduction in percentage of women smoking at time of delivery. ▪ Increased percentage of women breast feeding (initiation and at 6-8 weeks).		
Responsible Officer:	Julia Rosser	**Linked Indicators:**	PH 1.02, PH 2.01, PH 2.02, PH 2.03,

Ref	Description	15/16 Actual	16/17 Target	16/17 Actual	17/18 Target
PH 1.02	School readiness	61.9%			66%
PH 2.02	Breastfeeding 6-8 weeks after birth	21.8%		22.0%	23%
PH 2.03	Smoking status at time of delivery	19.3		16.4	15%
PH 2.06	Child excess weight in 4-5 and 10-11 year olds i reception year ii year 6	i 26.9% ii 37.9%		i 26.6% ii38.3%	i 26.0 ii 38
PH 2.10	Self-Harm Emergency Admissions ((Emergency admissions, all ages, directly standardised rate per 100,000 population))	341.5	301.3	336.7 *(provisional)*	298.3
PH 2.13	Proportion of physically active adults (Percentage of adults achieving at least 150 minutes of physical activity per week)	58.1%	49.0% (2016)		49.5% (2017)
PH 2.14	Smoking prevalence – adults (over 18s) (% adults who currently smoke)	20.1% (2015)	19.5% (2016)	16.6% (2016)	19.0% (2017)
PH 2.19	Cancer diagnosed at stage 1 and 2	50.3%			52%

		(2015 experimental data)			
PH 2.20	National screening programmes i breast screening coverage ii cervical screening coverage iii bowel screening coverage	i74.1% ii71.8% iii53.3% (2016)			i74.5% ii72.0% iii55%
PH 2.22	Take up of the NHS Health Check programme (cumulative % of those offered a health check that took it up)	45.1% 2013/4 – 16/17)			
PH 2.23	Self-reported well-being (% of people with a low happiness score)	12.7%	12.6%		12.7%
PH 3.02	Chlamydia detection rate (rate of chlamydia detection per 100,000 15-24 year olds)	1786 (2016)			1800
PH 4.04	Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke) (Directly Standardised Rate, per 100,000 population) *Published data based on calendar year, please note year for targets*	93.4 *(2014-16)*	93.1 (2015-17)		92.1 (2016-18)
PH 4.05	Under 75 mortality rate from cancer (Directly Standardised Rate, per 100,000 population) *Published data based on calendar year, please note year for targets*	169.2 (2014-16)	167.5 (2015-17)		165.8 (2016-18)
PH 4.10	Suicide rate (age standardised mortality rate form suicide and injury of undetermined intent per 100,000 population)	7.5 (2014-16)	7.3 (2015-17)		7.1 (2016-2018)