REPORT TO:	Health and Wellbeing Board
DATE:	4 July 2018
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	One Halton Prevention Framework and Model
WARDS:	Borough Wide

1.0 PURPOSE OF THE REPORT

To provide Health and Wellbeing Board members with the final version of the One Halton Population Health Framework and Model.

2.0 RECOMMENDATION: That the Board endorse the One Halton Framework and model.

3.0 SUPPORTING INFORMATION

The One Halton Population Health Framework developed in conjunction with Cheshire and Merseyside Health & Care Partnership Prevention Board, Public Health England (PHE), Halton Borough Council, NHS Halton CCG, NHS providers, the voluntary sector and third sector seeks to support the delivery of the prevention challenge.

Traditionally efficiencies have been delivered through improved delivery of care but meeting the current goals of saving lives, reducing morbidity, improving quality, being more cost effective and reducing inequalities requires a new solution and a focus on stemming demand through delaying or preventing the onset of need.

This Population Health Framework sets out evidence based guidelines partners can use to create a transformational and sustainable shift in the health and wellbeing of the Cheshire and Merseyside population.

This approach promotes the integration of health, mental health and social care services, the development of multidisciplinary and multisector teams working together to improve population health. This includes individual care management, the mobilisation of community assets, committing to integrated care models, and making every contact count across sectors, as well as population level interventions like access to employment and workplace health and education.

In support of this approach the Prevention Framework provides practical guidelines and the opportunity to self-assess and review against them for each place based care system working on population health with:

- Local system leaders
- Local communities
- General Practices or Primary Care Hubs
- Local tertiary and acute providers

4.0 POLICY IMPLICATIONS

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

5.0 FINANCIAL IMPLICATIONS

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

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

The best start in life is essential if children and young people are to have good physical, social and emotional health. A robust prevention framework and model will ensure this is embedded throughout the system.

6.2 Employment, Learning and Skills in Halton

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton. The prevention model and framework includes child development as a priority.

6.3 A Healthy 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

6.4 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

Developing the Prevention Model and Framework does not present any obvious risk however, there are risks associated with the sustainability of the health system if we do not implement the model. These will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

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 1 Halton Prevention Model and Framework 2018

Lead Officer: Eileen O'Meara

One Halton Population Health Framework

About this Population Health Framework

The One Halton Population Health Framework developed in conjunction with Cheshire and Merseyside Health & Care Partnership Prevention Board, Public Health England (PHE), Halton Borough Council, NHS Halton CCG, NHS providers, the voluntary sector and third sector seeks to support the delivery of the prevention challenge.

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Systems Leaders Framework

1. To embed Prevention within corporate governance structures, appoint a board level champion for prevention and ensure health is in all policies.

2. To prioritise a relentless focus on wellbeing, prevention and early intervention.

3. To develop the workforce so they deliver on prevention and embed *Making Every Contact Count* (*MECC*) within all contracts and commissioning, ensuring data collection and contract management reflects MECC outcomes.

4. To work in partnership through commissioning bodies and Health and Wellbeing Boards to mainstream commissioning for prevention and develop clear prevention and lifestyle service pathways with a single point of access.

5. To tackle unwarranted variation across clinical services, and reduce exception reporting within the Quality Outcomes Framework.

6. To adopt a universal approach to prevention with additional resources for areas of acute deprivation and need.

7. To have a digitally mature system with shared health and social care records so we identify issues sooner and treat people more effectively.

8. To recognise that the residents of Cheshire and Merseyside will be key agents in supporting and achieving better health outcomes.

9. To develop a Corporate Social Responsibility Strategy with social value and prevention at its heart to maximise the organisation's impact for prevention across its staff, estates and corporate activity.

10. To consider **system, scale** and c**onsistency** in implementation, delivery, marketing and communication of population health programmes.

Community Framework

1. To utilise the local community and the voluntary sector as a key asset for prevention and co-create health and wellbeing initiatives with Halton communities, the voluntary sector and local social networks.

2. To build capacity and increase the use of local non health workforces to deliver prevention: fire & rescue services, housing associations, sports clubs, community development teams, social prescribing, voluntary and third party sector, etc.

3. To work with local companies to engage with the local community, deliver the workforce health charter and offer workplace health initiatives.

4. To work with planners to develop healthy neighbourhoods that encourages an active lifestyle and is dementia and disability friendly.

5. To provide support in a variety of ways for local people who have a disability, long term illness or mental health condition, including safeguarding them from harm and acting on allegations of neglect or abuse.

6. To train and accredit community champions, volunteers and advocates such as dementia friend training.

7. To work with local retailers to retail products that have an impact on health responsibly.

8. To offer Healthy Schools and Early Years Programmes.

9. To offer integrated self-help, wellness and lifestyle programmes in the community including: managing long term conditions, diet, exercise, reducing harm from alcohol, stopping smoking and improving emotional resilience and access to psychological therapies.

10. To enable local communities to access information digitally and in hard copy on local assets.

Primary Care Framework

1. Health and Wellbeing staff including: health trainers, youth workers, drug and alcohol staff, social workers, mental health staff, as required, be part of the Primary Care Hubs and the Multi-Disciplinary Team model for intermediate and complex care patients.

2. Public health nurses, health visitors, family nurse practitioners, school nurses and social care workers linked to Primary Care Hubs.

3. Systematic referral to sources of non-clinical support through social prescribing and community connecting roles, aligned with wider approaches to community capacity building and stronger partnerships with voluntary organisations.

4. Embed shared decision making and enabling choice, so that people are knowledgeable and supported as equal partners in decisions about their care and treatment.

5. People and families are supported in the way they need to manage their health that suits them best, tailored to their level of knowledge, skills and confidence. This includes focused care, health coaching, self-management education and systematic access to peer support options; measured through tools such as the Patient Activation Measure.

6. Hospital specialists have a more holistic understanding of patients by linking into Primary Care Hubs and participating in MDTs, offering phone advice, electronic advice and delivering training.

7. Provide personalised care and support planning as a proactive process, bringing together people's and families physical, mental health and wellbeing needs into a single conversation focused on what is important to them and co-ordinating better access to personalised care and treatment, alongside psychosocial and community based support.

8. Have integrated personalised commissioning, including personal health budgets and integrated personal budgets, enabling people who could benefit to take control of resources to meet their health and care needs.

9. Increase awareness of the value of national screening programmes and increase uptake.

10. In house training and education programmes for staff and patients on self-management, health

literacy, behaviour change, MECC and specialist topics.

Provider Framework

1. Tertiary and secondary prevention that reduces the impact of established disease through interventions such as lifestyle advice and cardiac or stroke rehabilitation programmes embedded in all Trusts.

2. Commonality of prevention pathways across all Trusts.

3. Have holistic approaches to history taking to address lifestyle and other risk factors and use this information in care planning and include in discharge summaries.

4. To share information on clinical and lifestyle risks in referral and discharge summaries to ensure that prevention is addressed at all points in pathways and that patients are included on relevant disease registers as early as possible.

5. Systematically adopt a Making Every Contact Count (MECC) approach with the delivery of all services supported by necessary staff training and IT infrastructure to record activity and outcomes.

6. Mandatory common competency and training frameworks for the workforce.

7. All Trusts aligned to the national lifestyle CQUINs. Ensure healthy food provision within all premises, removing sugary snacks and beverages from vending machines in public sector buildings.

8. A regional dashboard to compare and contrast shared outcomes from prevention work.

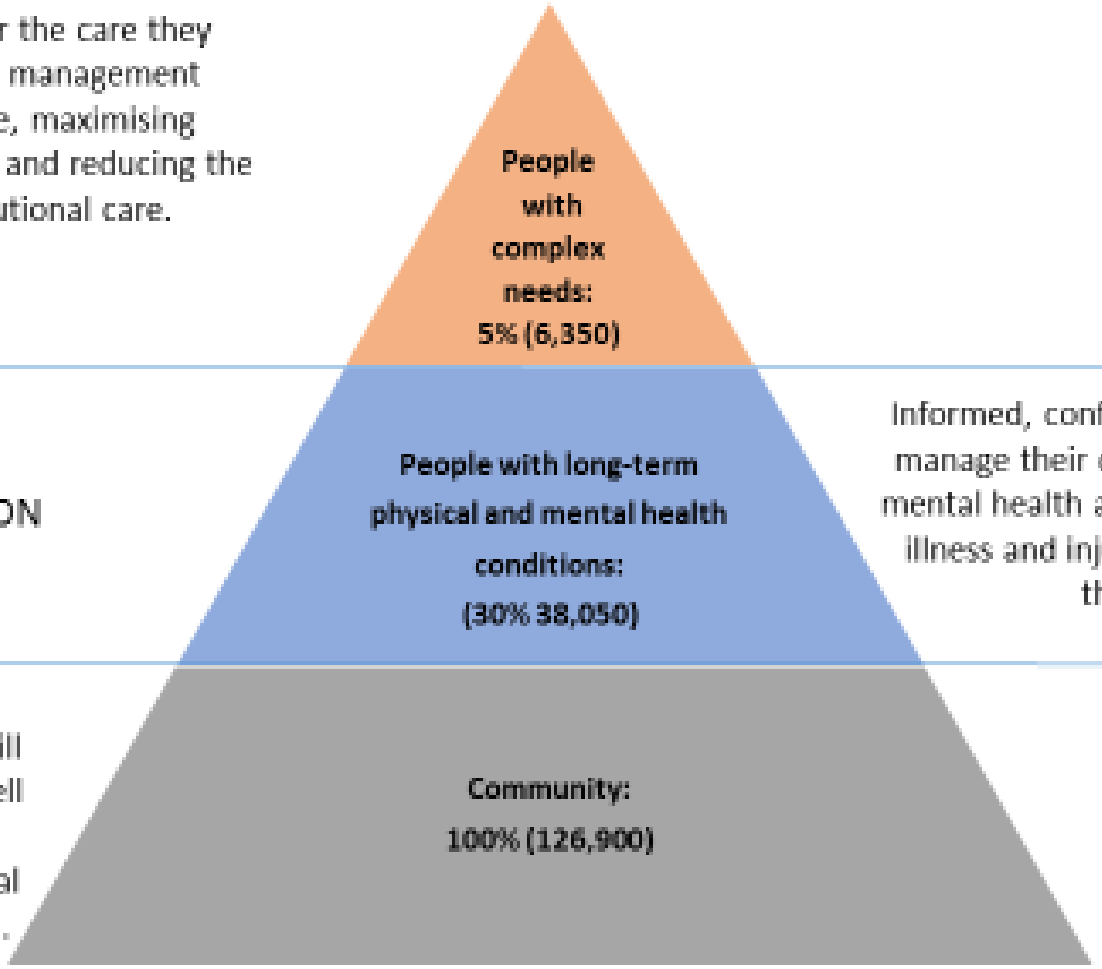
9. Hospital specialists and Community Trust specialists run joint clinics in the community and be part of primary care Multi-Disciplinary Teams.

10. A holistic approach to health and social care for all; integrating physical and mental health during consultations and treatment.

THE ONE HALTON PREVENTION & POPULATION HEALTH MODEL
TARGET POPULATIONS AND OUTCOMES.

Informed, confident individuals better skilled to have choice and control over the care they receive due pro-active case management promoting earlier discharge, maximising rehabilitation and re-ablement and reducing the need for long-term institutional care.

TERTIARY PREVENTION

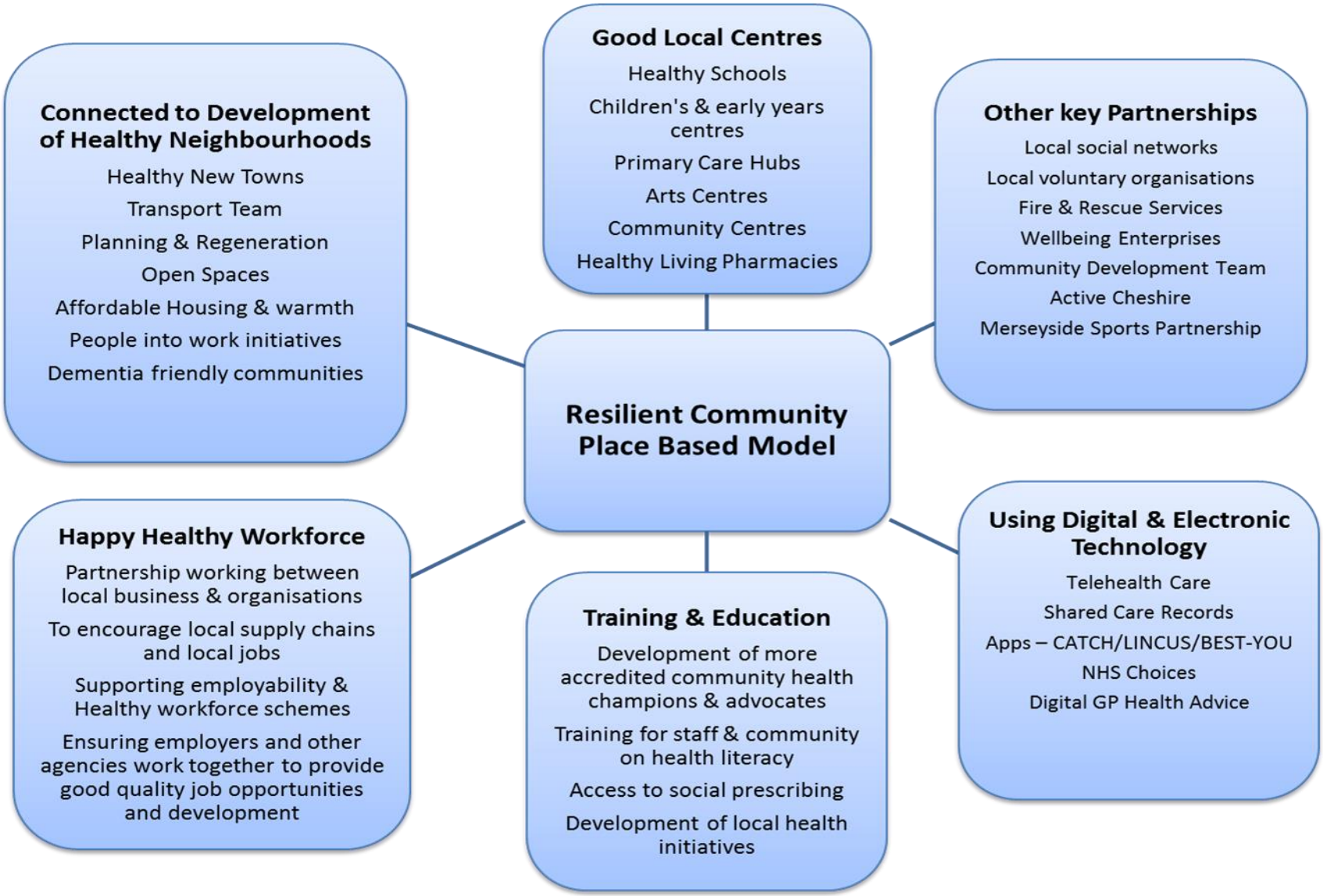


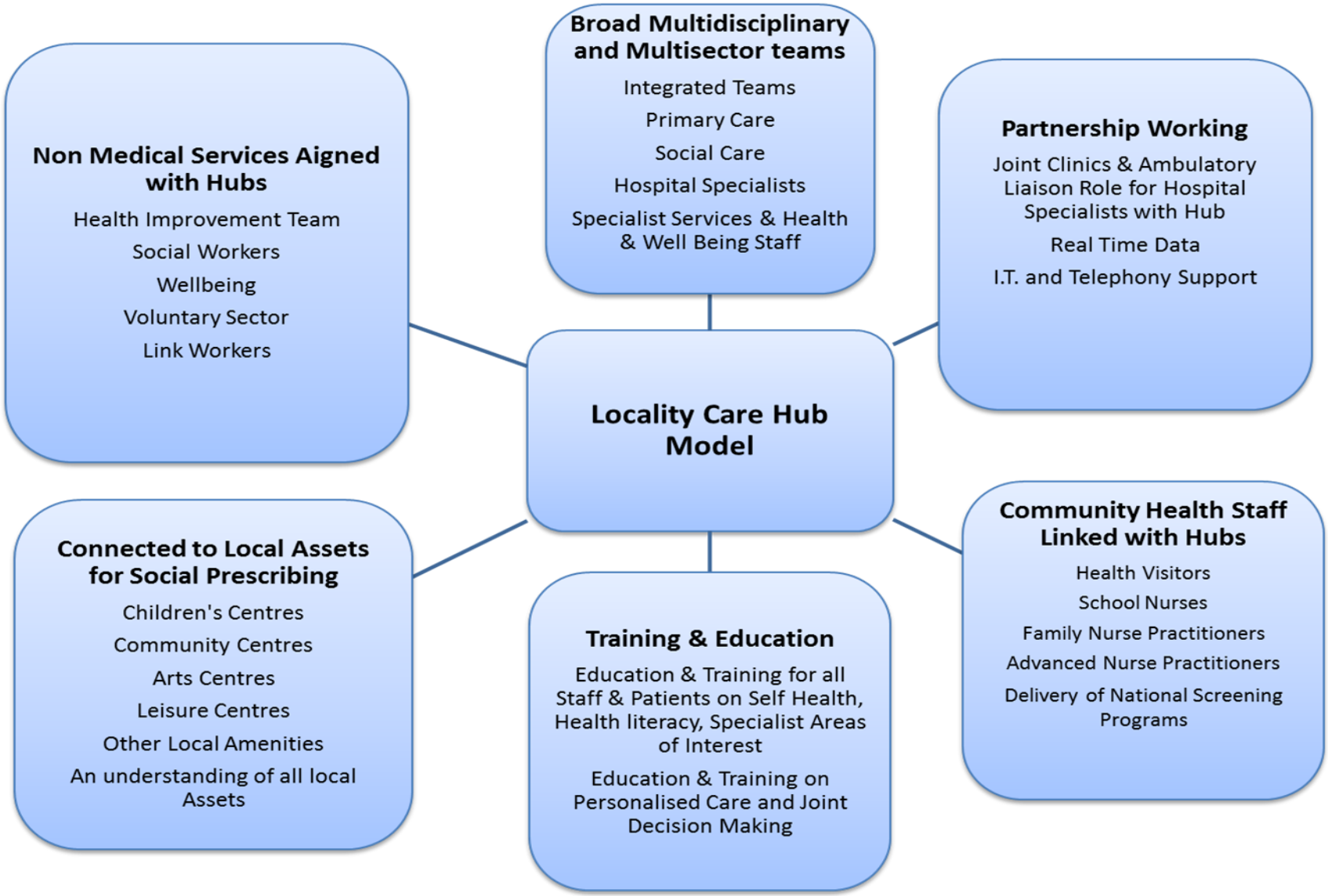
Informed, confident individuals better skilled to manage their own long term health conditions, mental health and disabilities and their children's illness and injury and able to manage changes that occur with aging.

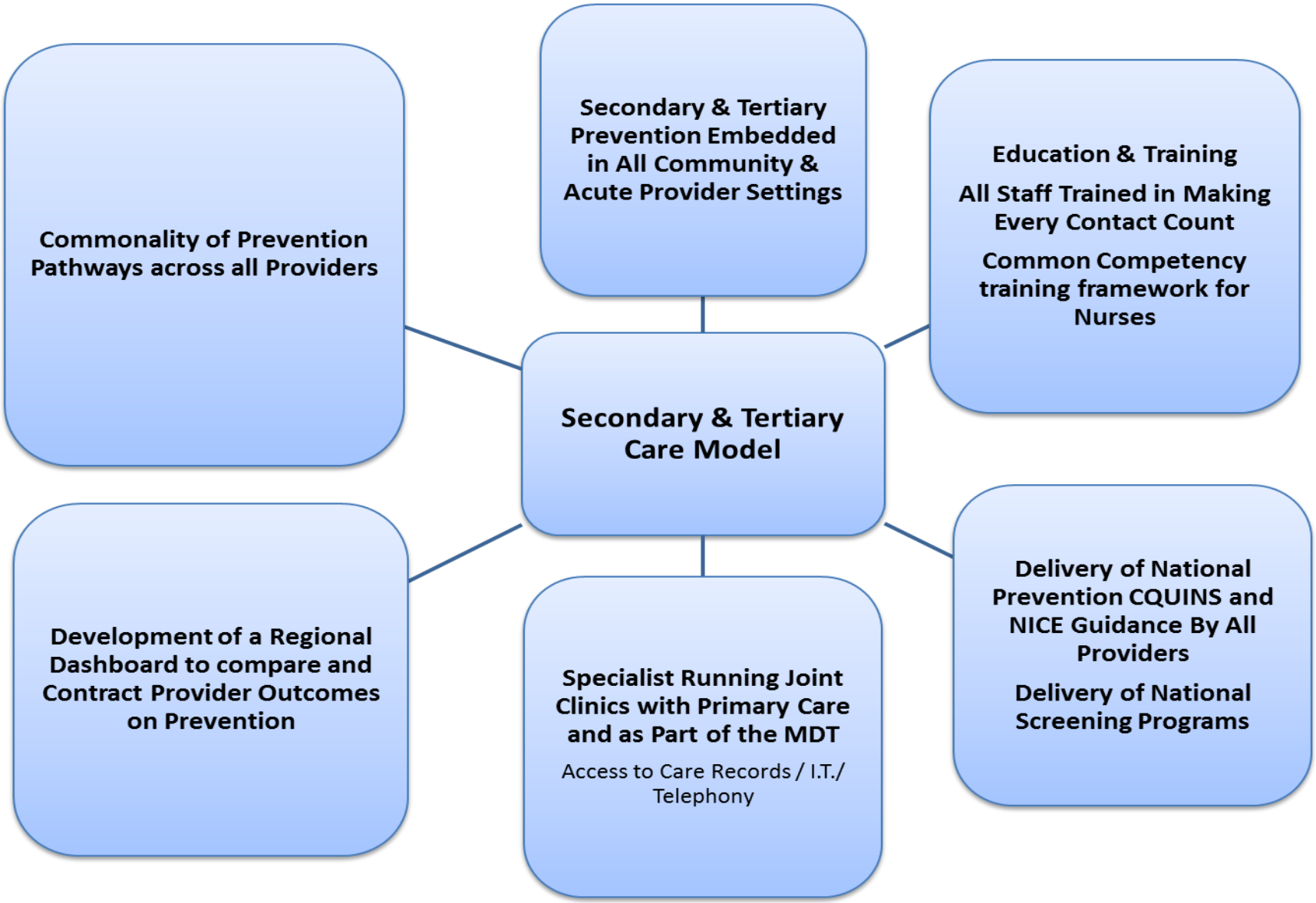
SECONDARY PREVENTION

Active resilient communities redressing the determinants of ill health and supported to stay well and look after themselves to maximise mental, physical, social prescribing and spiritual health.

PRIMARY PREVENTION


Resilient Community Place Based Model
Good Local Centres
Healthy Schools
Children's & early years centres
Primary Care Hubs
Arts Centres
Community Centres
Healthy Living Pharmacies
Connected to Development of Healthy Neighbourhoods
Healthy New Towns
Transport Team
Planning & Regeneration
Open Spaces
Affordable Housing & warmth
People into work initiatives
Dementia friendly communities
Other key Partnerships
Local social networks
Local voluntary organisations
Fire & Rescue Services
Wellbeing Enterprises
Community Development Team
Active Cheshire
Merseyside Sports Partnership
Happy Healthy Workforce
Partnership working between local business & organisations
To encourage local supply chains and local jobs
Supporting employability & Healthy workforce schemes
Ensuring employers and other agencies work together to provide good quality job opportunities and development
Training & Education
Development of more accredited community health champions & advocates
Training for staff & community on health literacy
Access to social prescribing
Development of local health initiatives
Using Digital & Electronic Technology
Telehealth Care
Shared Care Records
Apps – CATCH/LINCUS/BEST-YOU
NHS Choices
Digital GP Health Advice


Broad Multidisciplinary and Multisector teams
Integrated Teams
Primary Care
Social Care
Hospital Specialists
Specialist Services & Health & Well Being Staff
Non Medical Services Aigned with Hubs
Health Improvement Team
Social Workers
Wellbeing
Voluntary Sector
Link Workers
Partnership Working
Joint Clinics & Ambulatory Liaison Role for Hospital Specialists with Hub
Real Time Data
I.T. and Telephony Support
Locality Care Hub Model
Connected to Local Assets for Social Prescribing
Children's Centres
Community Centres
Arts Centres
Leisure Centres
Other Local Amenities
An understanding of all local Assets
Training & Education
Education & Training for all Staff & Patients on Self Health, Health literacy, Specialist Areas of Interest
Education & Training on Personalised Care and Joint Decision Making
Community Health Staff Linked with Hubs
Health Visitors
School Nurses
Family Nurse Practitioners
Advanced Nurse Practitioners
Delivery of National Screening Programs


Secondary & Tertiary Care Model
Commonality of Prevention Pathways across all Providers
Secondary & Tertiary Prevention Embedded in All Community & Acute Provider Settings
Education & Training
All Staff Trained in Making Every Contact Count
Common Competency training framework for Nurses
Development of a Regional Dashboard to compare and Contract Provider Outcomes on Prevention
Specialist Running Joint Clinics with Primary Care and as Part of the MDT
Access to Care Records / I.T./ Telephony
Delivery of National Prevention CQUINS and NICE Guidance By All Providers
Delivery of National Screening Programs

References

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- Addressing Prevention through the Development of New Care Models. 2016, Public Health England, Dr Marilena Korkodilos.
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- Memorandum of understanding for Personalised Care Network Sites. NHSE 2018
- Meeting the Prevention Challenge, East Midlands PHE and NHS Clinical Senate 2015
- Cumbria and Lancashire Population Health Model 2016